

2021

MARYLAND

VIRAL HEPATITIS EPIDEMIOLOGICAL PROFILE

2015 to 2019

CENTER FOR VIRAL HEPATITIS

Infectious Disease Prevention and Health Services Bureau
Prevention and Health Promotion Administration



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ABBREVIATIONS

ACS	American Community Survey
AIDS	Acquired Immune Deficiency Syndrome
Anti-HCV+	HCV Antibody Positive
Ant-HCV-	HCV Antibody Negative
ASTHO	Association of State and Territorial Health Officials
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
COMAR	Code of Maryland Regulations
CSTE	Council of State and Territorial Epidemiologists
CVH	Center for Viral Hepatitis
CSTE	Council of State and Territorial Epidemiologists
DAA	Direct-acting antiviral
DPSCS	Department of Public Safety and Correctional Services
eHARS	Enhanced HIV/AIDS Reporting System
HAV	Hepatitis A virus
HBV	Hepatitis B virus
HBI-DC	Hepatitis B Initiative of Washington DC
HBIG	Hepatitis B Immunoglobulin
HBsAG+	Hepatitis B surface antigen positive
HCV	Hepatitis C virus
HET	Heterosexual
HIV	Human Immunodeficiency Virus
HSCRC	Health Services Cost Review Commission
ICD-9	International Classification of Diseases, Ninth Revision
ICD-10	International Classification of Diseases, Tenth Revision
IDU	Injection Drug Use
IG	Immuno globulin
JHU	Johns Hopkins University
LTC	Linkage-to-care
LHD	Local Health Department
MAT	Medication-Assisted Treatment
MDH	Maryland Department of Health
MSM	Men who have Sex with Men
NEDSS	National Electronic Disease Surveillance System
NHANES	National Health and Nutrition Examination Survey
OTP	Opioid treatment program
PEP	Post exposure prophylaxis
PHPA	Prevention and Health Promotion Administration
PRISM	Patient Reporting Investigation Surveillance Manager
PVST	Post vaccine serologic testing
PWID	Persons who Inject Drugs
RNA	Ribonucleic Acid
SVR	Sustained Virologic Response
SAMHSA	Substance Abuse and Mental Health Services Administration
SSP	Syringe Service Programs
STC	Sharing the Cure
STI	Sexually Transmitted Infection
VHPC	Viral Hepatitis Prevention Coordinator

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EXECUTIVE SUMMARY

SURVEILLANCE

From 2015 to 2019:

233 Reported Cases of Hepatitis A

195 Reported Cases of Acute Hepatitis B

8,913 Reported Cases of Chronic Hepatitis B

178 Reported Cases of Acute Hepatitis C

24,580 Reported Cases of Chronic Hepatitis C

72,000 or 1.2% of Marylanders are Estimated to be Chronically Infected with Hepatitis C



HEPATITIS IN SPECIAL POPULATIONS



Among the people living in Maryland diagnosed with HIV:

2% Were Co-Infected With Hepatitis B

12% Were Co-Infected With Hepatitis C

In 2016, It was estimated there are:

6,200 Persons Who Inject Drugs Who Are HCV RNA Positive

From 2016 to 2019:

49 Known Hepatitis B Positive Inmates

8,288 Known Hepatitis C Positive Inmates

BURDEN OF DISEASE

Among Inpatient Hospitalizations from 2015 to 2018:

735 Were Any Diagnosis of HAV

4,543 Were Any Diagnosis of HBV

72,179 Were Any Diagnosis of HCV



Among reported deaths from:

22 Were HBV-related deaths

364 Were HCV-related deaths

Among reported cancer cases from 2015 to 2017:

1,636 Were liver cancer cases

290 Were intrahepatic bile duct cancer

HEPATITIS SCREENING

From 2015 to 2019 HBV Screening:

155 Unique Patients Tested HBSAG Positive

From 2015 to 2019 HBV Treatment:

109 HBSAG Positive Patients Treated for Hepatitis B



From 2017 to 2019 HCV Screening:

10,273 HCV Rapid Test Kits Administered

574 or 5.3% were anti-HCV Positive Patients

381 HCV RNA Positive Patients

From 2017 to 2019 HCV Linkage to Care:

151 Referred to/Already in Care

HEPATITIS C TREATMENT

From 2015 TO 2019 Maryland Community-Based Programs to Test and Cure Hepatitis C:

3,366 Patients seen by a Sharing the Cure Provider

2,876 or 85% Patients identified as infected with HCV

Among those patients currently infected with HCV:

1,124 Patients were prescribed HCV Treatment of which:

84% Patients completed treatment of which:

75% Patients were cured of HCV

BACKGROUND

DEMOGRAPHICS OF MARYLAND

Maryland is a state in the Mid-Atlantic region of the United States. To the south and west of Maryland are Virginia, West Virginia, and Washington, D.C; Pennsylvania to its north; and Delaware to its northeast. The state's largest city is Baltimore and the capital is Annapolis.

► **24** | Jurisdictions

► **23** | Counties

► **1** | Independent city

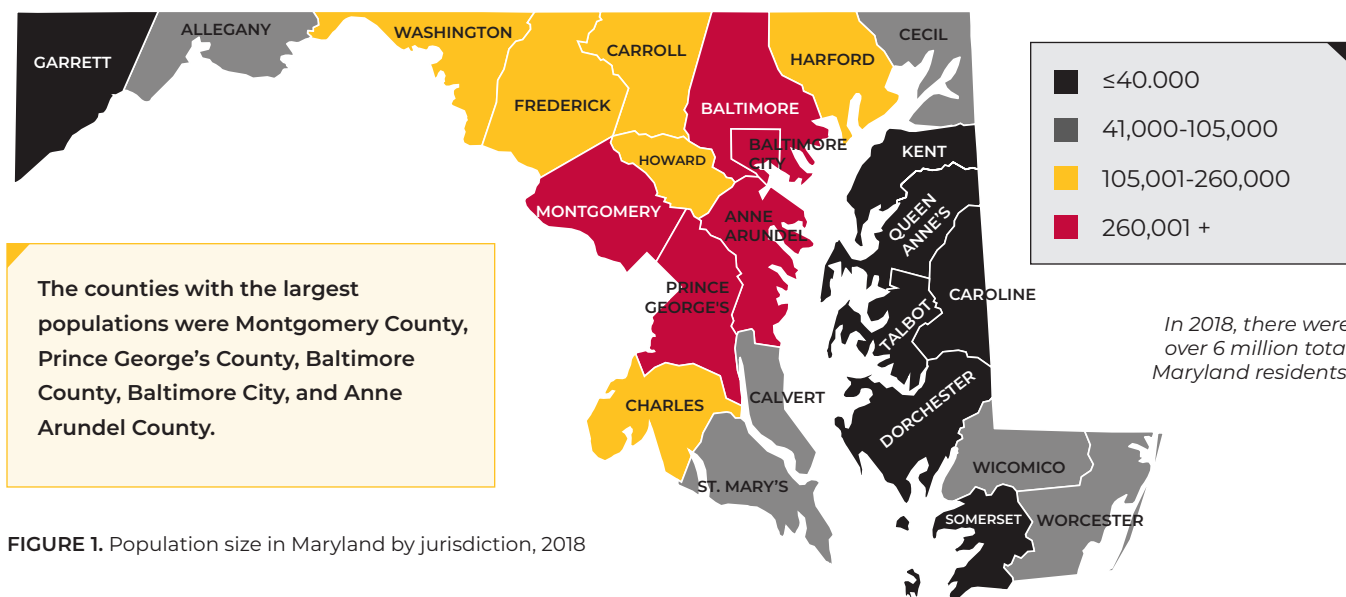


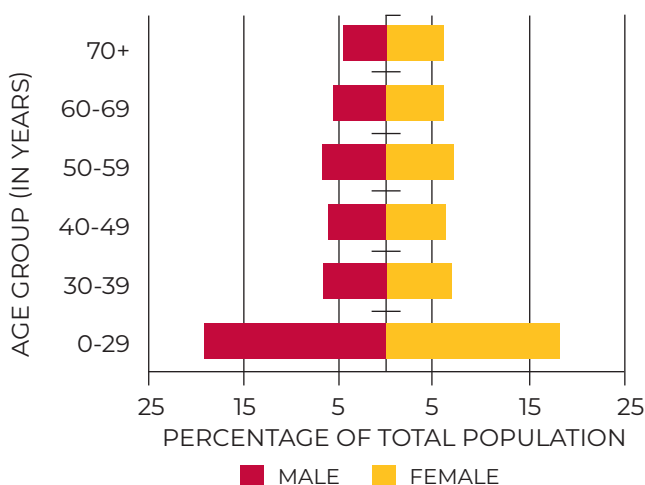
FIGURE 1. Population size in Maryland by jurisdiction, 2018

There is nearly a 50% female and 50% male distribution among Marylanders. More than half (64%) of Marylanders are 49 years or younger. Men aged 50 years or older accounted for 17% of Marylanders compared to 20% women in the same aged group. In 2018, there were more than 6 million total Maryland residents.

Maryland's population distribution by race/ethnicity does not closely resemble the national distribution. In 2018, approximately 50% of Marylanders identified as non-Hispanic White compared to 61% nationally and 30% of Marylanders identified as non-Hispanic Black compared to 12% nationally.

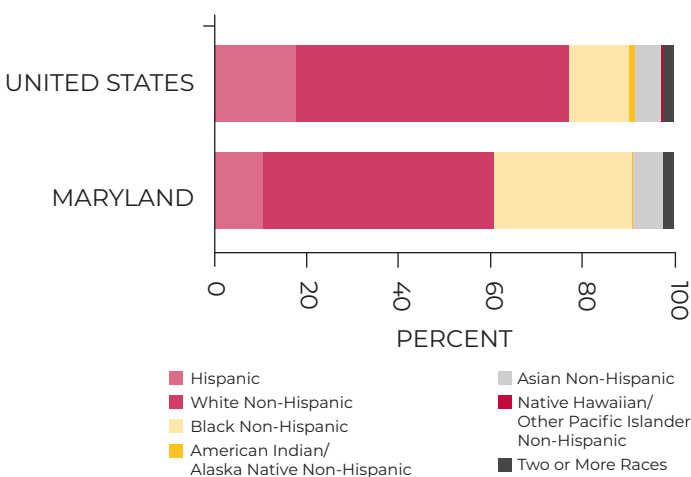
Characteristics of Maryland Residents by sex, age group, and racial group

FIGURE 2. Maryland residents by age group and sex, 2019



Source: Maryland Residents by Age Group and Sex, 2019

FIGURE 3. Race/ethnicity in Maryland Versus nationally, 2019



Source: 2019 U.S. Census Estimate

DEMOGRAPHICS OF MARYLAND

MEDIAN HOUSEHOLD INCOME

\$83,242

Overall, Maryland households earned a median income of 83,242 in 2018. The median income among Maryland counties varied from a high of \$117,730 in Howard County to \$42,165 in Somerset County in 2018.

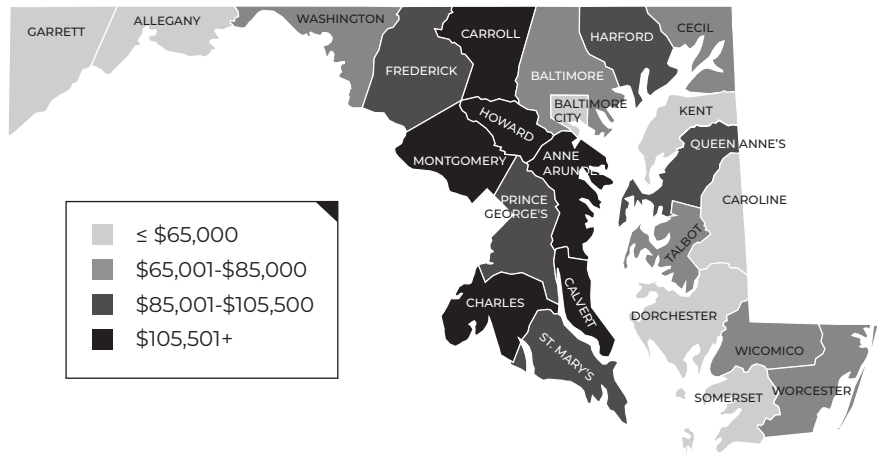
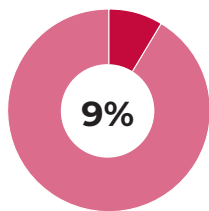


FIGURE 4. Median income of Maryland residents by jurisdiction, 2018
Source: 2018 American Community Survey

PEOPLE LIVING IN POVERTY



In 2018, 9% of Marylanders lived in poverty or had an annual income of less than \$12,140 for a single person or \$25,100 for a family of four.

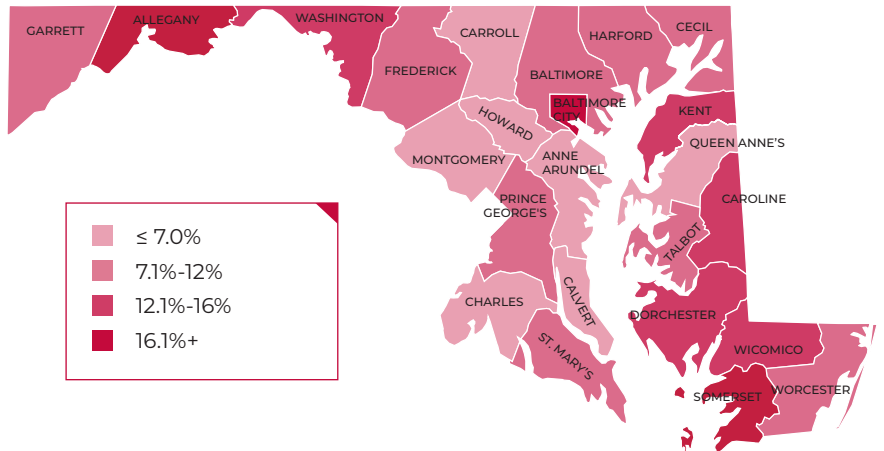
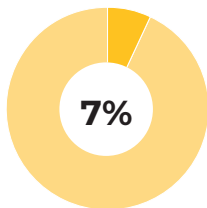


Figure 5. Percentage of Maryland residents living in poverty by jurisdiction, 2018
Source: 2018 American Community Survey

PEOPLE WITHOUT HEALTH INSURANCE COVERAGE



In Maryland, 7% of residents were living without health insurance coverage. The highest percentage of Marylanders living without health insurance coverage was reported in Prince George's County at 11%.

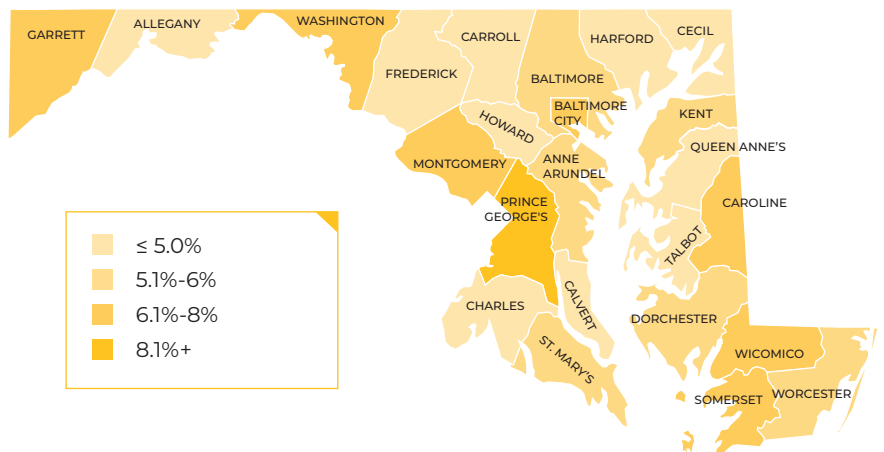


Figure 6. Percentage of Maryland residents without health insurance coverage by jurisdiction, 2018
Source: 2018 American Community Survey

VIRAL HEPATITIS SURVEILLANCE AND EPIDEMIOLOGY IN MARYLAND

REPORTING REQUIREMENTS

Maryland National Electronic Disease Surveillance System

Maryland statute, specifically Maryland Code Annotated, Health-General §§18-201 and 18-202 requires reporting of certain conditions to public health, including hepatitis A, B and C. The Code of Maryland Regulations (COMAR) 10.06.01.03 C details the diseases, conditions, outbreaks, and unusual manifestations that are reportable to Maryland. Electronic laboratory reports of viral hepatitis A, B, and C test results are sent directly to Maryland's National Electronic Disease Surveillance System (NEDSS). Paper laboratory and provider test results are sent to local health departments, for manual entry into NEDSS.

HEPATITIS A

Hepatitis A is a liver disease caused by an infection from the Hepatitis A virus (HAV). HAV is an acute liver disease that can be cleared by the immune system when the infection is mild, however severe infections may require medical treatment.

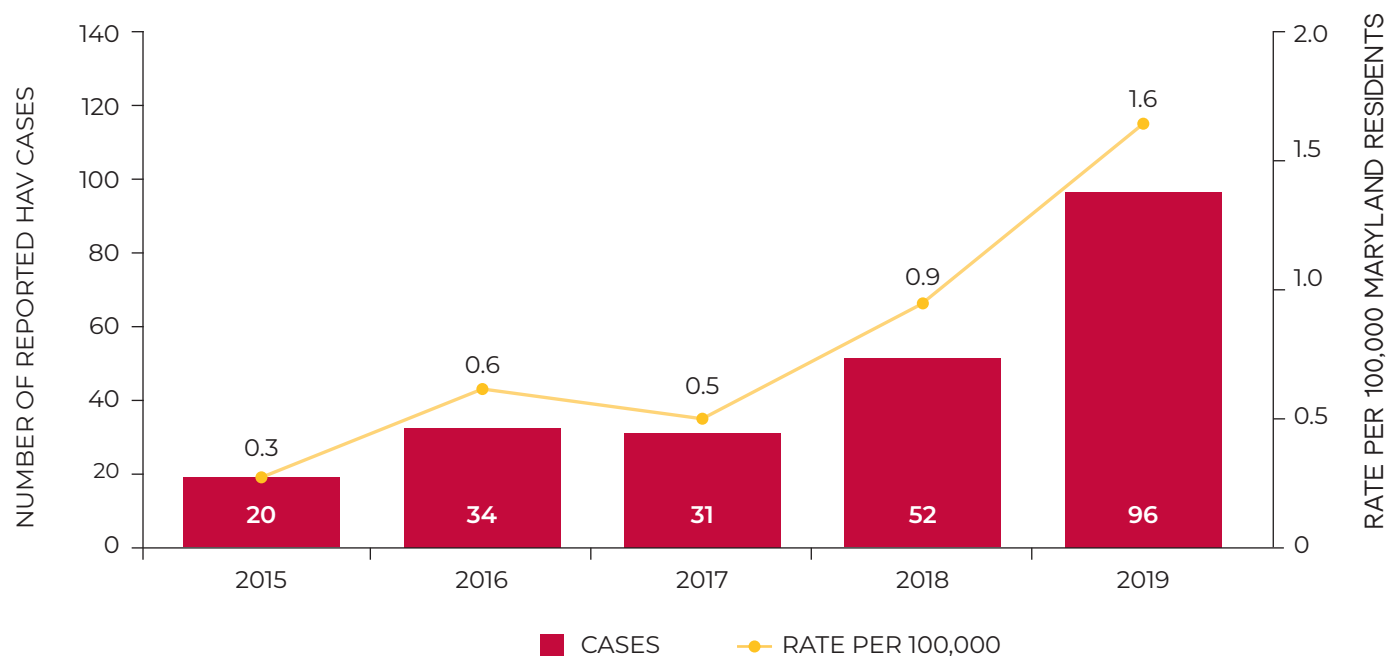
Reported Hepatitis A Viral Infections

► **233** | Reported cases of **hepatitis A** during 2015-2019

► **3.9** | Rate of reported cases of **hepatitis A** per 100,000 residents from 2015-2019

New infections or hepatitis A virus (HAV) cases have increased in Maryland since 2015.

Figure 7. Reported number and rate of hepatitis A cases in Maryland by year, 2015-2019

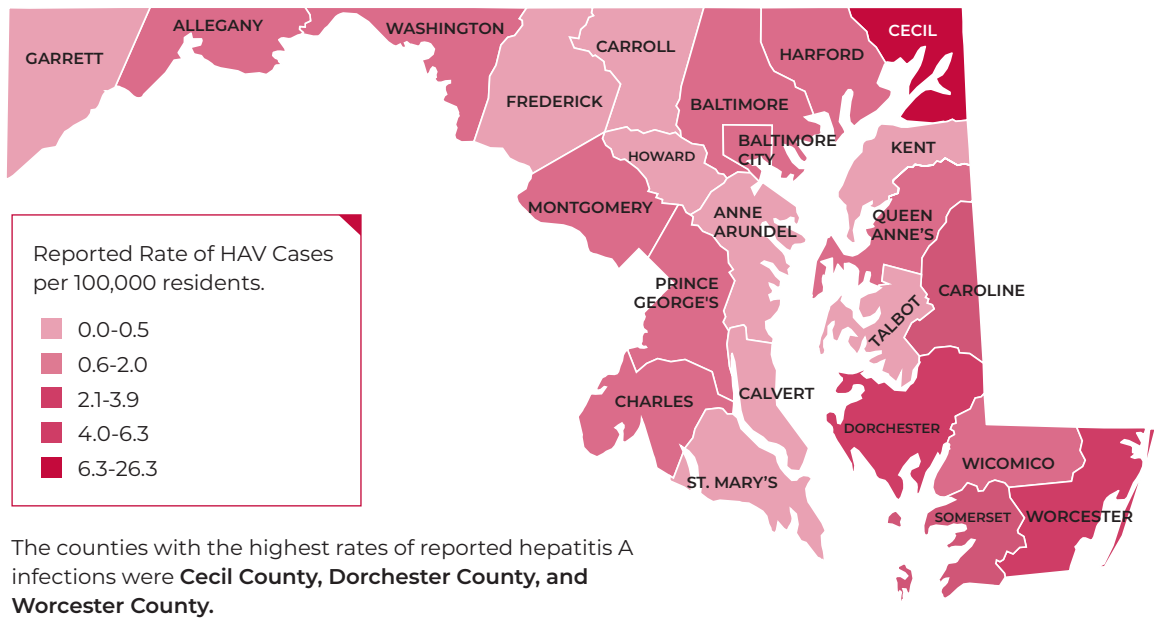


Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019

HEPATITIS A

Geographical Distribution of Hepatitis A

Figure 8. Reported rate of HAV cases in Maryland by jurisdiction, 2019

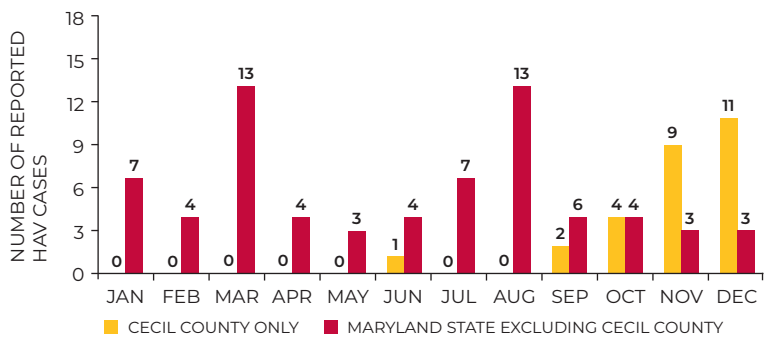


Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2019

2019 Cecil County Hepatitis A Outbreak

In December 2019, an outbreak of Hepatitis A was declared in Cecil County among persons experiencing homelessness and persons who inject drugs. More than 75% of cases associated with this outbreak reported some drug use including injection drug use.

Figure 9. Number of hepatitis A cases in Cecil County and Maryland by month, 2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2019

Health Department Recommendations

Vaccination is the best way to protect against hepatitis A. Two doses of the vaccine given 6 months apart are needed for full, long term protection. The vaccine is routinely recommended for persons 12 months of age and older:

- All children at age 1 year (i.e. 12-23 months)
- Men who have sex with men
- Persons with chronic (lifelong) liver disease, such as hepatitis B & C
- Travelers to countries that have high rates of hepatitis A
- Users of injection and non-injection drugs
- People with clotting factor disorders, such as hemophilia
- Persons who work with HAV in a laboratory setting

Good personal hygiene is another prevention measure. Wash hands with soap and water:

- After using the toilet or changing diapers.
- Before preparing any food or drink and before eating.

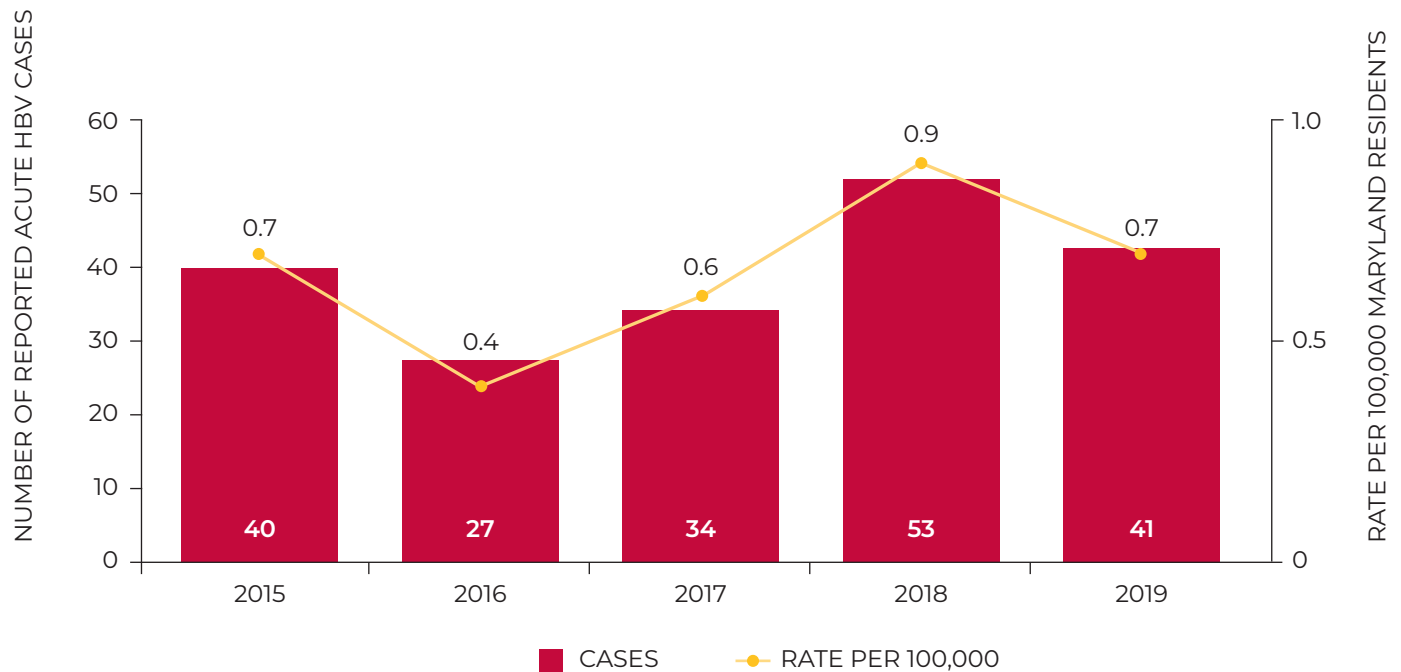
HEPATITIS B

Hepatitis B is a liver disease caused by an infection from the Hepatitis B virus (HBV). HBV attacks the liver and can cause both acute and chronic disease.

Reported Acute Hepatitis B Viral Infections



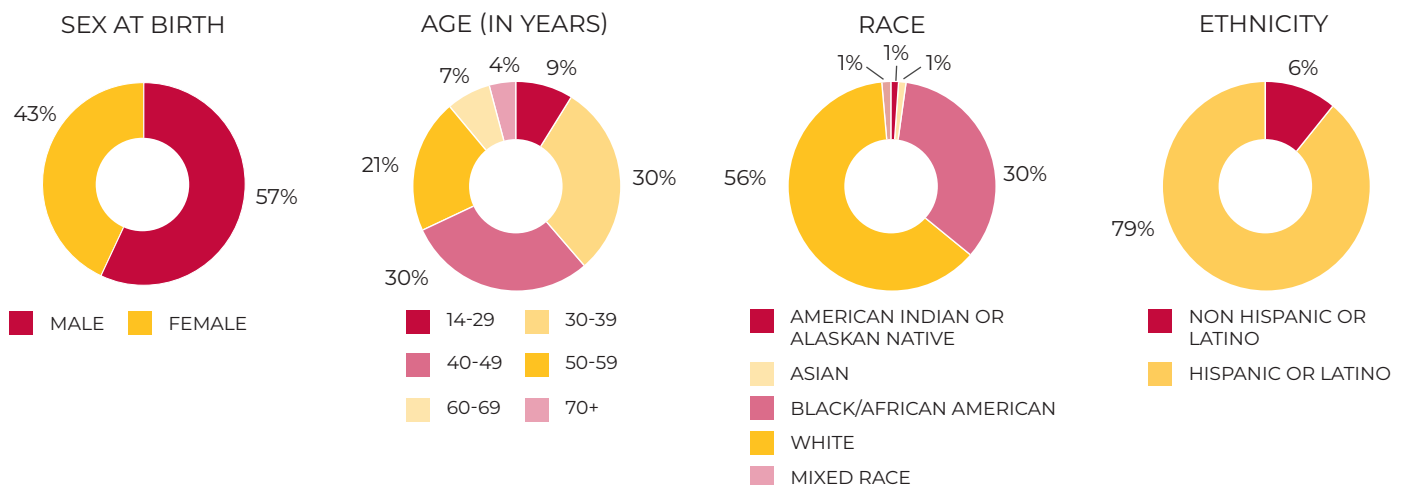
Figure 10. Reported number and rate of acute hepatitis B cases in Maryland by year, 2015-2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019

Characteristics of Acute Hepatitis B Viral Infections

Figure 11. Percentage of people reported with acute hepatitis B by sex, age, race, and ethnicity in Maryland, 2015-2019

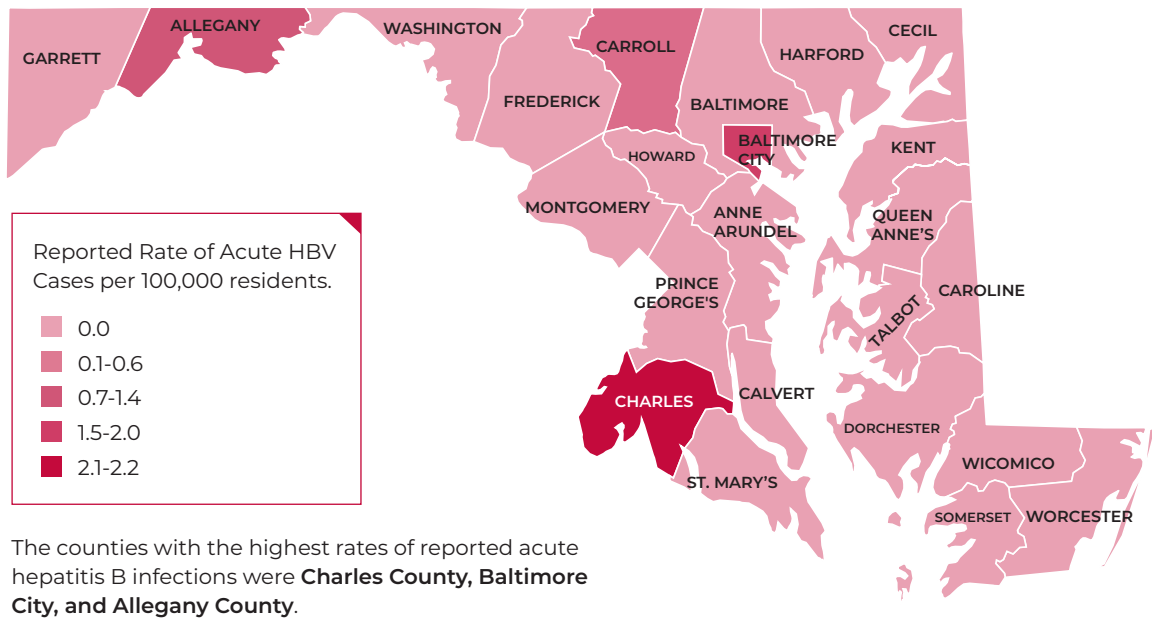


Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019

HEPATITIS B

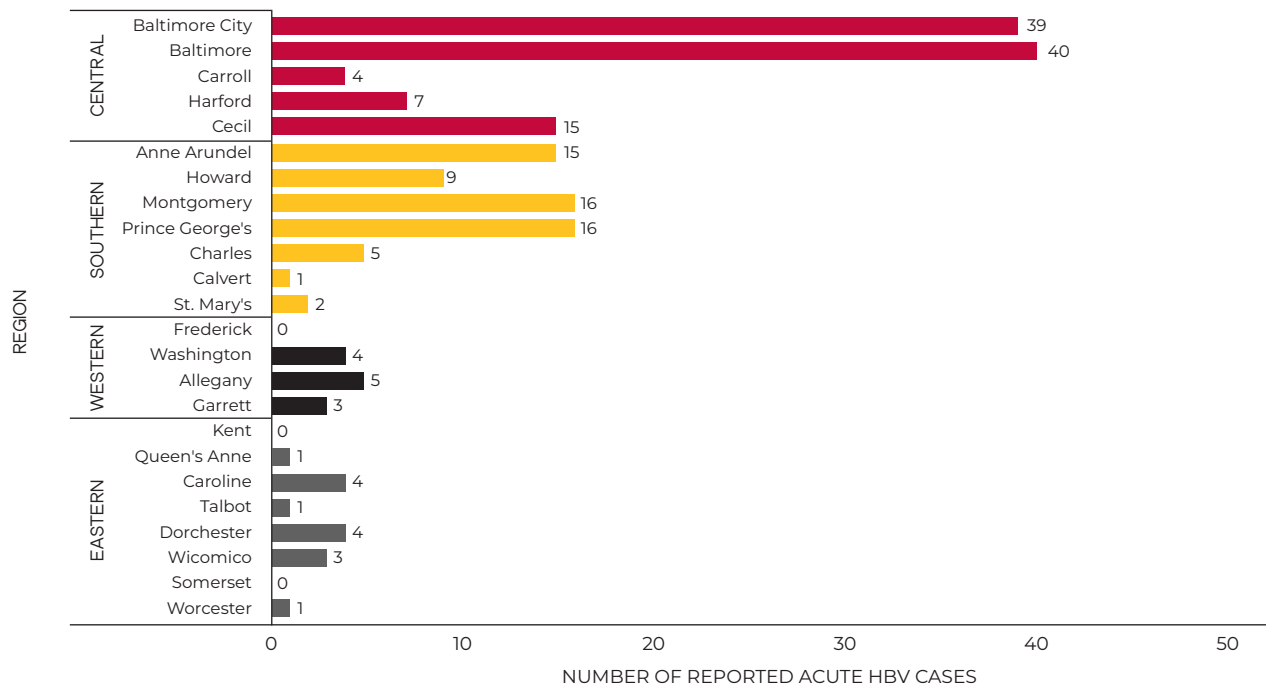
Geographical Distribution of Acute Hepatitis B

Figure 12. Reported rate of acute HBV cases in Maryland by jurisdiction, 2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2019

Figure 13. Reported number of acute HBV cases in Maryland by region, 2015-2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015-2019

HEPATITIS B

Reported Chronic Hepatitis B Viral Infections

►

8,913

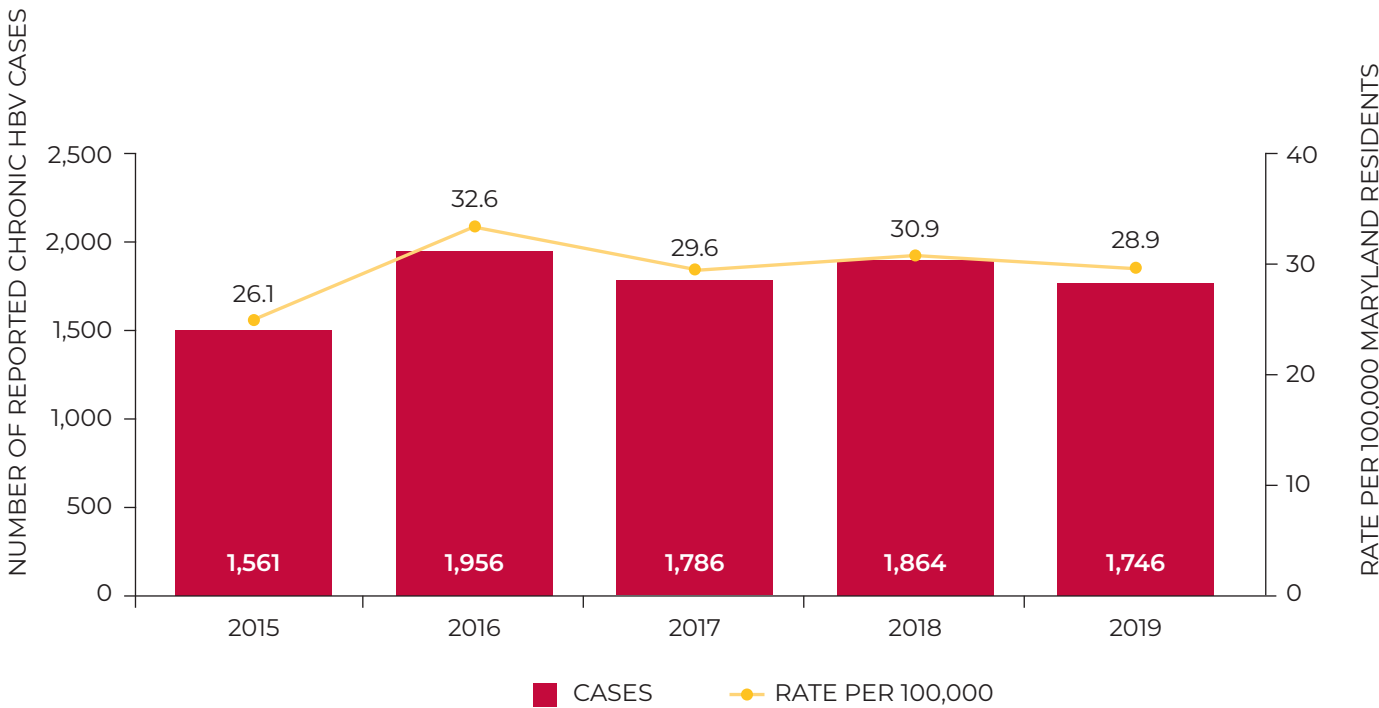
Reported cases of chronic hepatitis B during 2015-2019

►

148.0

Rate of reported cases of chronic hepatitis B per 100,000 residents from 2015-2019

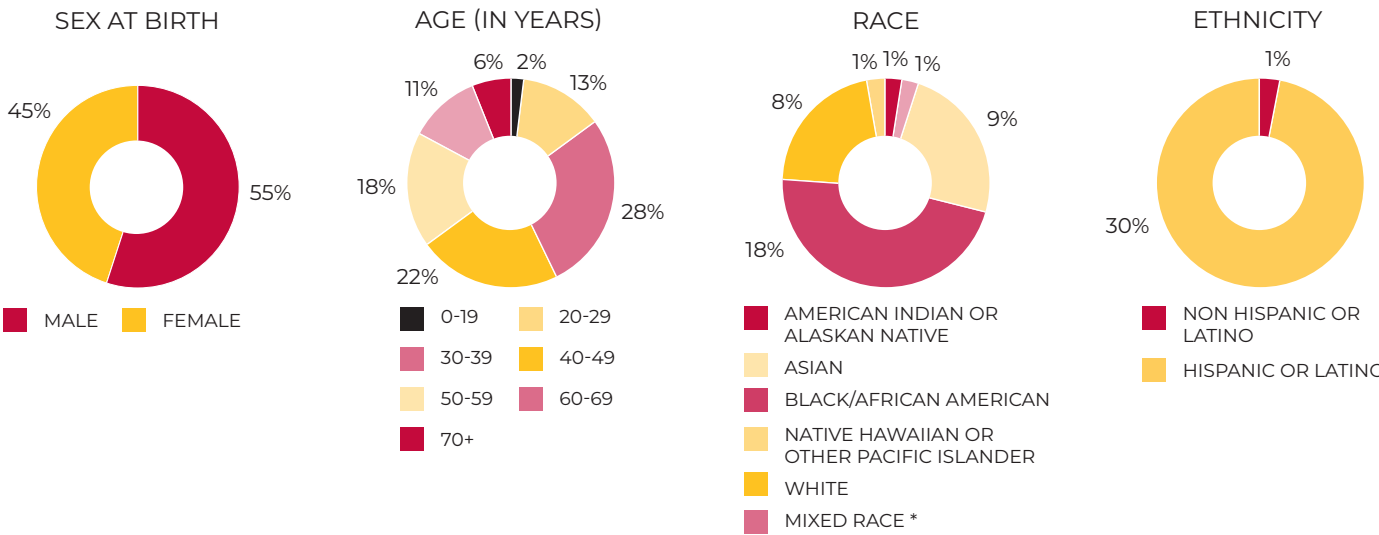
Figure 14. Reported number and rate of chronic hepatitis B cases in Maryland by year, 2015-2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019

Reported Chronic Hepatitis B Viral Infections

Figure 15. Percentage of people reported with chronic hepatitis B by sex, age, race, and ethnicity in Maryland, 2015-2019*

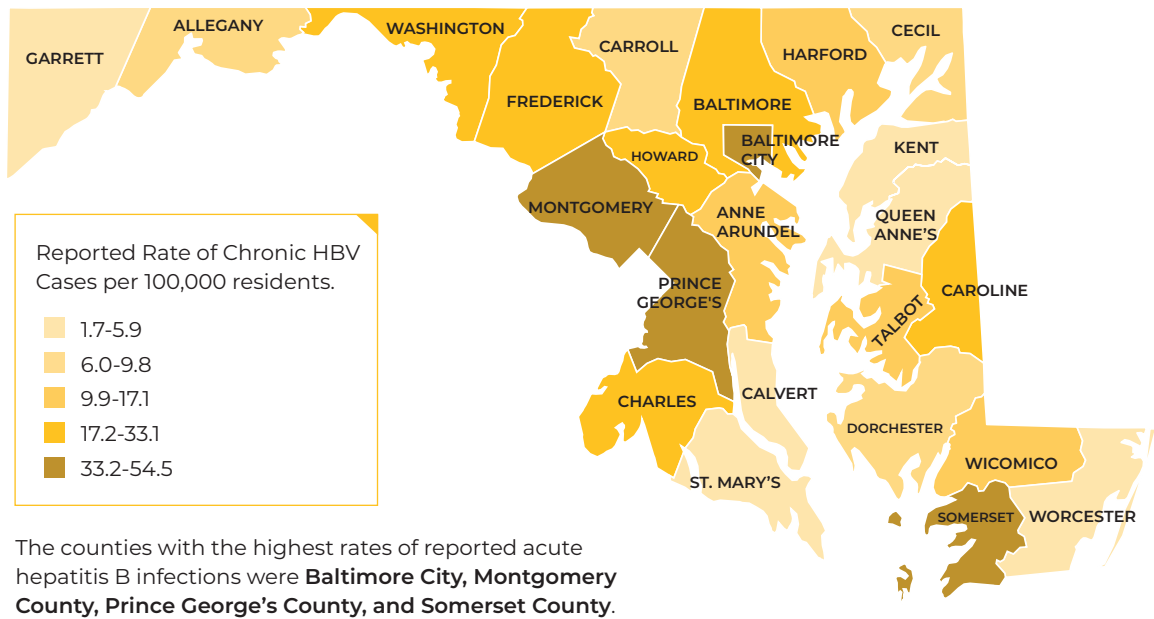


Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019

HEPATITIS B

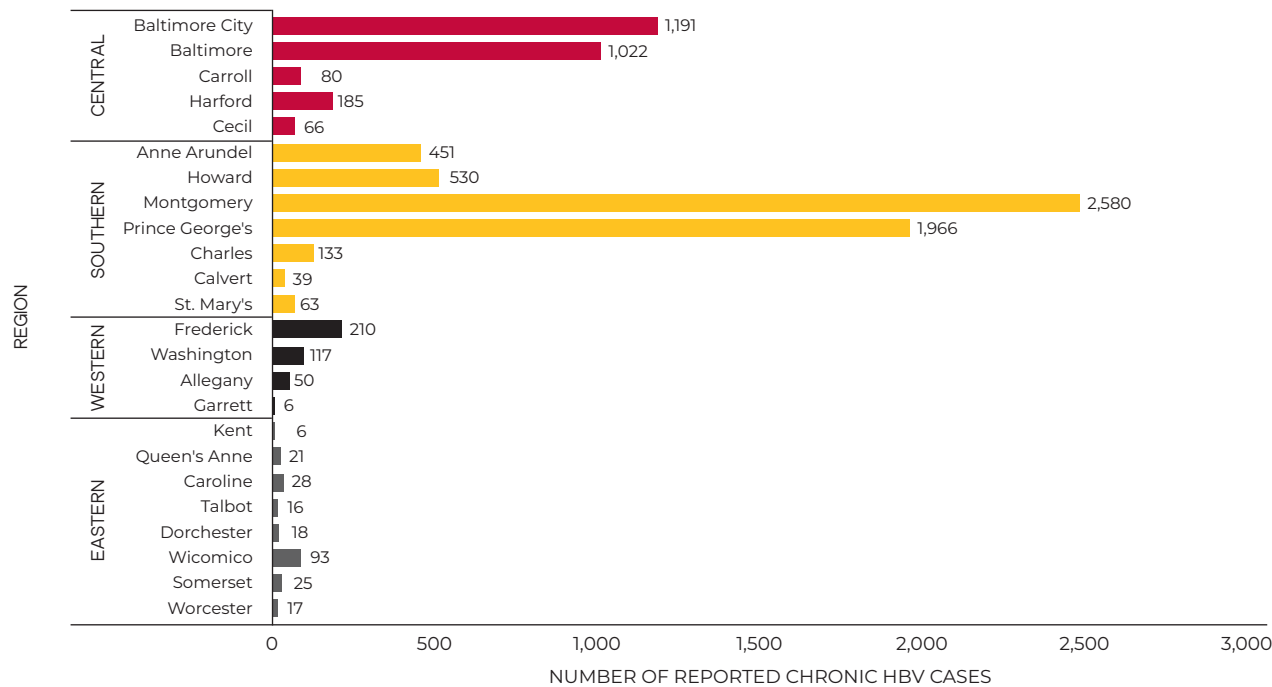
Geographical Distribution of Chronic Hepatitis B

Figure 16. Reported rate of chronic HBV cases in Maryland by jurisdiction, 2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2019

Figure 17. Reported Number of Chronic HBV Cases in Maryland by Region, 2015-2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015-2019

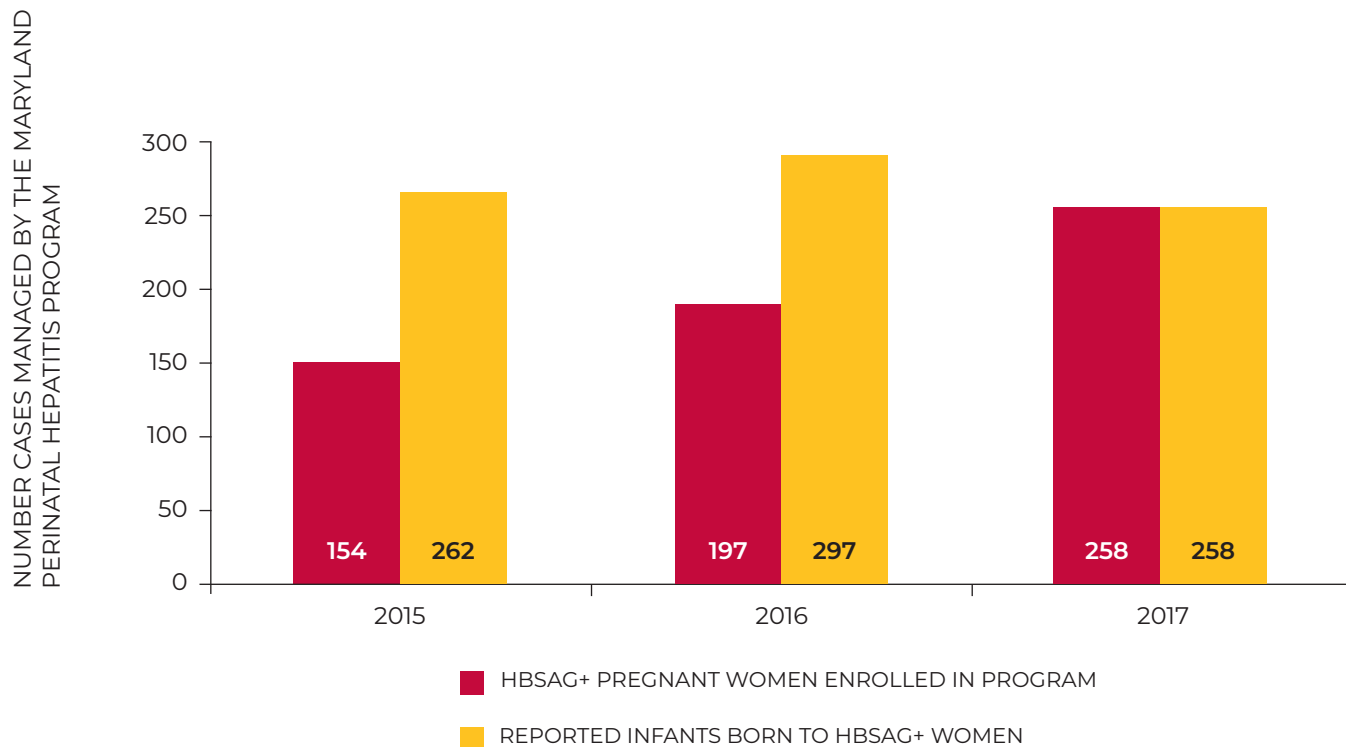
MARYLAND PERINATAL HEPATITIS B PROGRAM

Maryland Department of Health (MDH) provides case management to hepatitis B surface antigen positive (HBsAg+) pregnant Maryland residents. HBsAg+ pregnant women are enrolled in the Maryland Perinatal Hepatitis B Program and case managed through the duration of their pregnancy. After delivery, infants born to these mothers receive case management through the completion of post-vaccination serology testing (PVST).

► **609** | HBsAg+ women enrolled in the Maryland Perinatal Hepatitis B Program with a delivery due date between 2015 to 2017.

► **809** | Infants case managed by the Maryland Perinatal Hepatitis B Program born between 2015 to 2017.

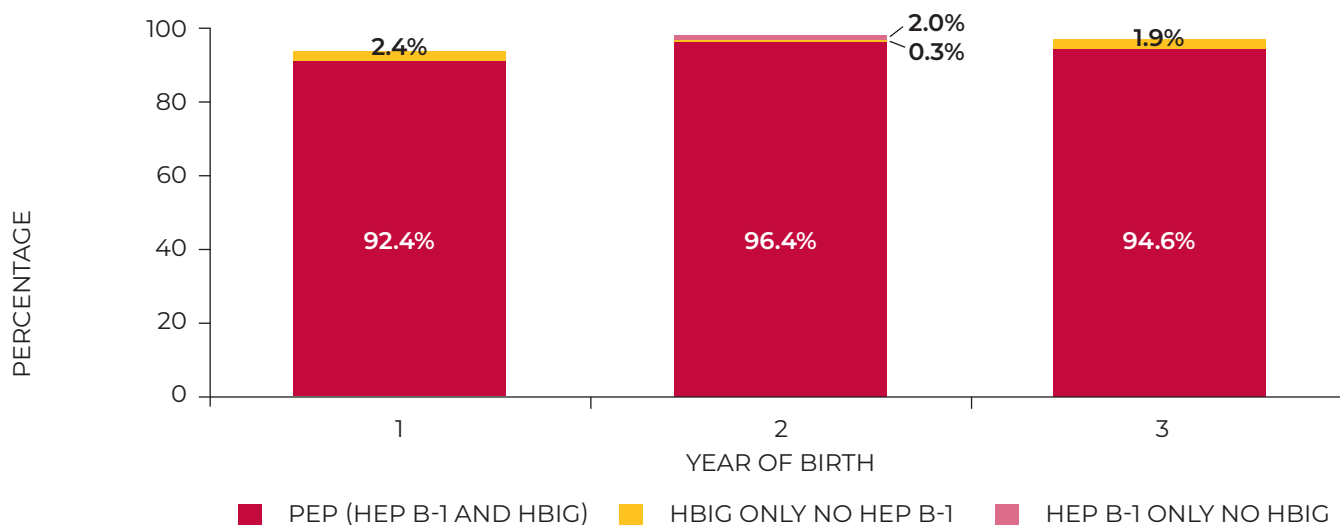
Figure 18. Number of HBsAg+ women enrolled and infants case managed in Maryland's Perinatal Hepatitis B Program by year, 2015-2017



Source: Center for Disease Control and Prevention - National Center for Immunization and Respiratory Diseases Annual Immunization Progress Report Annual Assessment of Progress Towards Goals to Prevent Perinatal Hepatitis B Transmission, Maryland Calendar Year 2015-2017

MARYLAND PERINATAL HEPATITIS B PROGRAM

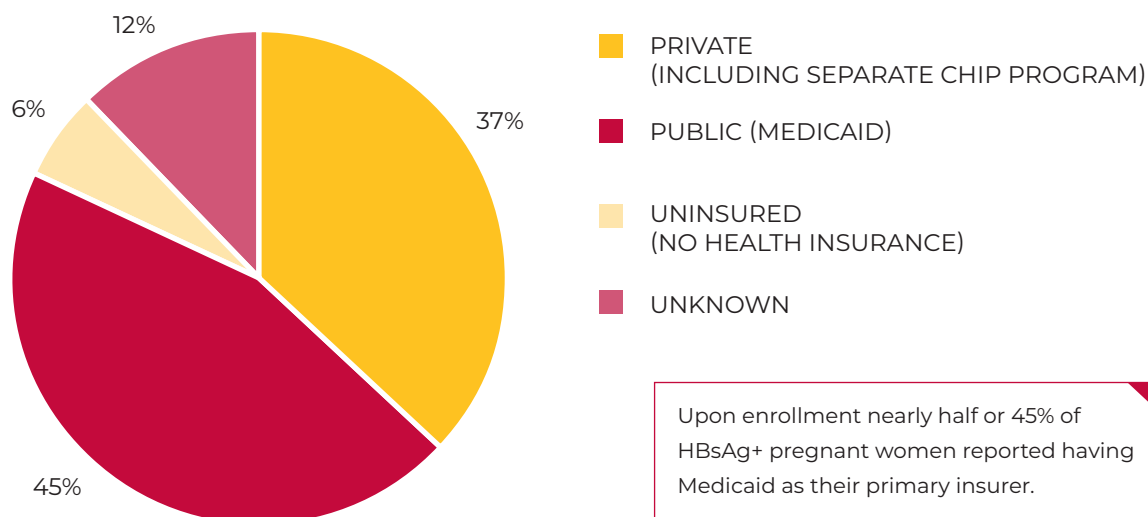
Figure 19. Receipt of recommended post-exposure prophylaxis within 1 calendar day of birth among infants case managed by Maryland's Perinatal Hepatitis B Program, 2015-2017



Source: Center for Disease Control and Prevention - National Center for Immunization and Respiratory Diseases Annual Immunization Progress Report Annual Assessment of Progress Towards Goals to Prevent Perinatal Hepatitis B Transmission, Maryland Calendar Year 2015-2017

Hepatitis B vaccine birth dose (hep B-1) was administered to 97% of infants within 1 calendar day of birth who were case managed by the program. Post-exposure prophylaxis, defined as receiving hep B-1 and hepatitis B immunoglobulin (HBIG) administration within 1 calendar day of birth increased from 92.4% in 2015 to 94.6% in 2017.

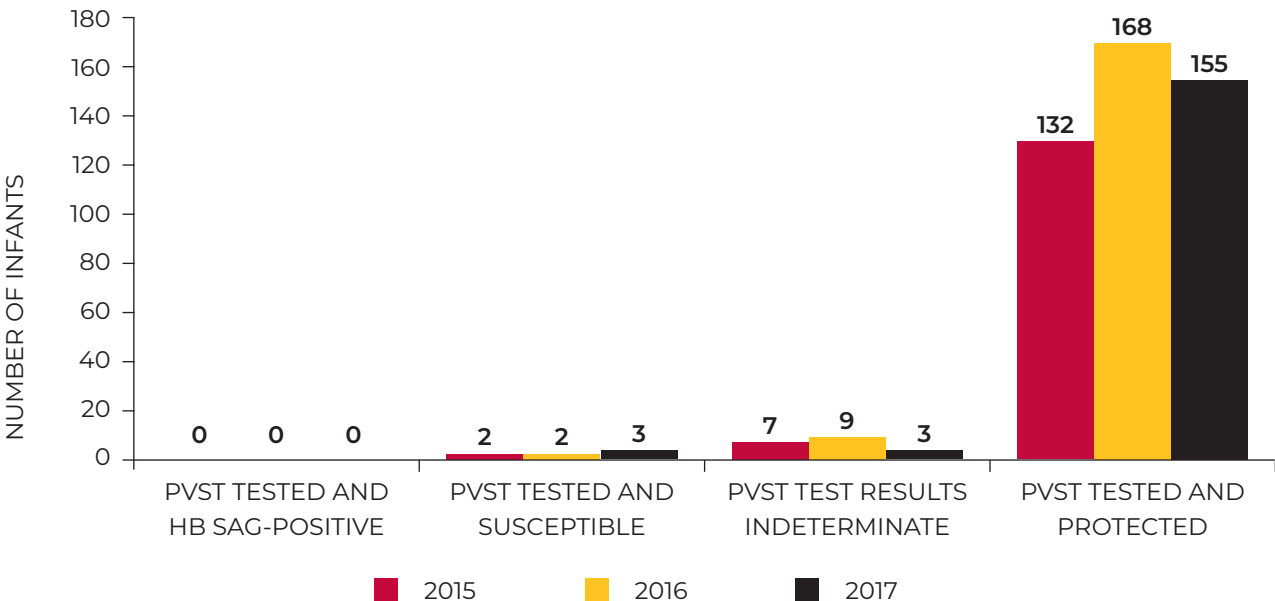
Figure 20. Insurance status among HBsAg positive pregnant women enrolled in Maryland's Perinatal Hepatitis B Program, with a delivery between 2015-2017



Source: Center for Disease Control and Prevention - National Center for Immunization and Respiratory Diseases Annual Immunization Progress Report Annual Assessment of Progress Towards Goals to Prevent Perinatal Hepatitis B Transmission, Maryland Calendar Year 2015-2017

MARYLAND PERINATAL HEPATITIS B PROGRAM

Figure 21. Post-vaccination serologic testing results among infants case managed by Maryland's Perinatal Hepatitis B Program, 2015-2017



Source: Center for Disease Control and Prevention - National Center for Immunization and Respiratory Diseases Annual Immunization Progress Report Annual Assessment of Progress Towards Goals to Prevent Perinatal Hepatitis B Transmission, Maryland Calendar Year 2015-2017

Hepatitis B vaccine series completion within 12 months of age was reported for 75% of infants. Post-vaccination serologic testing or PVST results were reported for 489 infants from 2015 to 2017. PVST results indicated that 93% of infants developed HBV immunity after the first vaccination series.

Health Department Recommendations

- All pregnant women should be routinely tested for hepatitis B surface antigen (HBsAg) during an early prenatal visit in each pregnancy.
- HBsAg testing should be repeated if the woman has never been vaccinated and has risk factors of hepatitis B virus infection such as an STI, injection drug use or history, or multiple sex partners. If a risk factor has been identified during pregnancy, the woman should be started on the hepatitis B vaccine series right away.
- A woman with an acute case of hepatitis B she should be retested for HBsAg and antibody to the surface antigen later in the pregnancy to determine either recovery or carrier status.

HEPATITIS C

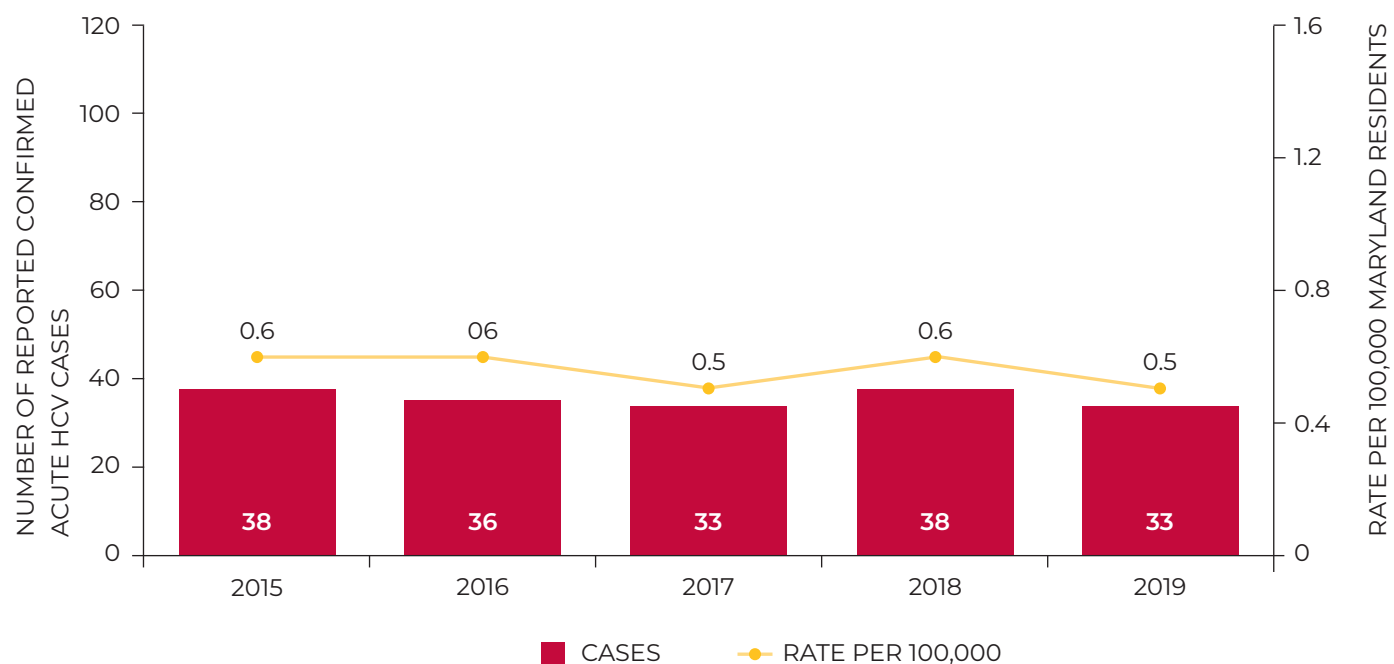
Hepatitis C is a liver disease caused by an infection from the Hepatitis C virus (HCV). HCV is the most common bloodborne infection in the United States.

Reported Acute Hepatitis C Viral Infections

► **178** | Reported confirmed cases of acute hepatitis C during 2015-2019

► **3.0** | Rate of reported cases of acute hepatitis C per 100,000 residents from 2015-2019

Figure 22. Reported number and rate of confirmed acute hepatitis C cases in Maryland by year, 2015-2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019

HEPATITIS C

Characteristics of Acute Hepatitis C Viral Infections

Figure 23. Percentage of people reported with confirmed acute hepatitis C by sex, age, and birth cohort in Maryland, 2015-2019

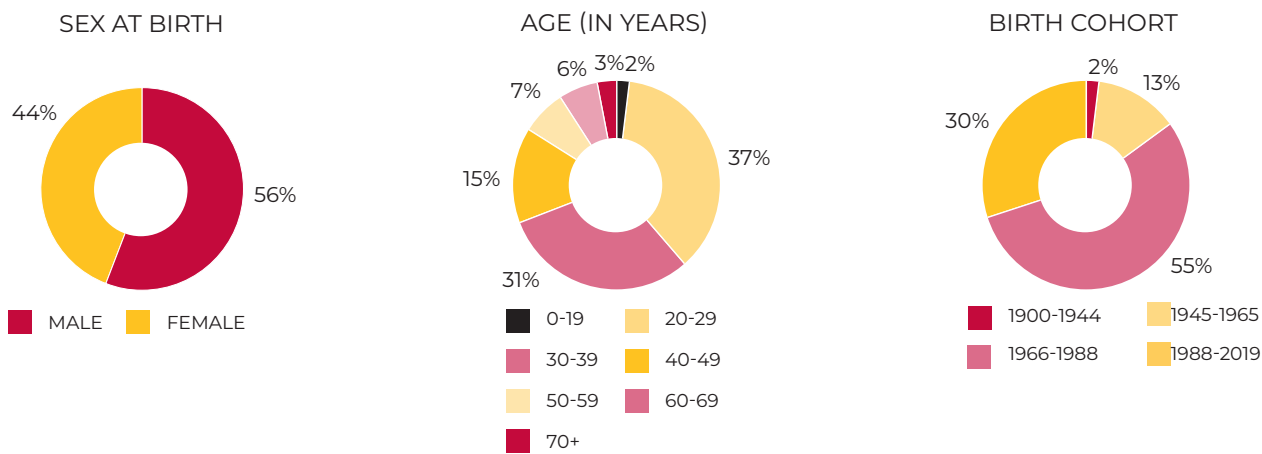
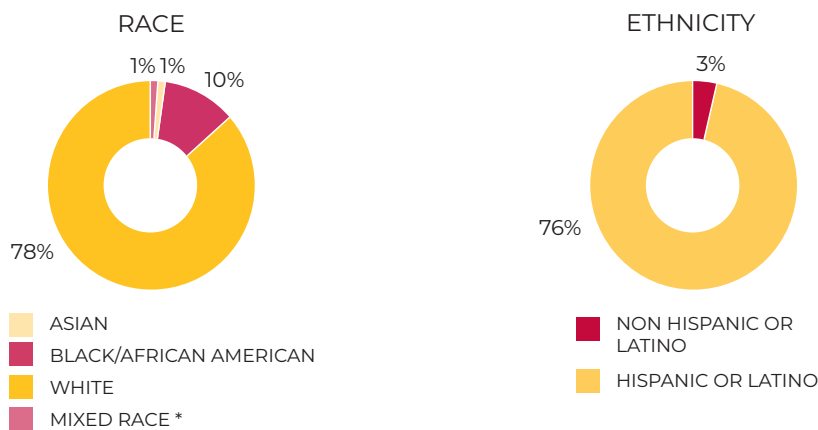


Figure 24. Percentage of people reported with confirmed acute hepatitis C by race and ethnicity in Maryland, 2015-2019*

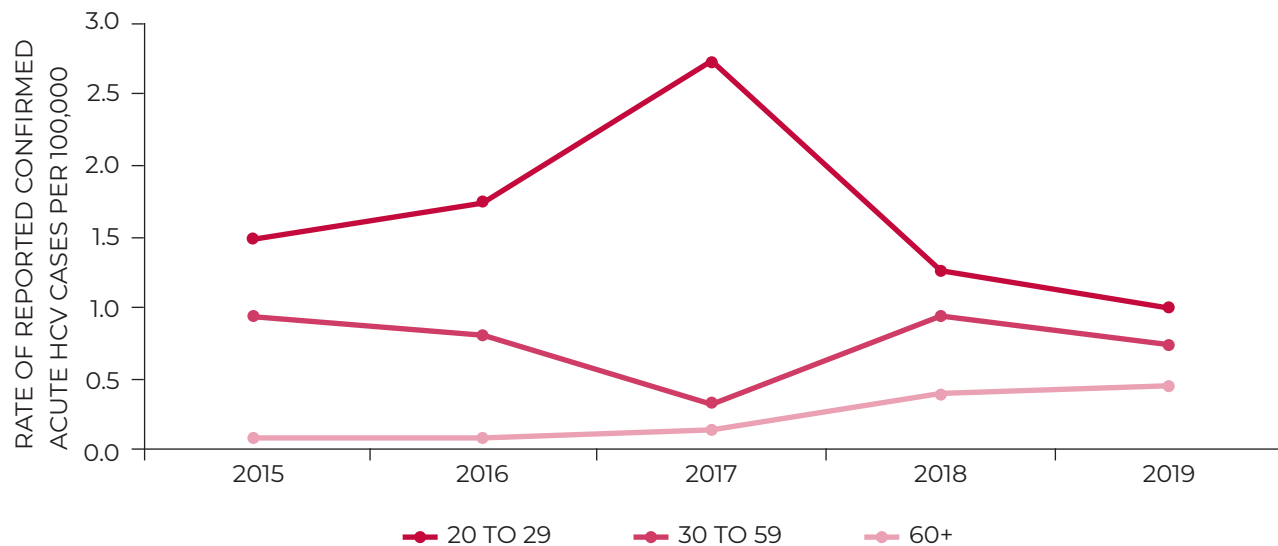


Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019

HEPATITIS C

Characteristics of Acute Hepatitis C Viral Infections

Figure 25. Rate of reported confirmed acute hepatitis C cases stratified by age group in Maryland by year, 2015-2019

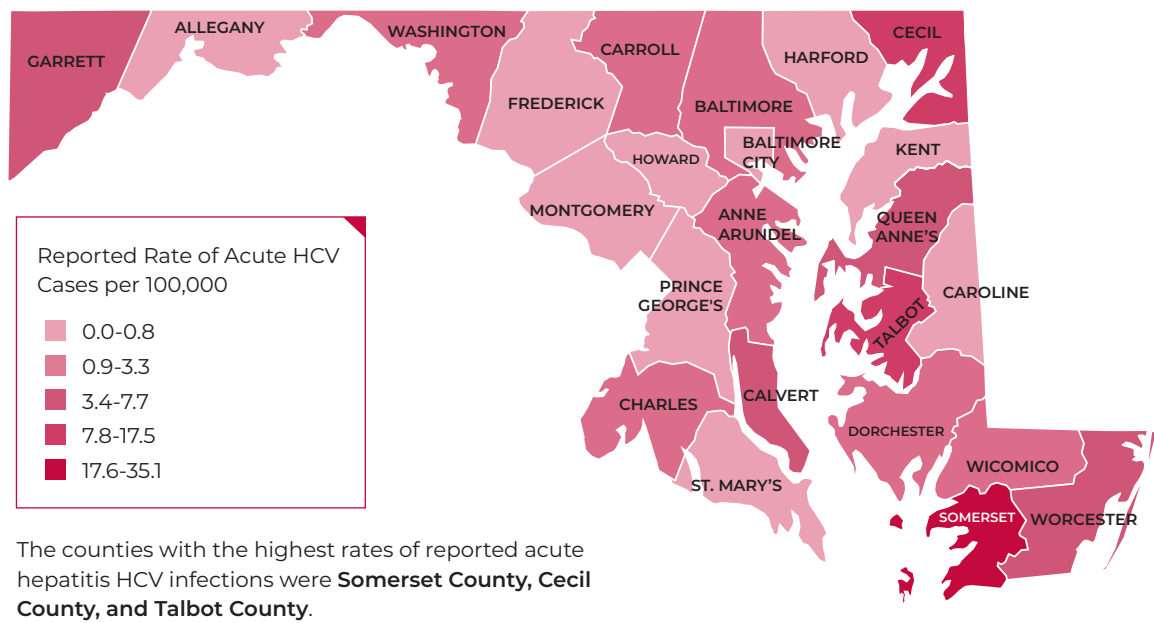


Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2019

HEPATITIS C

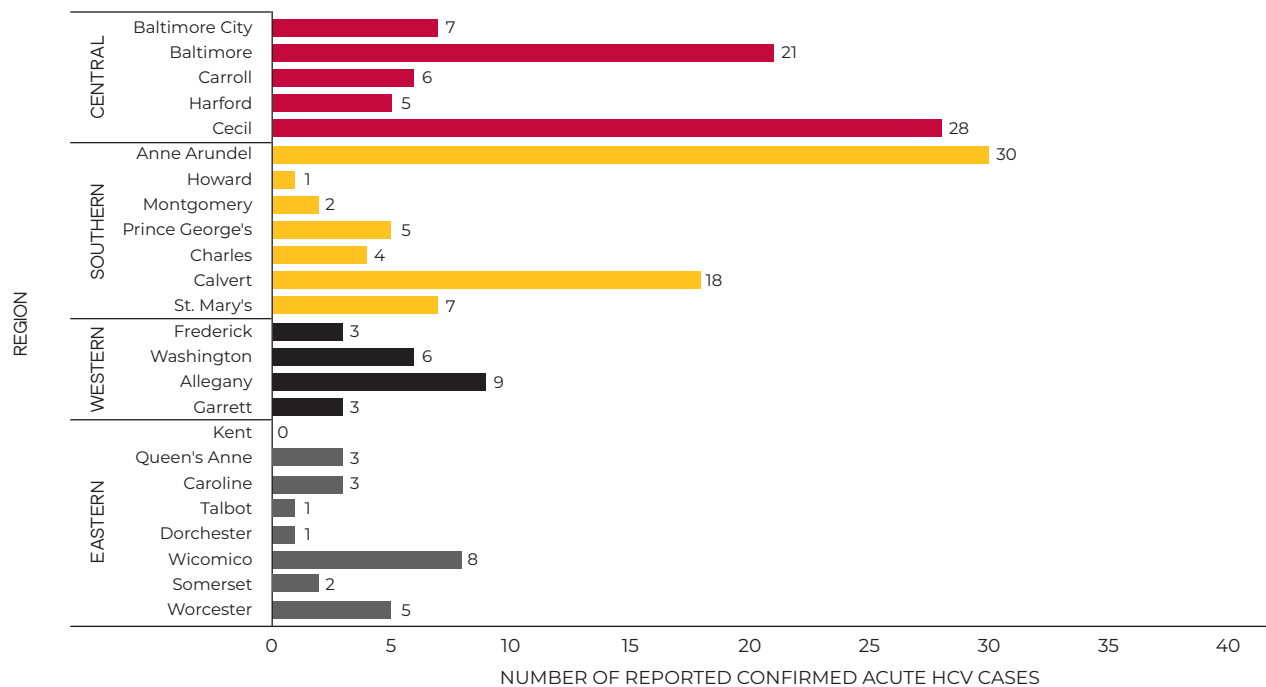
Geographical Distribution of Acute Hepatitis C

Figure 26. Reported rate of confirmed acute HCV cases in Maryland by jurisdiction, 2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2019

Figure 27. Reported number of confirmed acute HCV cases in Maryland by region, 2015-2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015-2019

HEPATITIS C

Prevalence of Chronic Hepatitis C

► **72,000** Marylanders are estimated to be **chronically infected with HCV** as of 2017 **OR** ► **1.2%** Marylanders are estimated to be **chronically infected with HCV** as of 2017

In 2018, the Center for Disease Analysis Foundation (CDAF) conducted an analysis using data from Maryland Department of Health (MDH), the Maryland Department of Public Safety and Correctional Services (DPSCS), the Johns Hopkins University (JHU), Association of State and Territorial Health Officials (ASTHO), Centers for Disease Control (CDC), and CDAF. In this analysis CDAF quantified and estimated the prevalence of hepatitis C and the prevalence of individuals chronically infected with HCV in Maryland as of 2010. These estimates were calculated using CDC guidelines adjusting values from the National Health and Nutritional Examination Survey (NHANES) data by including estimates of people who inject drugs (PWID), incarcerated, active-duty military, unsheltered homeless, and nursing home populations. It was initially estimated 1.4% or approximately 83,500 individuals are chronically infected with HCV in Maryland as of 2010.

TABLE 1. MARYLAND HEPATITIS C CHRONICALLY INFECTED PREVALENCE ESTIMATE ANALYSIS UTILIZING 2010 NATIONAL HEALTH AND NUTRITIONAL EXAMINATION SURVEY DATA AND ADDITIONAL POPULATIONS DATA CONDUCTED BY CENTER FOR DISEASE ANALYSIS FOUNDATION, 2010

2010 HCV RNA PREVALENCE‡			
POPULATION	POPULATION†	NUMBER	PREVALENCE
NHANES, 2003-2010	5,583,065*	60,000 (57,600 – 72,000)	1.1% (1.0% - 1.3%)
Additional populations			
Unsheltered homeless ²	31,000	5,100 (3,900 – 5,900)	16.3% (12.5% - 18.9%)
Incarcerated ³	131,894	19,000 (10,700 – 22,600)	14.4% (8.1% - 17.1%)
Active-duty military ⁴	28,888	120 (120 - 210)	0.4% (0.4% - 0.7%)
Nursing homes ⁵	23,347	900 (420 – 1,700)	3.9% (1.8% - 7.2%)
Additional Populations (subtotal)†	205,519	23,500	11.4%
Total†	5,788,584	83,500 (74,100 – 97,200)	1.4% (1.3% - 1.7%)

* Adjusted to exclude additional populations

† Values may not sum to column subtotal and total due to rounding and adjustment for overlap among homeless and incarcerated population
‡ Parenthesis indicate 95% Confidence Interval (NHANES, Active-duty military, Nursing Homes), Low/high Range (Unsheltered homeless, Incarcerated), and 95% Uncertainty Interval (Total)

1 Population sources: Center for Poverty Solutions; Bureau of Justice Statistics; DoD Defense Manpower Data Center; Data current as of Sept. 30, 2017; Kaiser Family Foundation

Prevalence sources:

2 Schwarz K, Garrett B, Alter MJ, et al., Seroprevalence of HCV Infection in Homeless Baltimore Families. Journal of Health Care for the Poor and Underserved 2008; 19:580-587

3 MD Department of Corrections

4 Hyams KC, Riddle J, Rubertone M, et al. Prevalence and incidence of hepatitis C virus infection in the US military: a seroepidemiologic survey of 21,000 troops. Am J Epidemiol. 2001;153(8):764–70.

5 Chien NT, Dundoo G, Horani MH, Osmack P, Morley JH, Di Bisceglie AM. Seroprevalence of viral hepatitis in an older nursing home population. J Am Geriatr Soc. 1999;47(9):1110–3.

Source: Center for Disease Analysis Foundation “Public health impact of a population based approach to HCV treatment in Maryland” in collaboration with Association of State and Territorial Health Officials, the Centers for Disease Control and Prevention, Maryland Department of Health, Maryland Department of Public Safety and Correctional Services, and the Johns Hopkins University Report, 2018

HEPATITIS C

Prevalence of Chronic Hepatitis C

The 2010 chronically infected HCV prevalence estimate was utilized in a model to estimate a more updated prevalence estimate. **Based on continued modeling and updated data it was estimated 1.2% or approximately 72,000 individuals are chronically infected with HCV in Maryland as of 2017.**

TABLE 2. MARYLAND HEPATITIS C CHRONICALLY INFECTED PREVALENCE MODELING ESTIMATE AS OF 2017 CONDUCTED BY CENTER FOR DISEASE ANALYSIS FOUNDATION, 2017

2017 HCV RNA PREVALENCE ‡		
	NUMBER	PREVALENCE
2017 HCV RNA Prevalence	72,000 (45,100 – 83,400)	1.2% (0.74% - 1.37%)

‡ Parenthesis indicate 95% Confidence Interval

Source: Center for Disease Analysis Foundation “Public health impact of a population based approach to HCV treatment in Maryland” in collaboration with Association of State and Territorial Health Officials, the Centers for Disease Control and Prevention, Maryland Department of Health, Maryland Department of Public Safety and Correctional Services, and the Johns Hopkins University Report, 2018

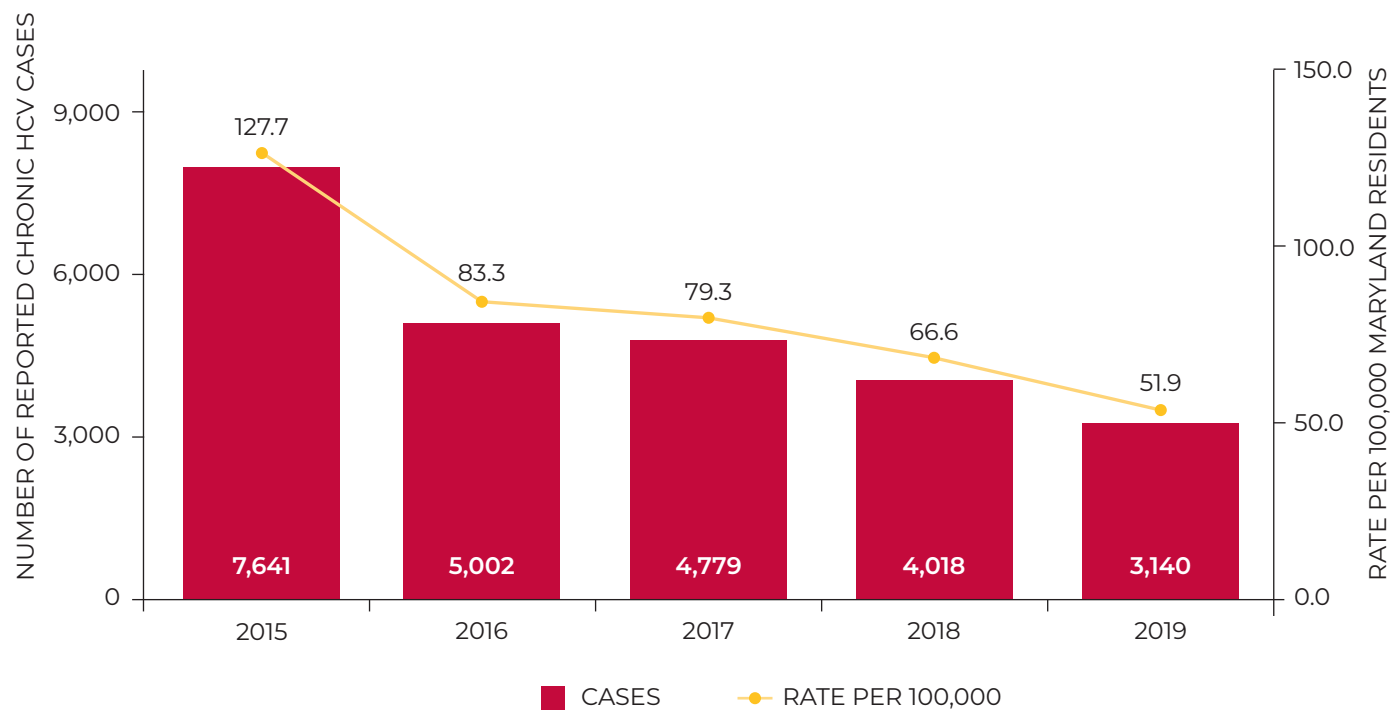
HEPATITIS C

Reported Chronic Hepatitis C Viral Infections

► **24,580** | Reported confirmed cases of **chronic hepatitis C** during 2015-2019

► **408.0** | Rate of reported confirmed cases of **chronic hepatitis C** per 100,000 residents from 2015-2019

Figure 28. Reported number and rate of confirmed chronic hepatitis C cases in Maryland by year, 2015-2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019

HEPATITIS C

Characteristics of Chronic Hepatitis C Viral Infections

Figure 29. Percentage of people reported with confirmed chronic hepatitis C by sex, age, and birth cohort in Maryland, 2015-2019

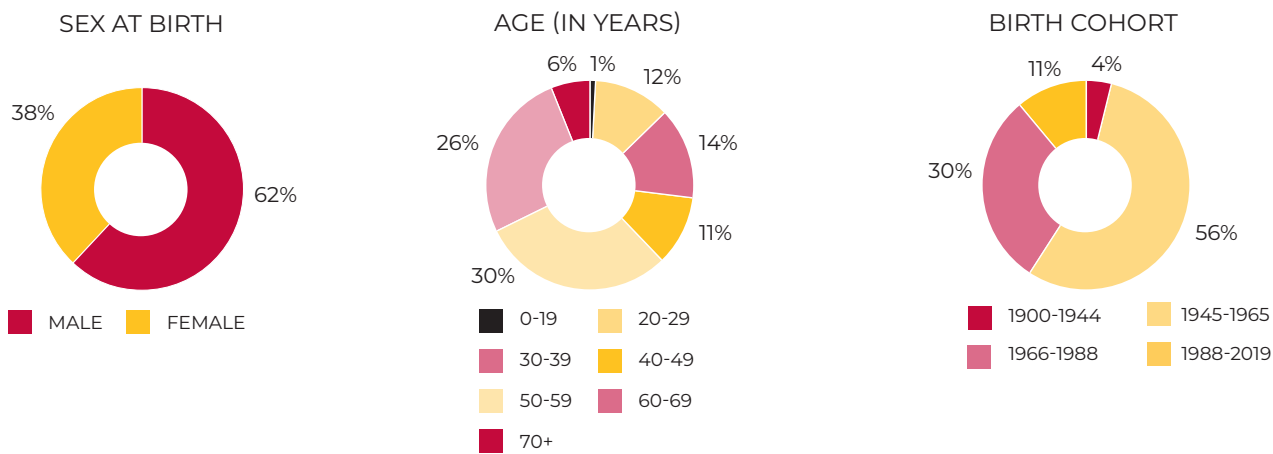
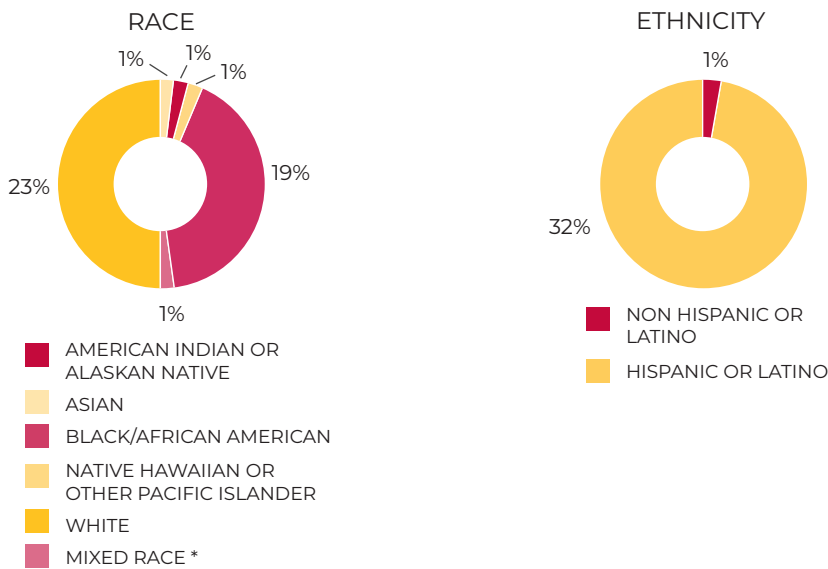


Figure 30. Percentage of people reported with confirmed chronic hepatitis C by race and ethnicity in Maryland, 2015-2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019

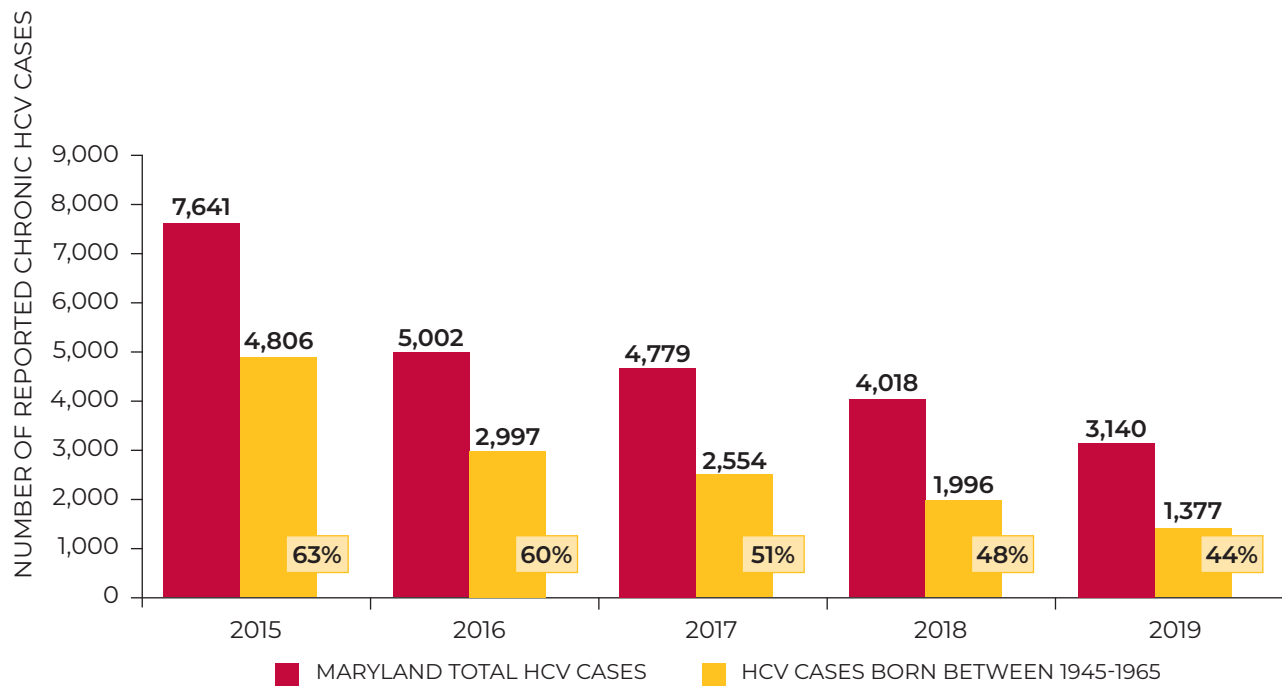
HEPATITIS C

Chronic HCV Birth Cohort 1945 to 1965

Those born from the years 1945 to 1965 (also known as “baby boomers”) account for approximately 75% of all HCV infections and are five times more likely to have HCV than other adults. It is believed that this is the case due to the lack of HCV screening in blood supply prior to 1992.

The estimated prevalence by age in the baby boomer population ranged from 1.5%-3.0% in Maryland in 2017. In total, 53% of all HCV infections in Maryland were estimated to be among baby boomers in 2017.

Figure 31. Reported confirmed chronic HCV cases in Maryland and among those born between 1945 to 1965, 2015-2019

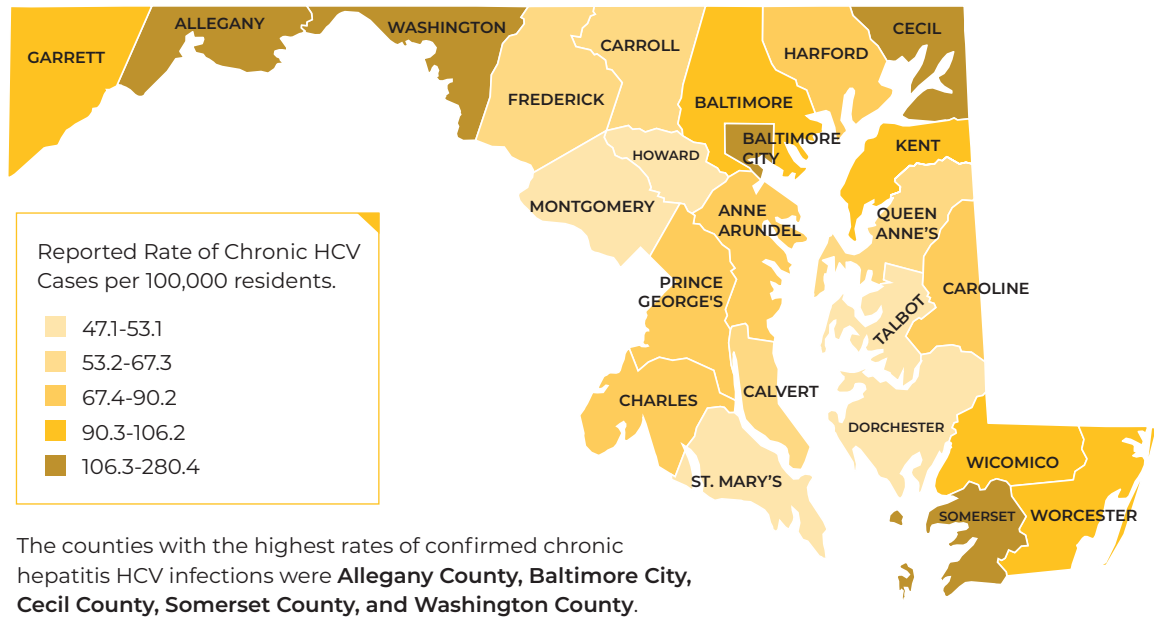


Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2019

HEPATITIS C

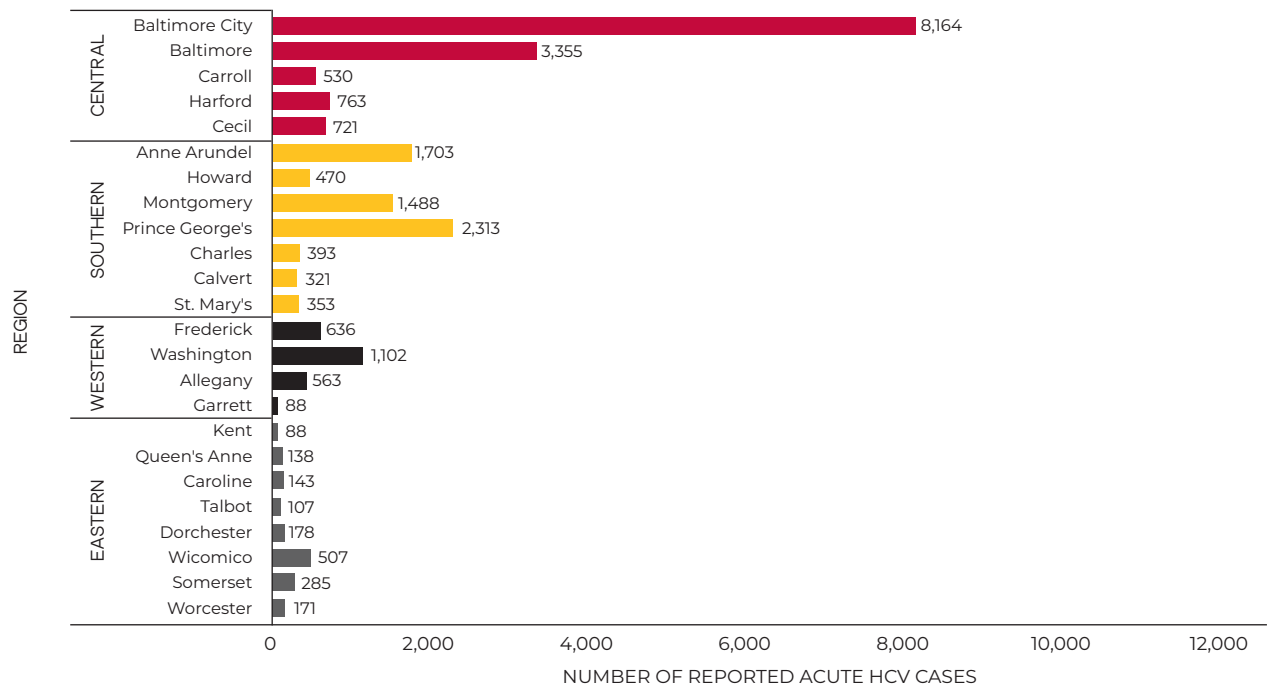
Geographical Distribution of Chronic Hepatitis C

Figure 32. Reported rate of confirmed chronic HCV cases in Maryland by jurisdiction, 2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2019

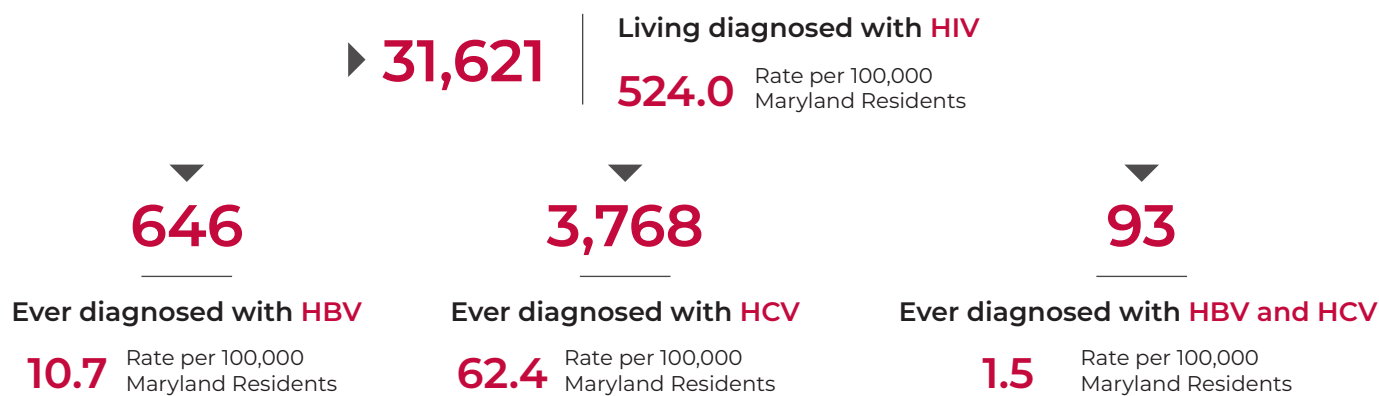
Figure 33. Reported number of confirmed chronic HCV cases in Maryland by region, 2015-2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015-2019

VIRAL HEPATITIS IN SPECIAL POPULATIONS IN MARYLAND

HIV COINFECTIONS



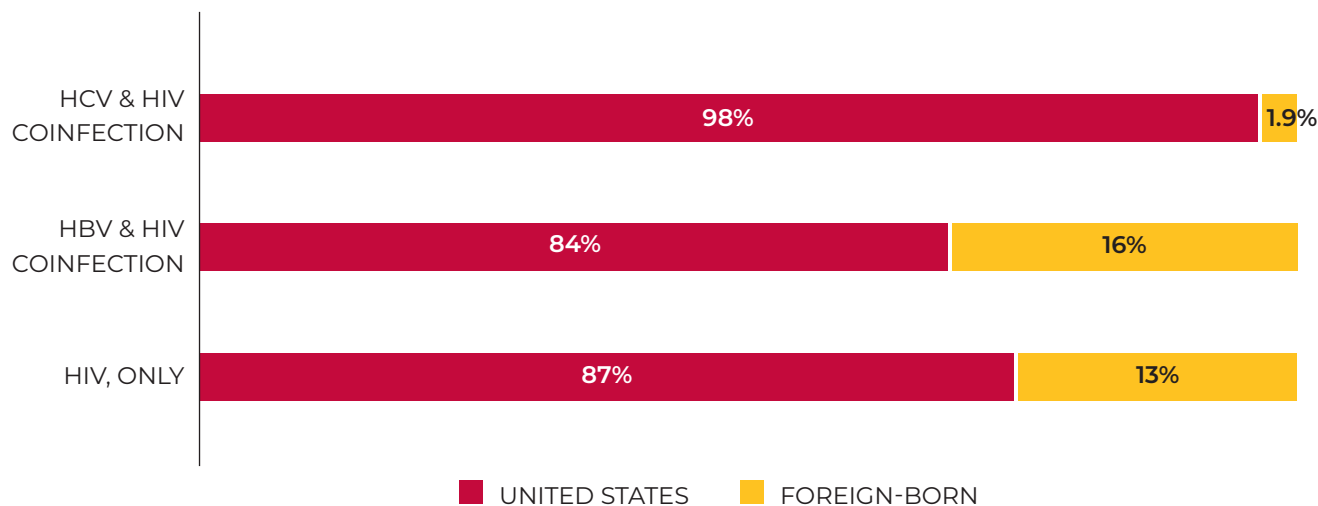
Hepatitis B and Hepatitis C infections increase the rate of liver disease progression in people living with HIV.

As of June 30, 2019, reported data showed that there were 31,621 people living in Maryland diagnosed with HIV. **Among those living with HIV 12% were co-infected with HCV and 2% were co-infected with HBV.**

Country of Birth

Reported data showed there were more people living in Maryland diagnosed with HIV only and HIV/HBV coinfection who were foreign-born (16% and 13%, respectfully) compared to with HIV/HCV coinfection (1.9%).

Figure 34. Country of birth among people living with diagnosed HIV ever diagnosed with HBV or HCV in Maryland, 2019



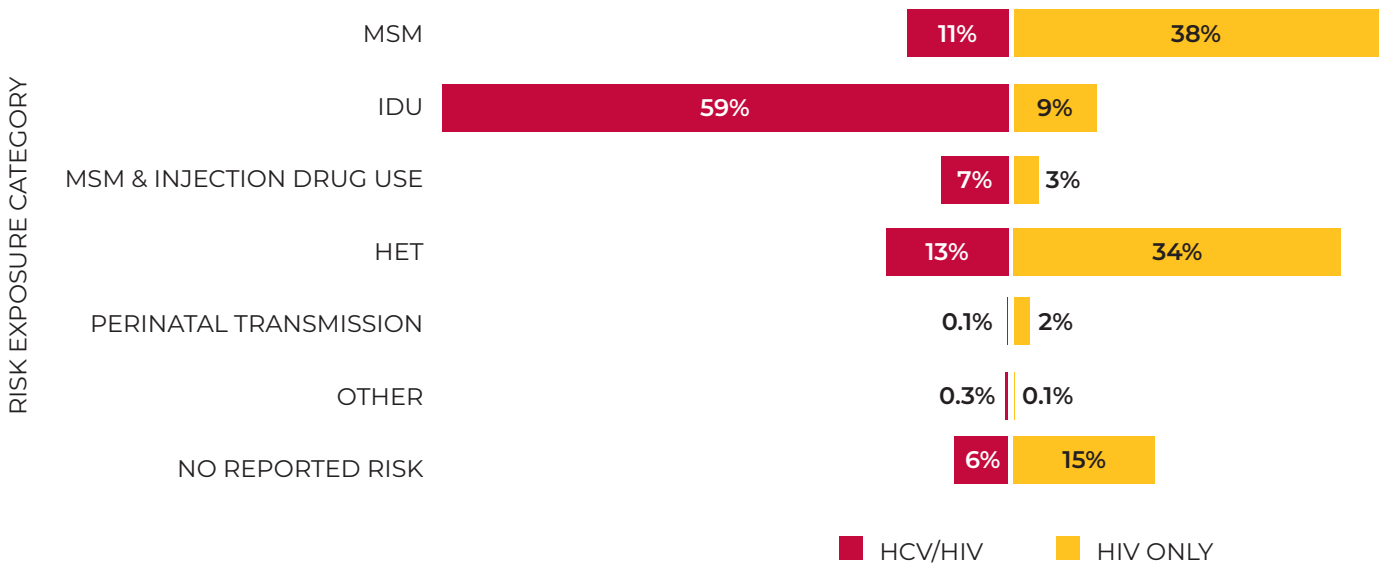
Source: Maryland Enhanced HIV/AIDS Reporting System, Data Reported through June 30, 2019 & NEDSS

HIV COINFECTIONS

HIV/HCV Co-Infection Transmission Risk Factors

Injection drug use was the leading reported risk exposure among HIV/HCV co-infected people living in Maryland.

Figure 35. Reported/Estimated risk exposure among people living with diagnosed HIV only and people living with HIV ever diagnosed with hepatitis C, 2019

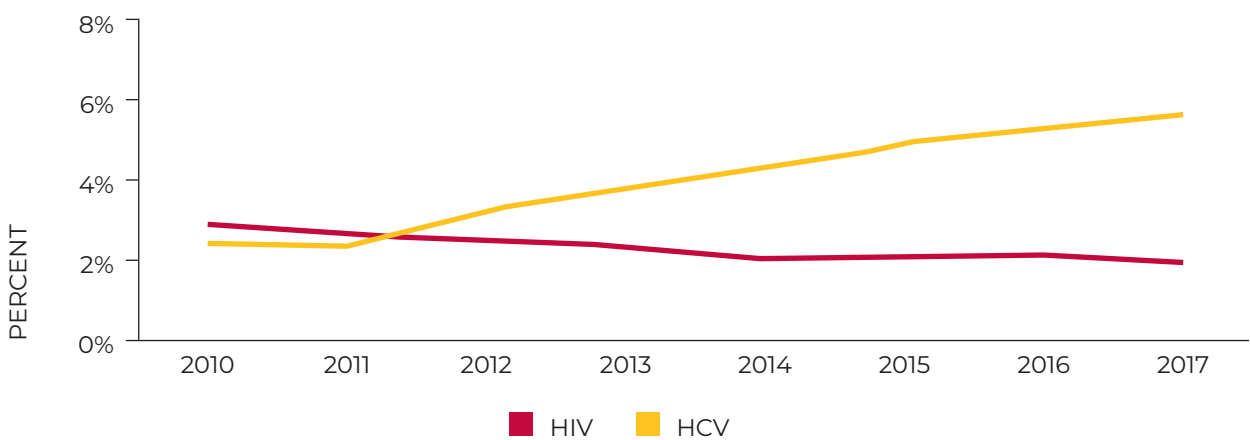


Source: Maryland Enhanced HIV/AIDS Reporting System, Data Reported through June 30, 2019 & NEDSS

HIV/HCV Co-Infection Mortality

Since 2012, the percent of deaths among people living with HIV ever diagnosed with HCV has steadily increased more than the percent of deaths among people living with HIV only.

Figure 36. Mortality Mortality among people living with HIV/HCV co-infection by year of death, 2010-2017



Source: Maryland Enhanced HIV/AIDS Reporting System, Data Reported through June 30, 2019 & NEDSS

PERSONS WHO USE OR INJECT DRUGS

Persons who currently or formerly use or inject drugs are at risk for HCV infection. Injection drug use is estimated to be the most common means of HCV transmission.

► **6,200**

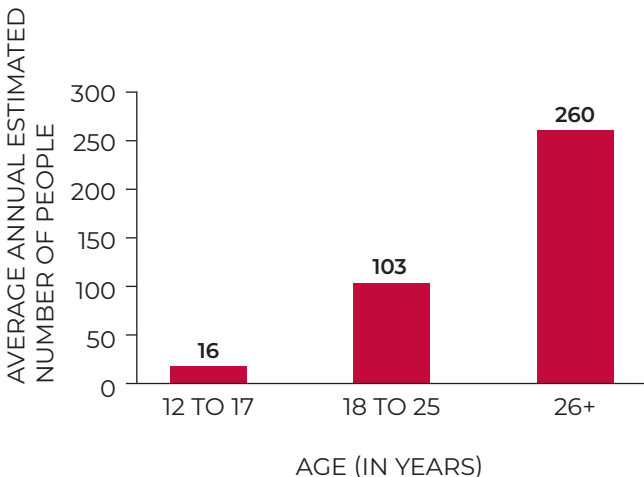
Marylanders who are estimated to be **chronically infected with HCV** are active persons who inject drugs as of 2016

The Center for Disease Analysis Foundation also conducted modeling in order to assess the prevalence of HCV among persons who inject drugs (PWID) as of 2016. CDAF in their modeling assumed 17,500 of Marylanders in 2016 were PWID, applied an anti-HCV rate of 43% and a viremic rate of 75%, and then adjusted for the drug poisoning mortality ratio. **Based on this modeling it was estimated that 6,200 of those chronically infected with HCV in Maryland were active PWID as of 2016.**

Substance Use Disorder

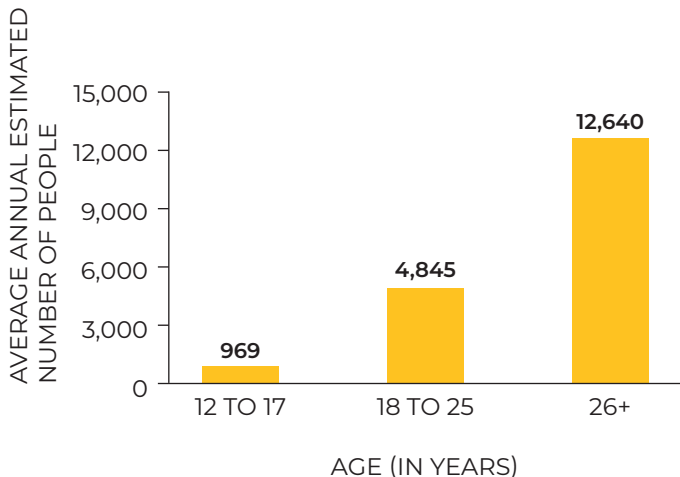
From 2015-2017, the average annual percent of people 12 years or older that had a substance abuse disorder in the past year was **7.8% in Maryland** compared to 7.5% nationally.

Figure 37. Average Annual Estimated Number of Substance Abuse Disorders in the Past Year by Age Group in Maryland based on 2016 and 2017 National Survey on Drug Use and Health



Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017

Figure 38. Average annual estimated number of people needing but not receiving treatment at a specialty facility for substance use disorder in the past year in Maryland based on 2016 and 2017 National Survey on Drug Use and Health



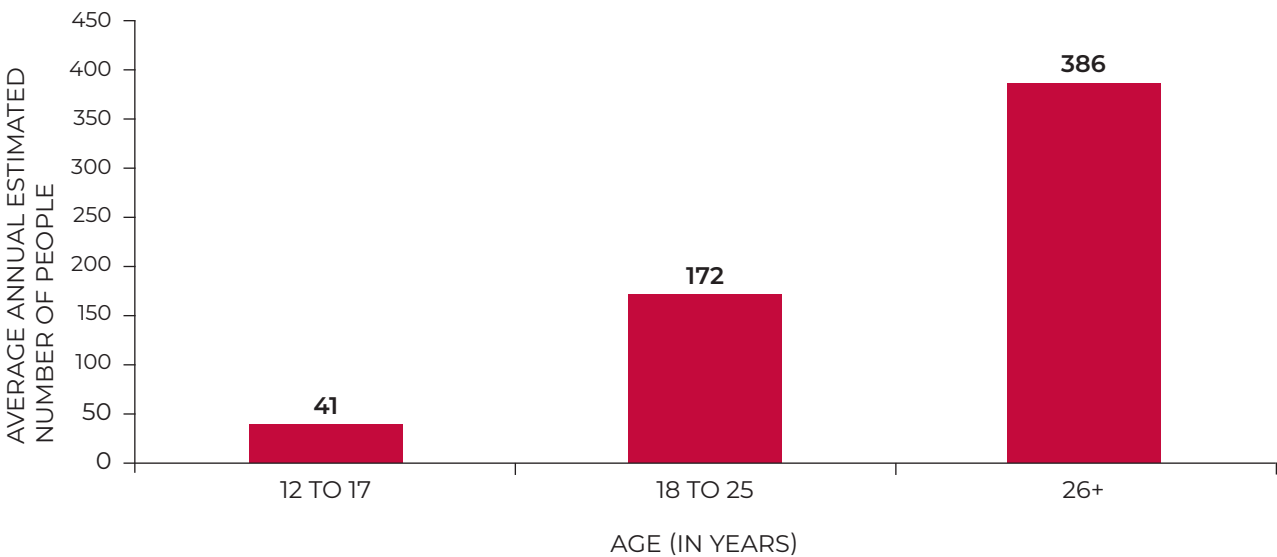
Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017

PERSONS WHO USE OR INJECT DRUGS

Heroin Use

From 2015-2017, the average annual percent of people 12 years or older that used heroin in the past year was 0.8% in Maryland compared to 0.3% nationally.

Figure 39. Average annual estimated number of heroin users in the Past Year by Age Group in Maryland based on 2016 and 2017 National Survey on Drug Use and Health



Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017

PERSONS WHO USE OR INJECT DRUGS

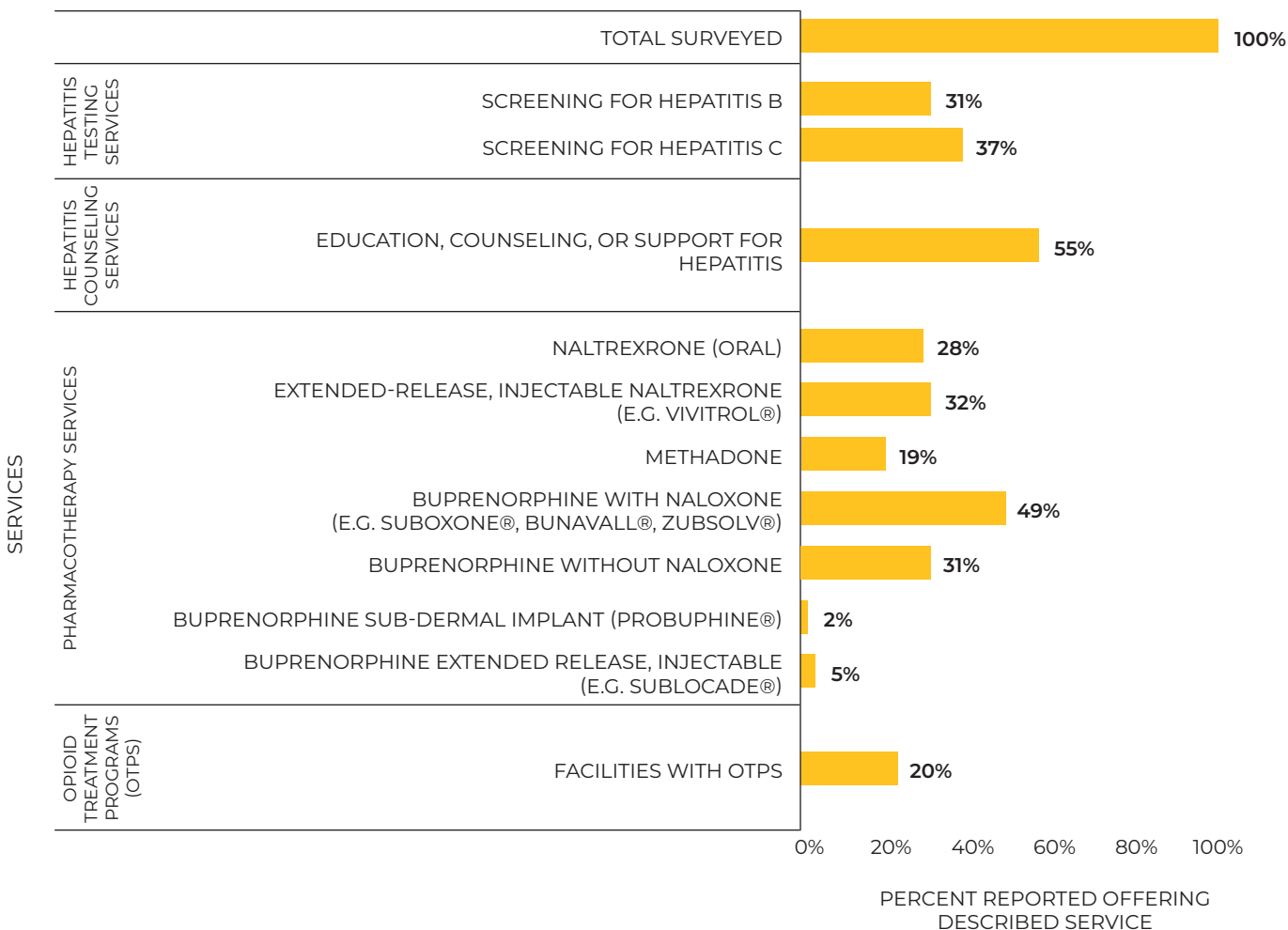
Opioid Use Disorder

From 2015-2017, the average annual percent of people 12 years or older that had an opioid use disorder in the past year was 0.9% in Maryland compared to 0.8% nationally.

Maryland's National Survey of Substance Abuse Treatment Services State Profile, 2018

In 2018, 413 substance abuse treatment facilities reported data as a part of the National Survey of Substance Abuse Treatment Services. These facilities reported on hepatitis testing services, pharmacotherapy services, hepatitis counseling services, and opioid treatment programs.

Figure 40. Services offered by substance abuse treatment facilities reported in Maryland's National Survey of Substance Abuse Treatment Services State Profile, 2018



Substance Abuse and Mental Health Services Administration National Survey of Substance Abuse Treatment Services 2018 Annual Report.
Released September 16, 2019

INCARCERATED

Department of Public Safety and Correctional Services Hepatitis C Policies

The Maryland Department of Public Safety and Correctional Services (DPSCS) operates state prisons in Maryland. DPSCS is committed to the prevention and control of viral hepatitis among incarcerated individuals in its facilities. DPSCS has a chronic care programs that coordinates the diagnosis, treatment, and prevention of chronic conditions among inmates. Hepatitis B and C are considered chronic care conditions. On-site clinical case management is provided to inmates. In addition, Hepatitis A and B immunizations are administered to inmates.

Hepatitis C related cases are presented to the DPSCS Panel, an interdisciplinary panel for consideration and recommendations of hepatitis C treatment. In 2016/2017 with the advancement of Direct Acting Antiviral (DAA) treatments, DPSCS implemented a policy that incorporated a DAA treatment prioritization policy for hepatitis C treatment based on the guidance of Federal Bureau of Prisons and American Association of the Study of Liver Diseases. The rationale for prioritization was to dedicate the limited resources to those patients who required treatment the most based on clinical presentation and the presence of certain clinical scenarios. This treatment policy required consulting with HCV Infectious Disease specialists in many steps of care and approval of fibrosis staging by the DPSCS panel before treatment consideration with no definitive timeline for assessment and treatment. DPSCS Infectious Disease clinician in conjunction with the DPSCS HCV panel prioritized treatment for HCV based on most urgent need as defined by the following clinical scenarios:

- a) Advanced hepatic fibrosis/cirrhosis (compensated);
- b) Liver transplant recipients;
- c) HIV co-infection;
- d) Comorbid medical conditions associated with HCV (HIV, HBV, etc);
- e) Relapsers/non Responders;
- f) Inability to tolerate pegylated interferon and ribavirin for prolonged duration;
- g) Contraindication to pegylated interferon and/or ribavirin.

However, in 2018/2019 DPSCS expanded the eligibility of inmates who could receive DAA treatments for hepatitis C virus infections moving away from the DAA treatment prioritization policy and towards a more progressive policy. The newly implemented treatment policy also changed to allow the DPSCS primary care teams to identify and treat inmates at risk of HCV as well as eliminating restrictions on ordering additional laboratory tests, ordering fibroscan test without panel approval, and requiring the overall process of first visit to treatment initiation to be less than 3 months. Thus, primary care team who have more frequent contacts with inmates can be actively involved in detection and treatment of HCV. This new policy and protocols are supported by the current HCV treatment guidance published by AASLD.

The goal for DPSCS is to treat everyone with hepatitis C who is eligible. The current DPSCS policy states the following patient eligibility to receive HCV treatment:

- a) Sentenced patients;
- b) Six (6) or more months on remaining sentence;
- c) Previously compliant with medical orders and lab tests;
- d) Pretrial inmate requiring continuation of HCV medications who has documented / demonstrated compliance with anti-viral HCV meds in the community following release of information permission and receiving community record confirmation.

INCARCERATED

Hepatitis B and C Screening, Diagnosis, and Treatment

Hepatitis B and C Screening and Diagnosis

The number of known hepatitis B virus positive inmates and known hepatitis C virus inmates in DPSCS facilities decreased from 2016 to 2019.

Figure 41. Known hepatitis B and C positives among incarcerated individuals in Maryland Department of Public Safety and Correction Services Facilities, 2016-2019



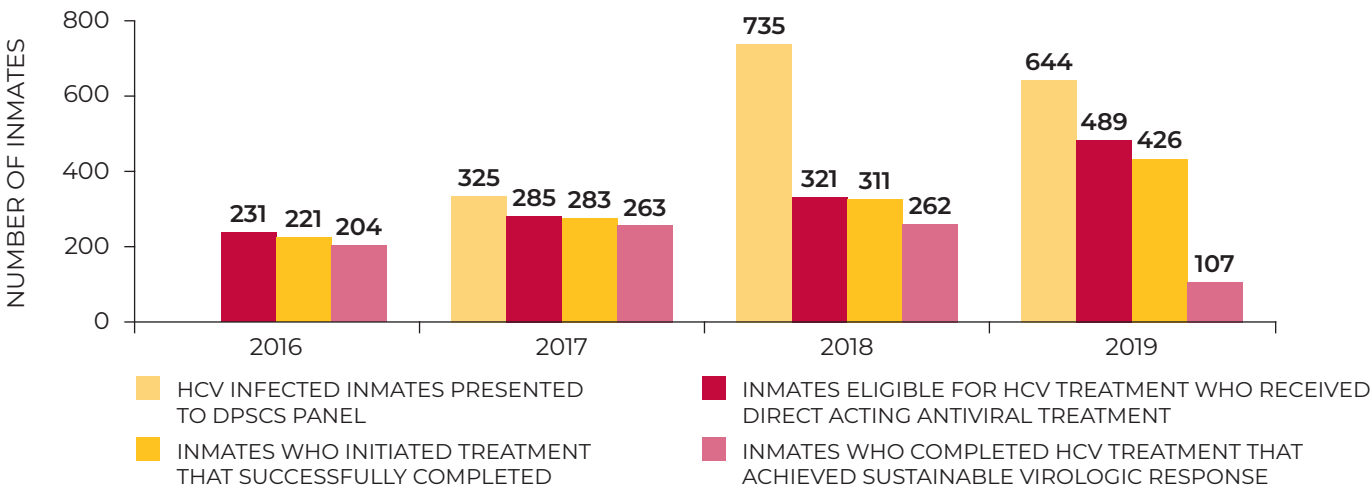
*Total Population number includes inmates detained and sentenced only, excludes those in probation/parole-criminal and drunk driving monitoring program categories
 Known positive is defined as inmates identified as positive upon entry into a Maryland Department of Public Safety and Correctional Services facility prior to any testing.
 Hepatitis B virus positive is defined as being hepatitis B surface antigen positive. Hepatitis C virus positive is defined as being hepatitis C antibody positive.

Source: Maryland Department of Public Safety and Correction Services

Hepatitis C Treatment

From 2016 to 2019, 1,241 inmates initiated HCV treatment in DPSCS facilities and successfully completed treatment. Among those who successfully completed HCV treatment, 836 achieved sustained virologic response and were cured of their HCV infection.

Figure 42. Treatment among HCV infected individuals incarcerated in Maryland Department of Public Safety and Correction Services Facilities, 2016-2019



*For 2016, the number of HCV infected inmates presented to DPSCS panel data unavailable

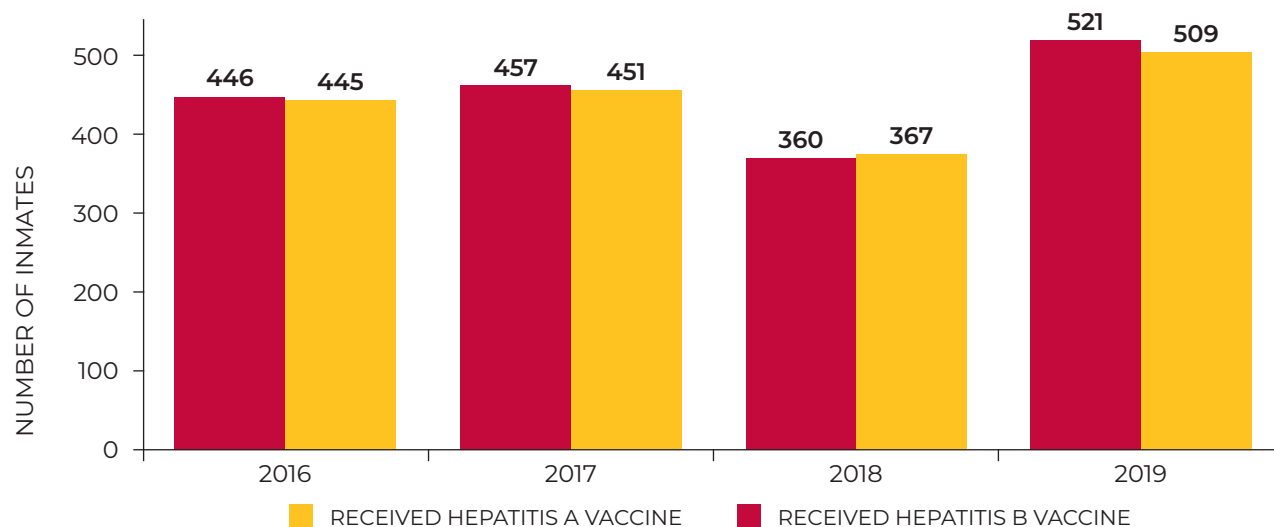
Source: Maryland Department of Public Safety and Correction Services

INCARCERATED

Hepatitis A and B Vaccination

The total number of inmates who received hepatitis A and hepatitis B vaccination while incarcerated in DPSCS facilities increased from 2016 to 2019.

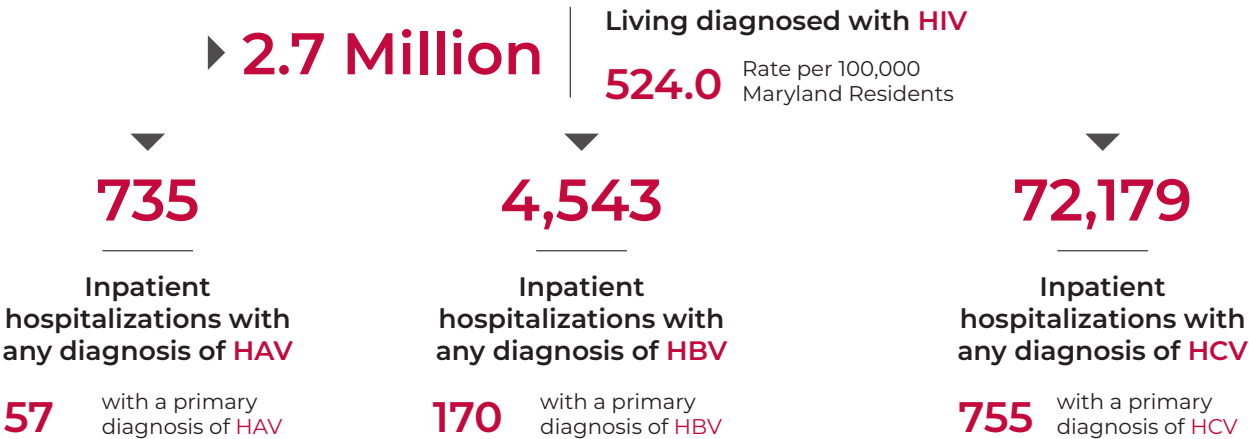
Figure 43. Hepatitis A and B Vaccination Among Incarcerated Individuals in Maryland Department of Public Safety and Correction Services Facilities, 2016-2019



Source: Maryland Department of Public Safety and Correction Services

BURDEN OF DISEASE FROM VIRAL HEPATITIS IN MARYLAND

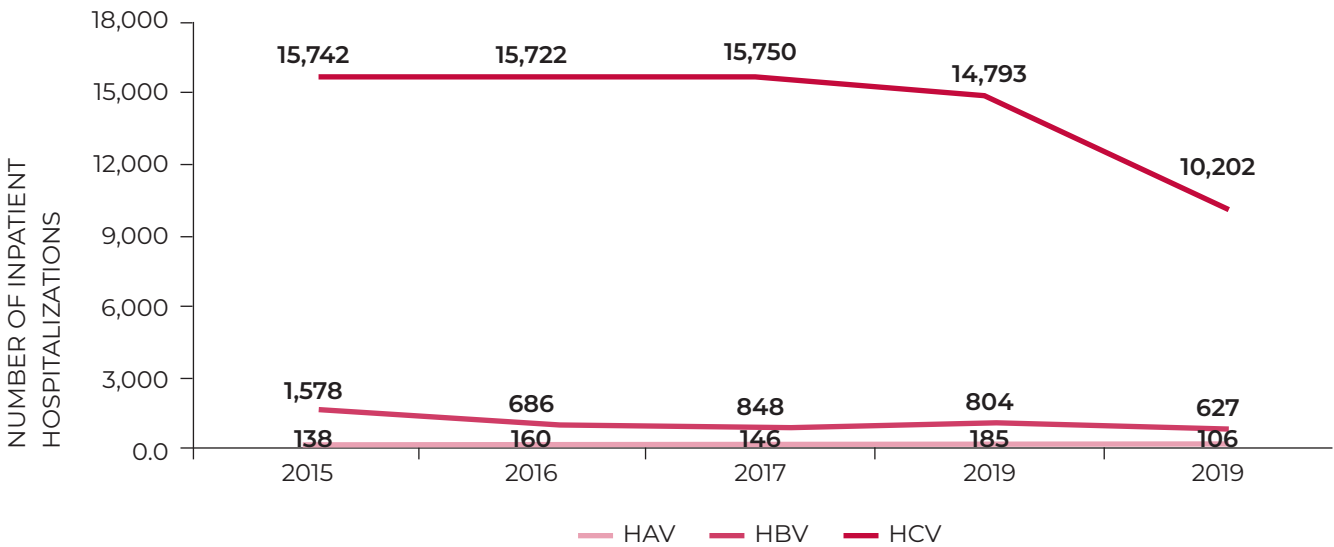
HOSPITALIZATIONS



The Maryland Health Services Cost Review Commission (HSCRC) collects inpatient hospitalization data from all acute care hospitals and licensed specialty hospitals in Maryland. Data presented here are based on data reported to Maryland HSCRC.

Between 2015 to 2019, the number of reported inpatient hospitalizations with any (including primary or secondary) diagnosis of hepatitis A and hepatitis B infections gradually declined in Maryland. Reported inpatient hospitalizations with any diagnosis of hepatitis C infection declined from 2015 to 2019 with a sharp decrease from 2018 to 2019.

Figure 44. Number of inpatient hospitalizations for any hepatitis A, hepatitis B, and hepatitis C infection by year in Maryland, 2015-2019



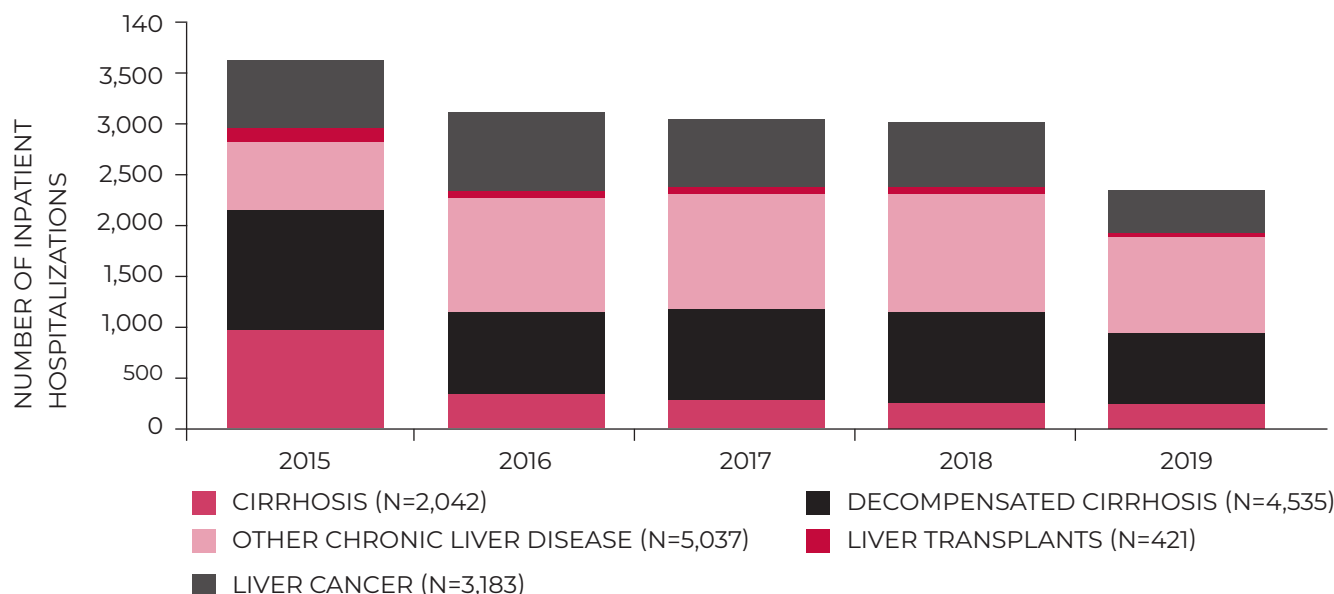
Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

Hospitalizations with any diagnosis of hepatitis A and B infection accounted for less than 1% of all hospitalizations in Maryland from 2015 to 2019 while hospitalizations with any diagnosis of hepatitis C infection accounted for 3% in the state.

HOSPITALIZATIONS

Among the reported inpatient hospitalizations with any diagnosis of HCV there were also liver disease related diagnoses. Liver disease diagnoses were separated into categories including cirrhosis, decompensated cirrhosis, other chronic liver disease, liver transplant, and liver cancer. **From 2015 to 2019, there were 15,218 inpatient hospitalizations with a primary diagnosis in a liver disease category.**

Figure 45. Number of inpatient hospitalizations with a primary diagnosis in a liver disease category by year in Maryland, 2015-2019

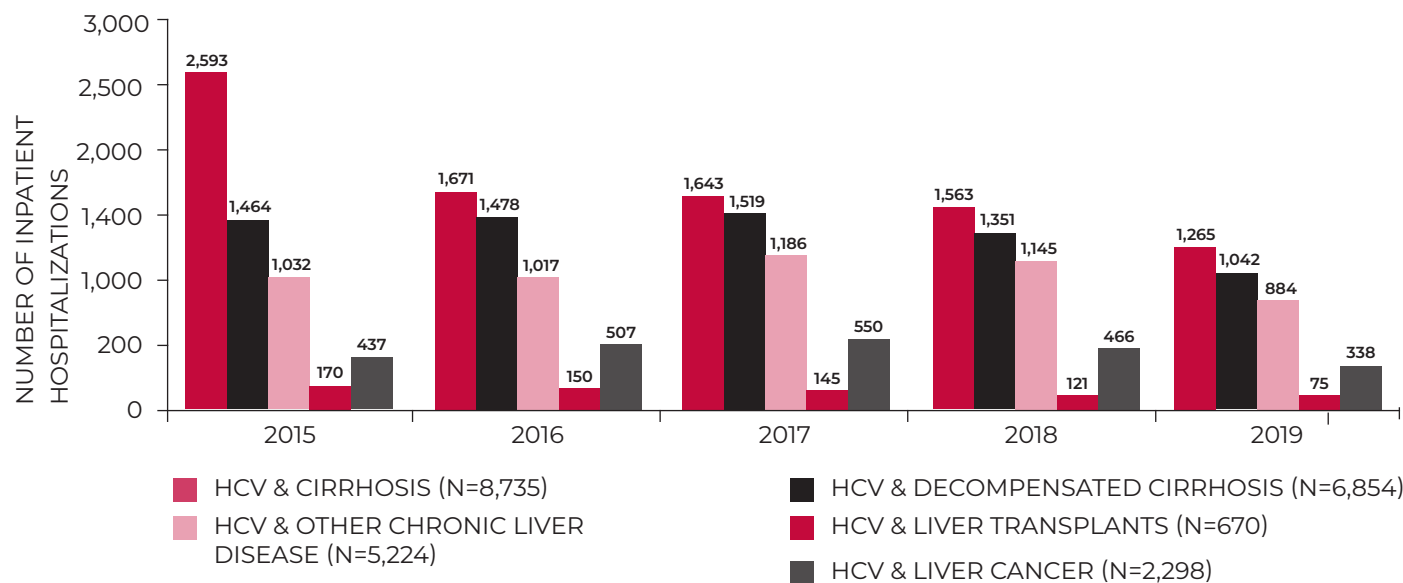


Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

Hepatitis C Infection Inpatient Hospitalizations

From 2015 to 2019, 8,735 inpatient hospitalizations were reported with any diagnosis of hepatitis C infection and cirrhosis, 6,854 hospitalizations with any diagnosis of hepatitis C and decompensated cirrhosis, 5,224 hospitalizations with any diagnosis of hepatitis C and other chronic liver diseases, 2,298 hospitalizations with any diagnosis of hepatitis C and liver cancer, and 670 hospitalizations with hepatitis C and liver transplants in Maryland.

Figure 46. Number of inpatient hospitalizations for any hepatitis C infection and any liver disease category by year in Maryland, 2015-2019



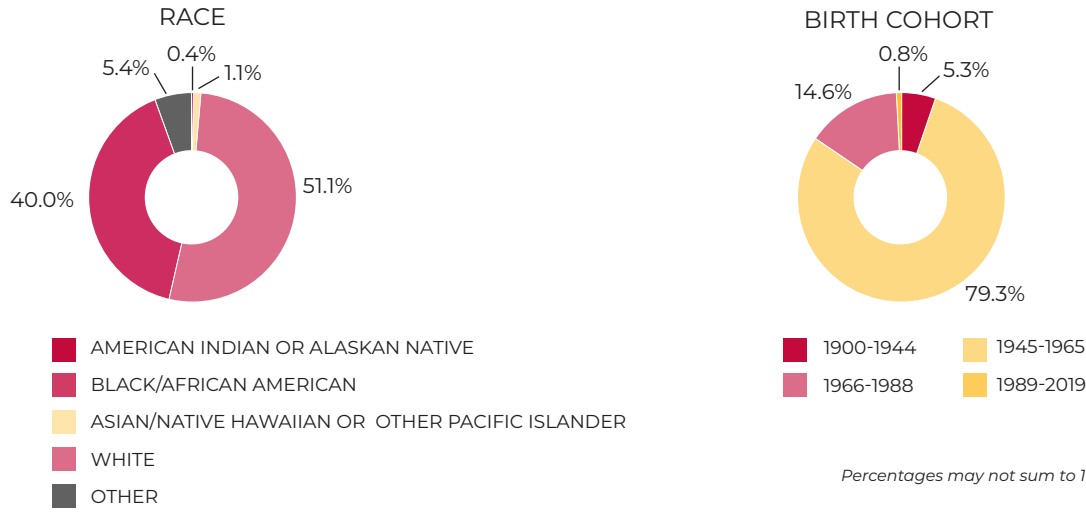
Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

HOSPITALIZATIONS

Hepatitis C Infection Inpatient Hospitalizations

Between 2015 to 2019, there were 755 reported inpatient hospitalizations with a primary diagnosis of hepatitis C infection. Half (51%) of these hospitalizations were reported as White and 40% were reported as Black/African American in Maryland. More than three-quarters (79%) were baby boomers or those born from 1945 to 1965.

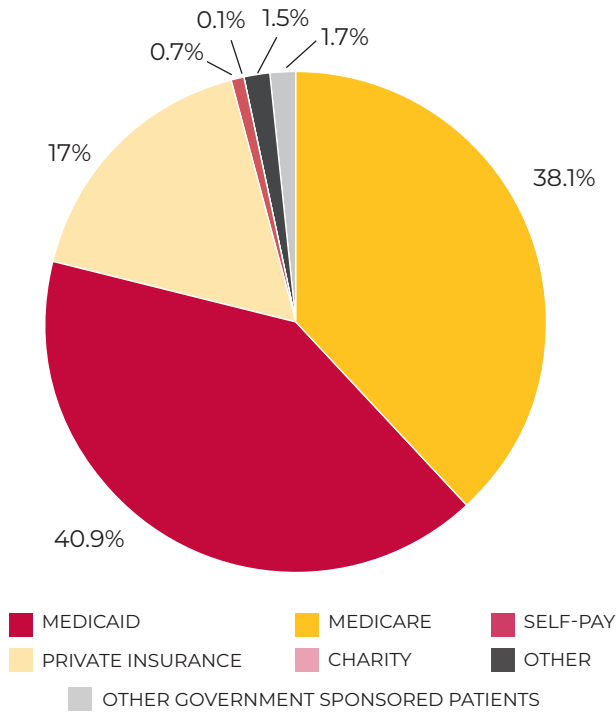
Figure 47. Percentage of inpatient hospitalizations with a primary diagnosis of hepatitis C infection by race and birth cohort in Maryland, 2015-2019



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019

In Maryland, from 2015 to 2019, Medicaid was the insurance payer billed the most, followed by Medicare and private insurance for inpatient hospitalizations with a primary diagnosis of hepatitis C infection.

Figure 48. Percentage of inpatient hospitalizations with a primary diagnosis of hepatitis C infection by primary insurance payer in Maryland, 2015-2019



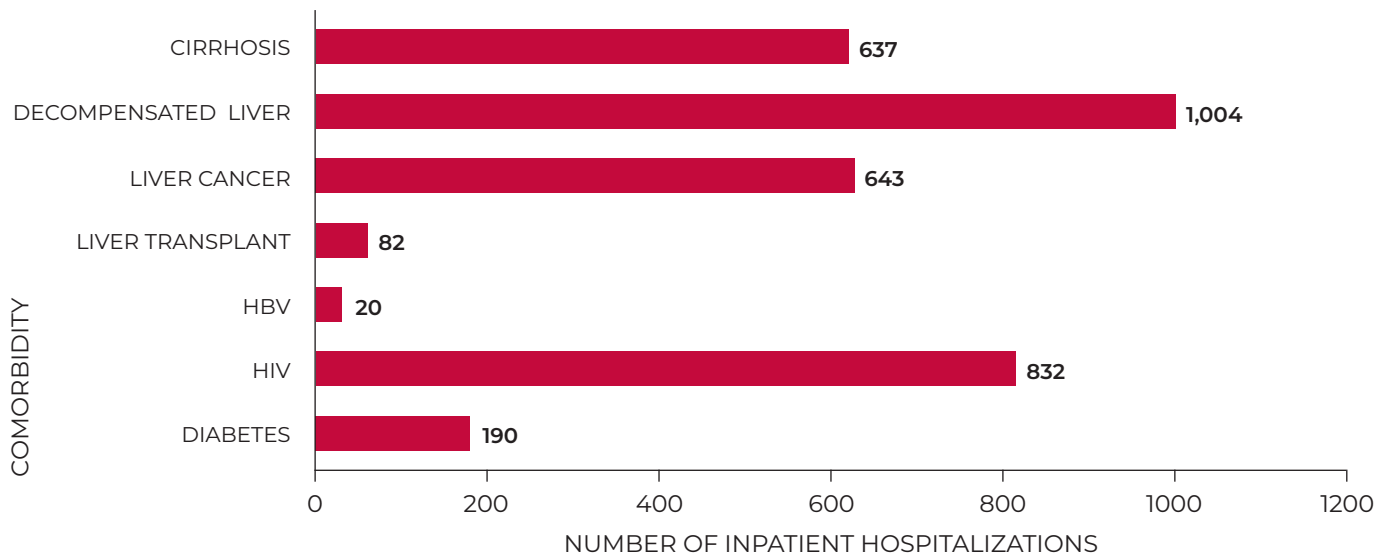
Percentages may not sum to 100 due to rounding error.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

HOSPITALIZATIONS

Hepatitis C Infection Inpatient Hospitalizations

Figure 49. Comorbidities among hospital inpatient hospitalizations with any diagnosis of hepatitis C infection in Maryland from 2015 to 2019

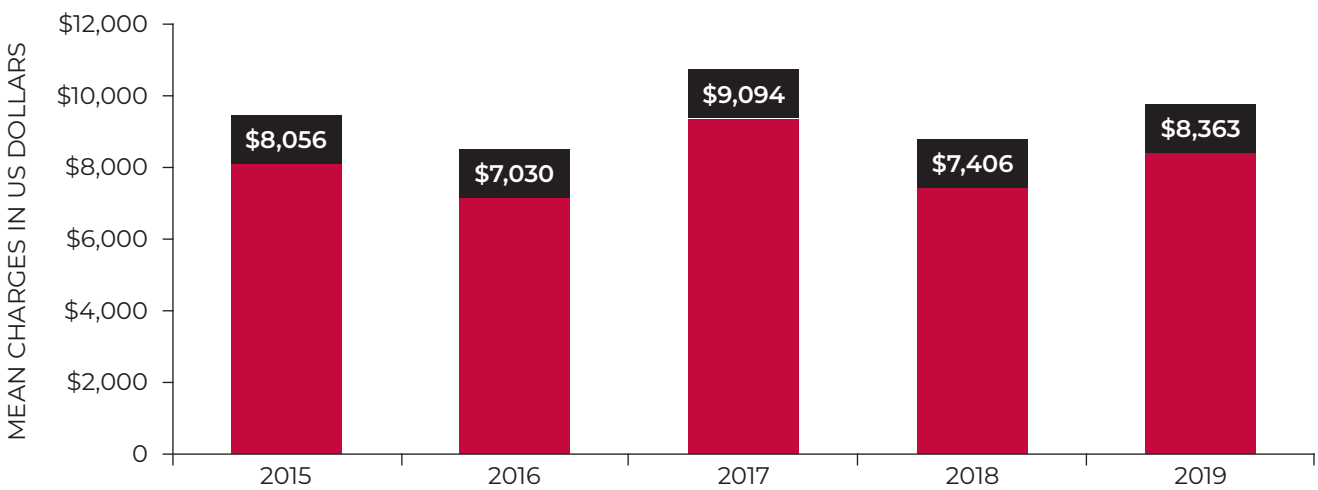


Source: Maryland Enhanced HIV/AIDS Reporting System, Data Reported through June 30, 2019 & NEDSS

Viral Hepatitis Infection Hospitalization Charges

Inpatient hospitalizations with any diagnosis of hepatitis A infection lasted on average 3 days with a 5-year average of \$8,000 charges from 2015 to 2019 in Maryland.

Figure 50. Average total charges among related inpatient hospitalizations for hepatitis A infections in Maryland by year, 2015-2019



Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

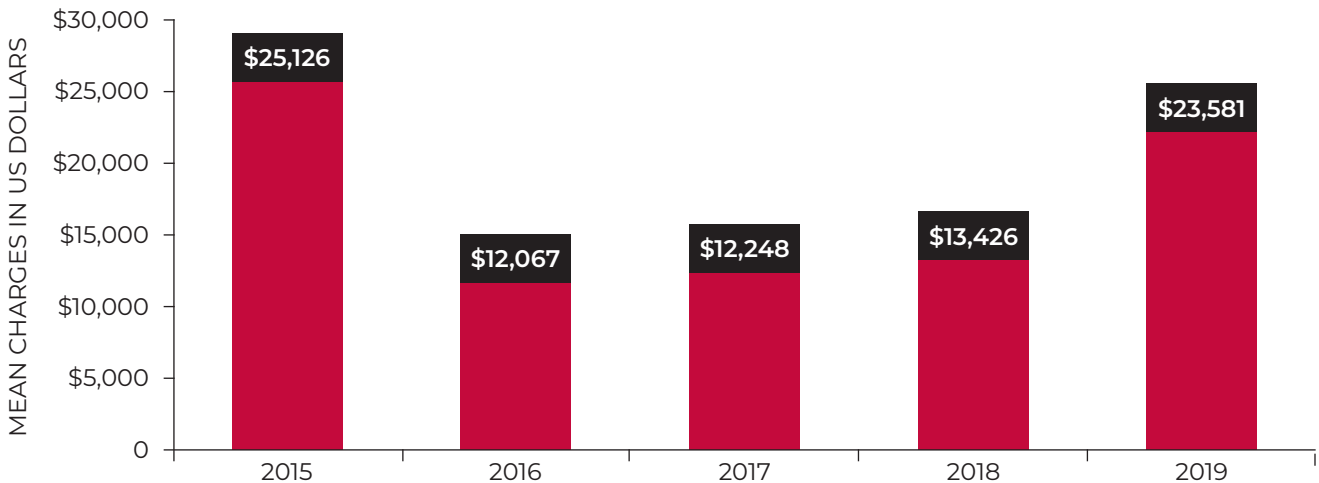
Between 2015 to 2019, the 5-year average total charges associated with a hepatitis A infection hospitalization was approximately \$448,000.

HOSPITALIZATIONS

Viral Hepatitis Infection Hospitalization Charges

Average charges for hospitalizations with any diagnosis of hepatitis B infection fluctuated from 2015 to 2019. Inpatient hospitalizations with any diagnosis of hepatitis B infection lasted on average 5 days with a 5-year average of approximately \$18,000 charges.

Figure 51. Average total charges among related inpatient hospitalizations for hepatitis B infections in Maryland by year, 2015-2019

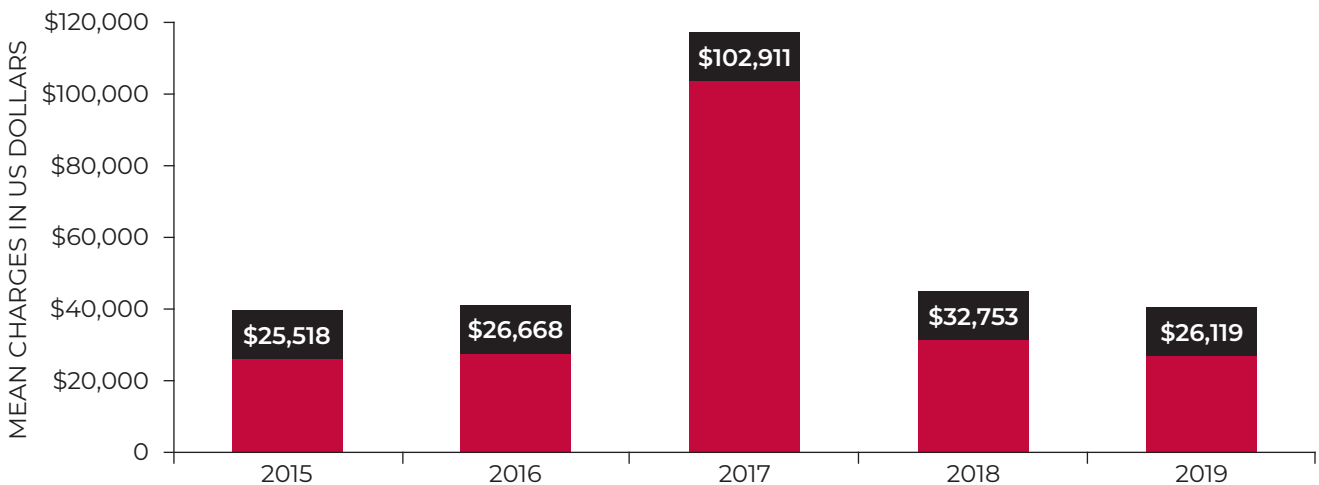


Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

Between 2015 to 2019, the 5-year average total charges associated with a hepatitis B infection hospitalization was approximately \$2 million.

Average charges for hospitalizations with any diagnosis of hepatitis C infection ranged from \$25,500 in 2015 to \$26,100 in 2019 peaking at \$103,000 in 2017. Inpatient hospitalizations with any diagnosis of hepatitis C infection lasted on average 7 days with a 5-year average of approximately \$30,000 charges.

Figure 52. Average total charges among related inpatient hospitalizations for hepatitis A infections in Maryland by year, 2015-2019



Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

Between 2015 to 2019, the 5-year average total charges associated with a hepatitis C infection hospitalization was approximately \$22 million.

MORTALITY

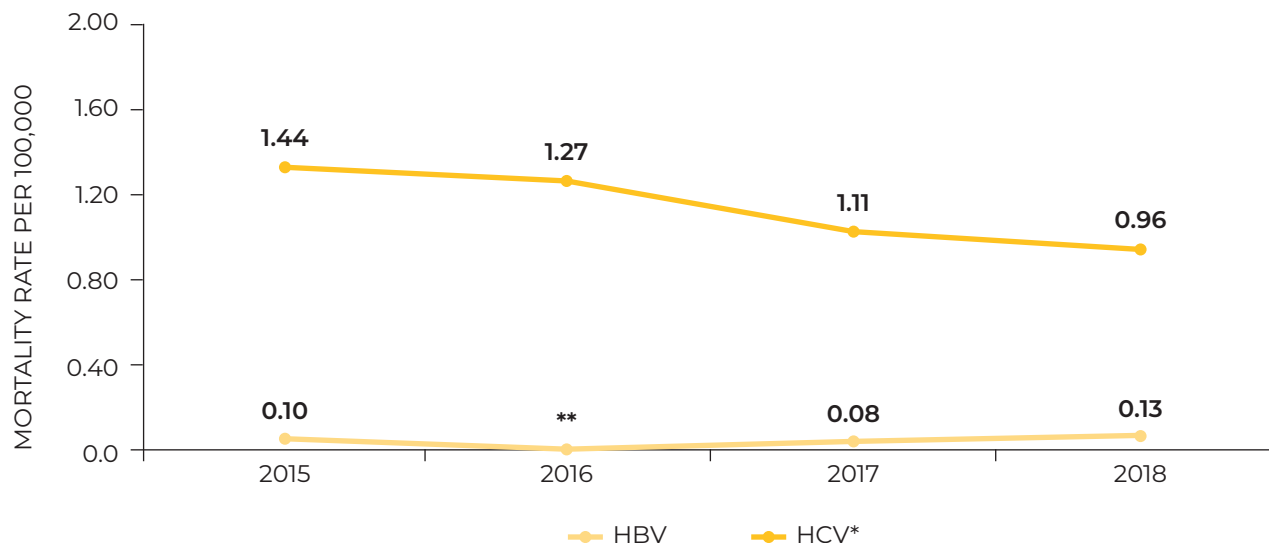
► **22** | Reported **HBV-related deaths** between 2015-2018

► **364** | Reported **HCV-related deaths** between 2015-2018

Liver complications from hepatitis B and C infections can lead to death. HBV-related and HCV-related deaths are reported to the Maryland Department of Health Vital Statistics Administration. HBV-related and HCV-related deaths are defined as having HBV and HCV, respectively, listed as an underlying or contributing cause on the death certificate.

The overall death rate for HBV-related deaths remained stable, while the overall age-adjusted death rate for HCV-related deaths declined from 2015 to 2018.

Figure 53. Mortality rates for hepatitis B-related and hepatitis C-related deaths in Maryland by year, 2015-2018



* HCV mortality rates are age-adjusted to the 2000 U.S. standard population

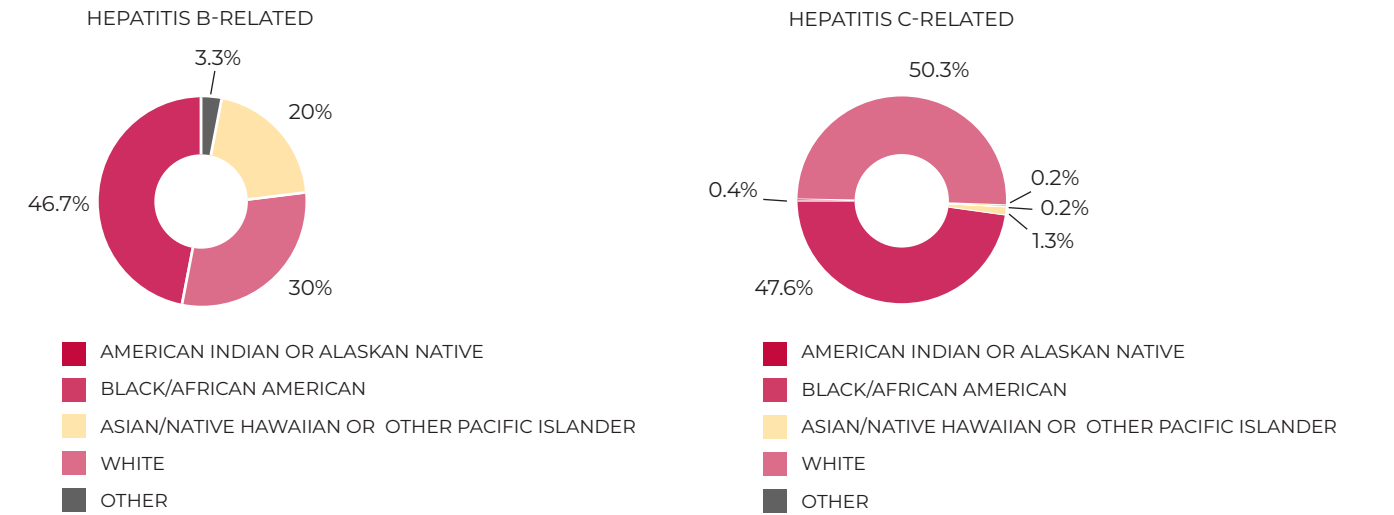
** Rates based on <5 events in the numerator are not presented since such rates are subject to instability.

Source: Vital Statistics Administration Maryland Department of Health, 2019

MORTALITY

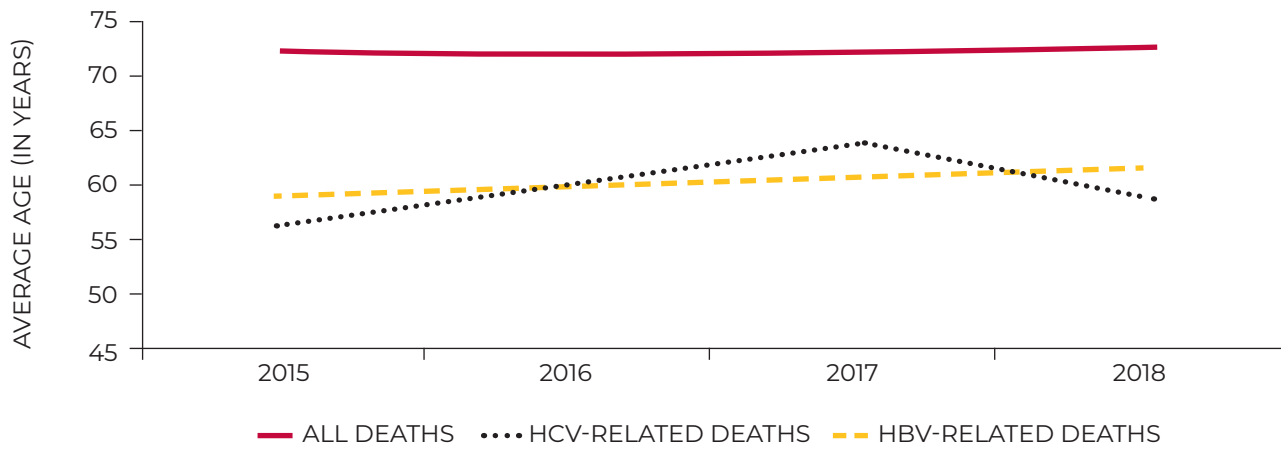
Between 2015 to 2018, 48% of both hepatitis B-related and C-related deaths were reported as Black/African American. Nearly a third (30%) of hepatitis-B related deaths were reported as White, while half of hepatitis C-related deaths were reported as White.

Figure 54. Percentage hepatitis B-related deaths and hepatitis C-related deaths by race in Maryland, 2015-2019



Source: Vital Statistics Administration Maryland Department of Health, 2019

Figure 55. Mortality rates for hepatitis B-related and hepatitis C-related deaths in Maryland by year, 2015-2018

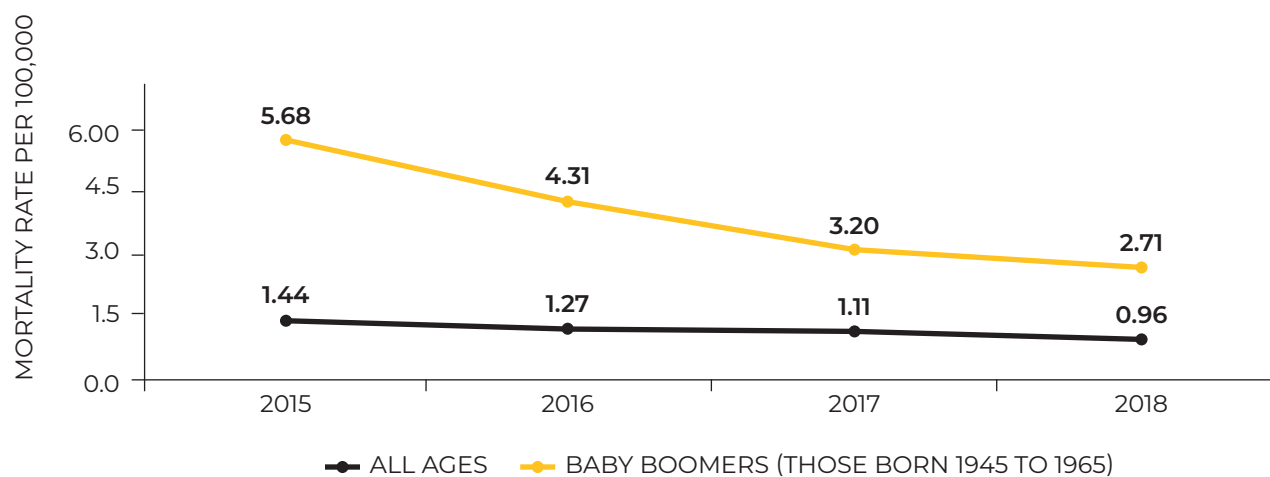


Source: Vital Statistics Administration Maryland Department of Health, 2019

MORTALITY

Baby boomers or those born from 1945 to 1965 are more likely to be chronically infected by HCV and experience fatal complications compared to those born in other years. **The hepatitis C-related death rate among baby boomers was higher than the death rate among all ages. In 2018, the hepatitis C-related death rate among baby boomers was 2.17 per 100,000 deaths while it was 0.96 per 100,000 deaths among all ages.**

Figure 56. . Mortality rates for hepatitis C-related deaths comparing baby boomers and all ages in Maryland by year, 2015-2018

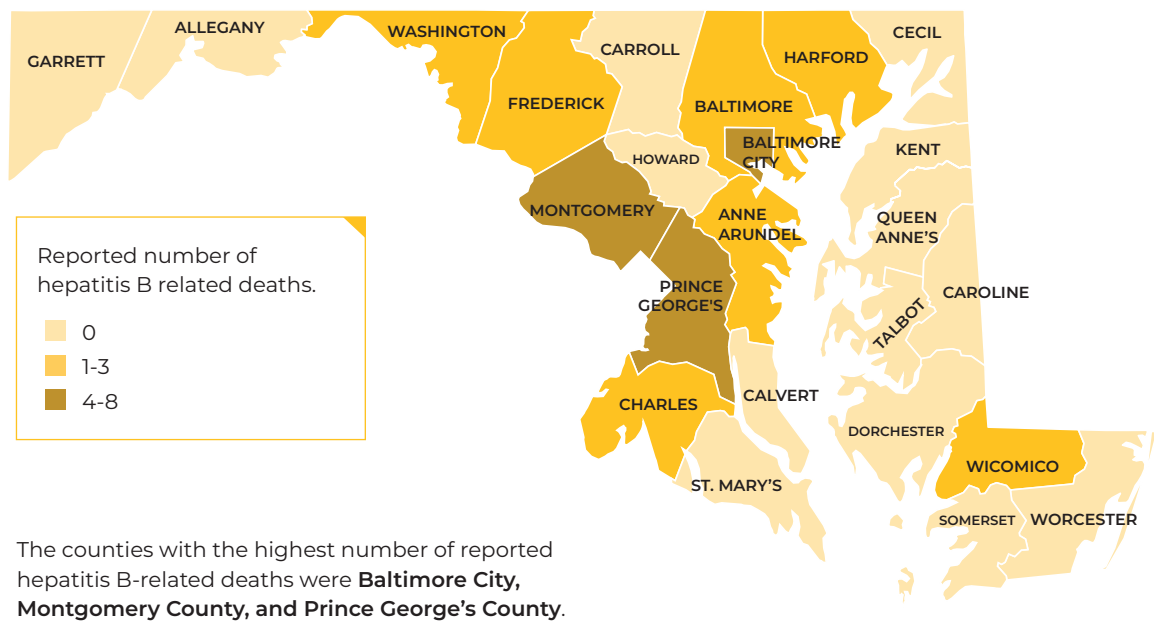


Source: Vital Statistics Administration Maryland Department of Health, 2019

MORTALITY

Geographical Distribution of Reported Hepatitis B-related Deaths

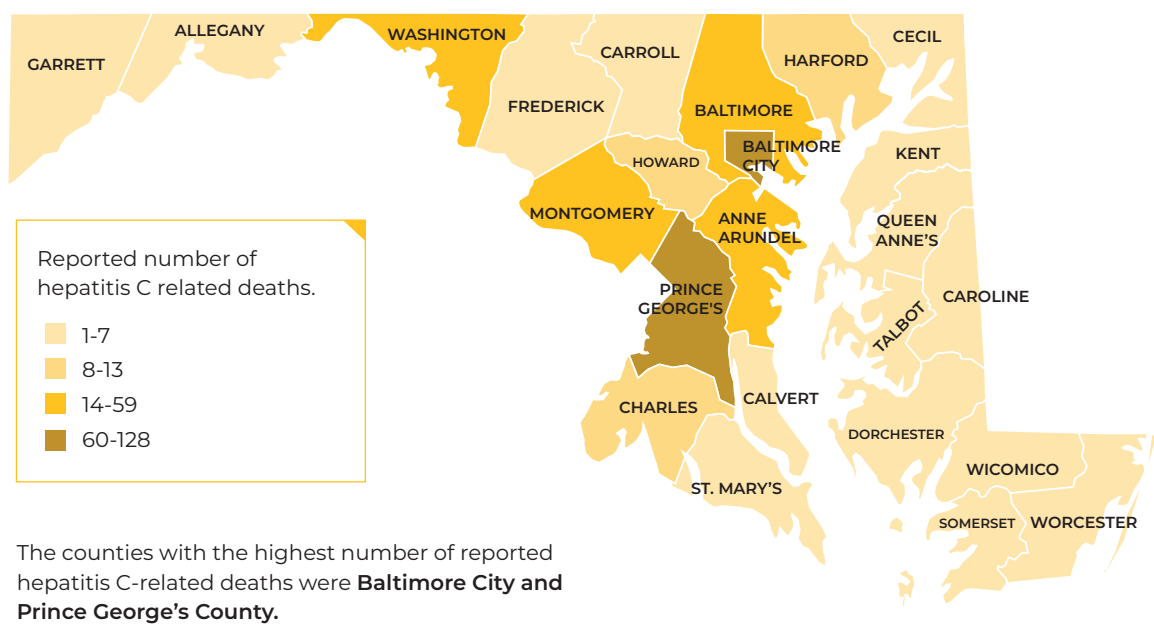
Figure 57. Number of Reported Hepatitis B-related deaths in Maryland by Jurisdiction, 2014-2018



Source: Vital Statistics Administration Maryland Department of Health, 2019

Geographical Distribution of Reported Hepatitis C-related Deaths

Figure 58. Number of Reported Hepatitis C-related deaths in Maryland by Jurisdiction, 2014-2018



Source: Vital Statistics Administration Maryland Department of Health, 2019

LIVER CANCER

► **1,636**

Reported cases of **liver cancer** between 2015-2017

► **290**

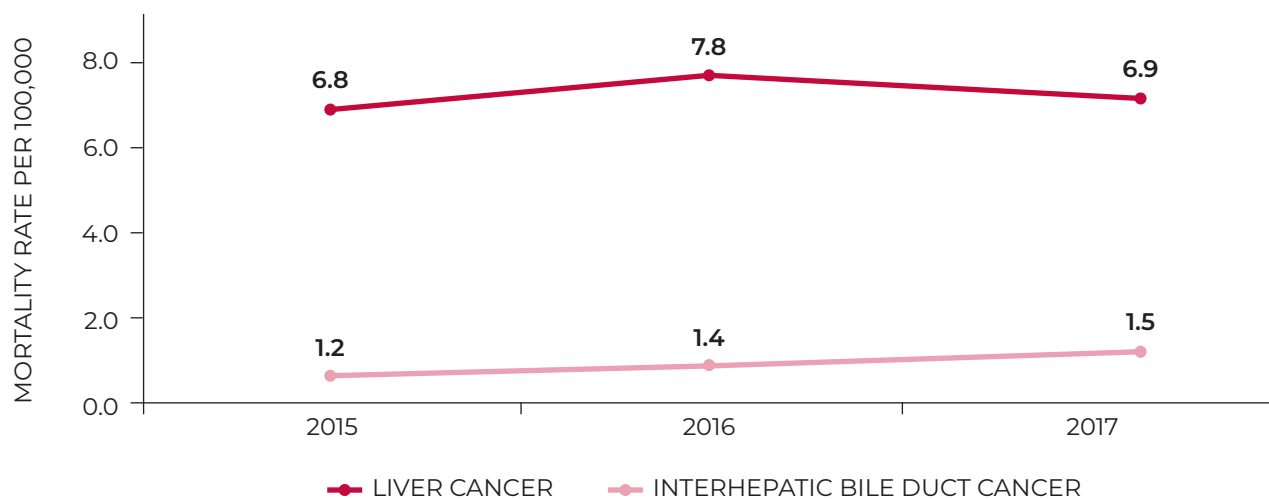
Reported cases of **intrahepatic bile duct cancer** between 2015-2017

The Maryland Department of Health Center for Cancer Prevention and Control Maryland maintains a cancer registry. Data presented here are based on data reported to the Maryland Cancer Registry.

Hepatocellular carcinoma or liver cancer is a common liver complication associated with viral hepatitis infections as well as intrahepatic bile duct (IHBD) cancer.

The rate of reported liver cancer cases from 2015 to 2017 remained stable in Maryland peaking at 7.8 per 100,000 cases in 2016. However, the rate of reported IHBD cancer cases steadily increased from 2015 to 2017 .

Figure 59. Mortality rates for hepatitis B-related and hepatitis C-related deaths in Maryland by year, 2015-2018

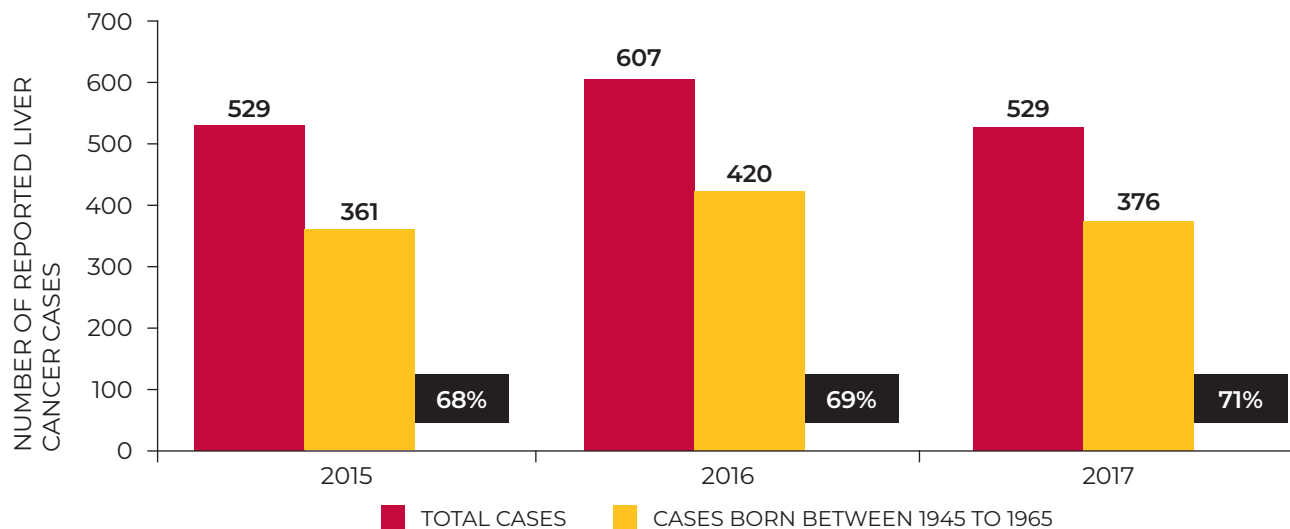


Source: Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry, 2019

LIVER CANCER

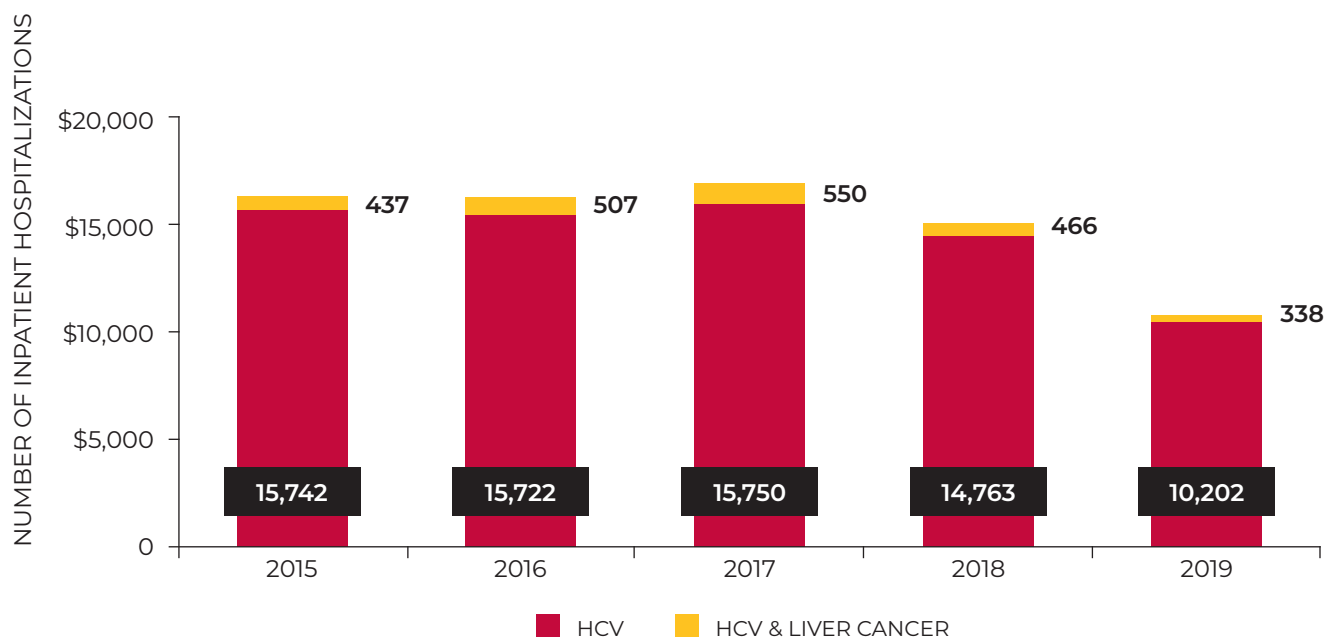
In Maryland baby boomers or those born from 1945 to 1965 were disproportionately affected by liver cancer, making up more than half of diagnoses per year from 2015 to 2017.

Figure 60. Number of reported liver cancer cases comparing baby boomers and all cases by year of diagnosis in Maryland, 2015-2017



Source: Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry, 2019

Figure 61. Rate of reported liver cancer cases by year of diagnosis in Maryland, 2015-2019

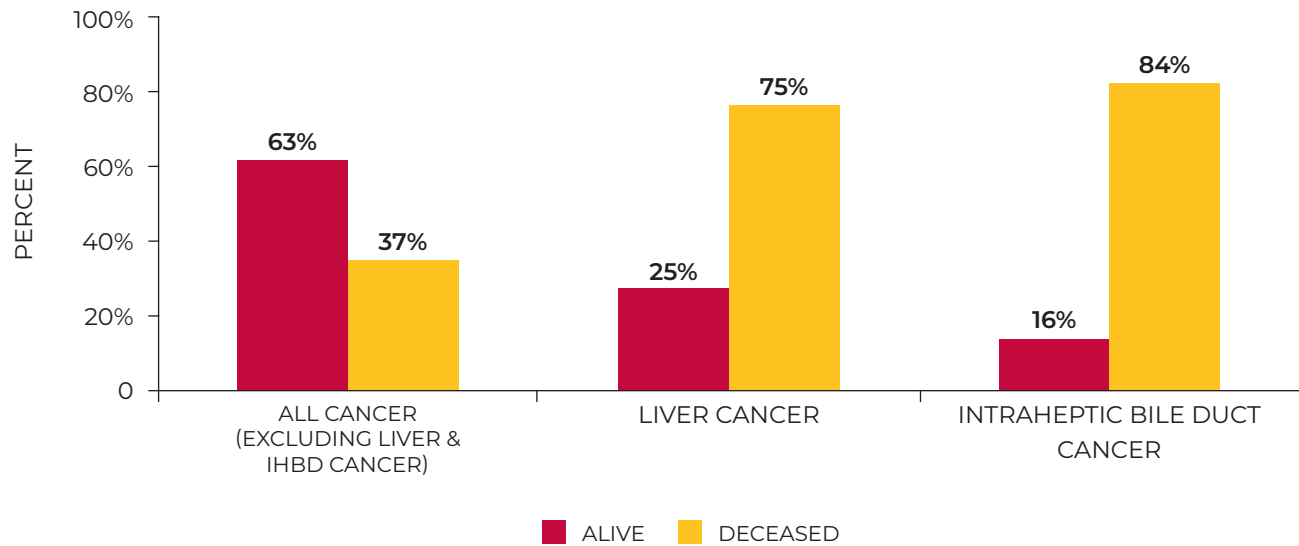


Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

LIVER CANCER

Between 2015 to 2017 reported cases of all cancer excluding liver and IHBD cancer were more likely to be alive than deceased compared to reported cases of liver cancer and IHBD. Three-quarters (75%) of reported liver cancer cases were reported as deceased, while 84% of IHBD cancer were reported as deceased.

Figure 62. . Vital status among reported liver cancer and intrahepatic bile duct cancer cases compared to all cancer in Maryland, 2015-2017



Source: Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry, 2019

ADDRESSING VIRAL HEPATITIS IN MARYLAND

The State of Maryland has established systems, infrastructures, policies, and strategies to address viral hepatitis in the state. Through the Department of Health, viral hepatitis prevention and surveillance activities are carried out in collaboration with local and city health departments, academic institutions, federally qualified health centers, the Department of Public Safety and Correctional Services, health care systems and laboratories, and community-based nonprofit organizations. Current strategies and activities being implemented to address viral hepatitis infections in the state are in line with the National Viral Hepatitis Action Plan and the Maryland Hepatitis C Strategic Plan. The key viral hepatitis interventions being implemented in the state are summarized below.

PREVENTION & EDUCATION

Hepatitis A prevention education is provided as part of health interventions for people experiencing homelessness, persons who inject drugs (PWID), and men having sex with men (MSM). Hepatitis A vaccine clinics are established at shelters, drop-in centers, syringe services programs, and other venues serving at-risk population. Capacity for enhanced surveillance for hepatitis A cases has been developed at the local health departments. During a recent outbreak in Cecil County, MDH collaborated with the local health department and community-based organization serving high risk populations to reduce outbreak transmission and provide hepatitis A vaccination.

Hepatitis B screening and prevention is largely focused on Asian and African immigrants in the counties with the highest reported cases- Prince George's County, Montgomery County, Baltimore County and Baltimore City. Screening and vaccination services are also promoted among high risk populations through collaboration with the Department of Public Safety and Correctional Services (DPSCS) to screen inmates and persons who use or have a history of injection drug use and MSM. The Maryland Perinatal Hepatitis B Program focuses on infants born to mothers with known HBV infection and preventing mother-to-child transmission.

Hepatitis C screening, diagnosis, and linkage to care services are integrated into comprehensive health services at local health department clinics and are also provided as part of community outreach services. The opioid crisis has worsened the transmission pattern of HCV infection with high rates of infection being reported among young persons with substance abuse disorders, especially PWID. In Maryland, the hepatitis C prevention program has prioritized screening and testing among PWID accessing services at syringe services programs (SSPs) and at medication-assisted treatment (MAT) programs. HCV screening is also integrated with HIV and STI screening at the local health department clinics and state correctional facilities. The Department also uses the Patient Reporting Investigation Surveillance Manager (PRISM) to collect and analyze HCV linkage-to-care data from clinical, community, and local health department sites that participate in the Maryland Hepatitis C Rapid Testing Program.

Unlike hepatitis A and B, there is no vaccine for the hepatitis C virus. Although there is great attention to recent curative treatment for HCV, diseases of the past have rarely been eradicated with focus on treatment alone. Prevention efforts, particularly education about HCV risk factors, must receive adequate consideration and resources. Individuals who engage in risk behaviors and have risk exposures may have low perceived risk of HCV transmission and the effects of HCV infection on the body. In addition to traditional forms of public health educational efforts, it is important to meet individuals who are at-risk for HCV infection where they are. The Maryland Department of Health encourages increasing education among trusted clinical and social service providers about HCV risk factors and further to ensure that such knowledge is shared in conversations with the individuals they serve. HCV education also must be integrated into existing services. Including HCV education to individuals who engage in high risk behaviors alongside services like opioid substitution treatment and needle and syringe programs can help reduce the risk of new HCV infections at highest risk for HCV.

In 2018, to improve access to reflex RNA testing and confirmation of HCV diagnosis, an inter-agency agreement was set up between the MDH's Infectious Disease and Prevention Health Services Center for Viral Hepatitis and the MDH's Laboratory Administration to provide HCV RNA confirmatory testing to local health departments and community based organizations offering rapid HCV testing. MDH laboratory provides training and other technical assistance to the HCV testing sites on HCV RNA sample collection, preparation, and transportation.

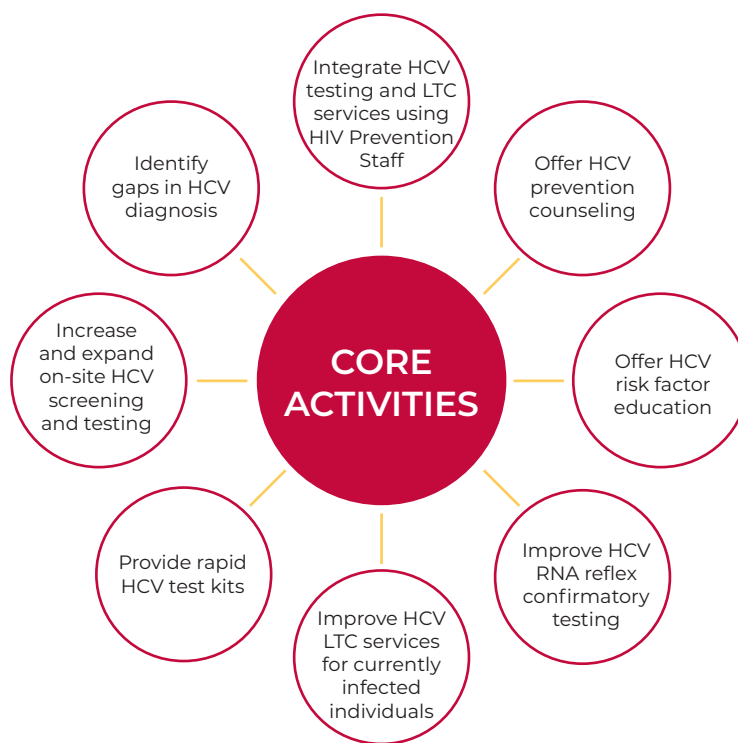
Since 2017 the Maryland Department of Health partners with the Maryland Department of Public Safety and Correctional Services (DPSCS) to develop an HCV linkage-to-care system for individuals who tested positive for the HCV antibody test during pre-release HCV screening. HCV testing is offered to inmates projected to be released from state correctional facilities by MDH trained officers deployed to the DPSCS clinic or through outreach testing team at local health departments. Positive logs are submitted to the Adult Viral Hepatitis Prevention Coordinator (VHPC) who coordinates with Linkage-to-Care (LTC) staff at the corresponding county of the address provided for the individual and collaborate with discharge planners to provide LTC and support services prior to and after reentry.

Through funding support from Gilead FOCUS program in 2019 the Center for Viral Hepatitis provided funding support to three jurisdictions (Baltimore County, Somerset County, and Washington County) burdened with hepatitis C to implement robust hepatitis C testing and linkage to care activities. Dedicated Case Managers or Community Navigators were deployed to each Hepatitis C program to follow up with identified HCV positive antibody cases, improve HCV RNA reflex testing, and ensure HCV RNA diagnosed patients attended their first medical appointment.

In 2019, as part of the CDC's opioid crisis funding in collaboration with MDH's Office of Preparedness and Response the Center for Viral Hepatitis provided funding support to three jurisdictions (Baltimore County, Somerset County, and Washington County) with rising rates of hepatitis C cases to provide prompt case investigation for newly notified hepatitis C cases. The objective of this initiative was to improve HCV surveillance data entry in order to identify any possible clusters of HCV cases quickly for a prompt response.

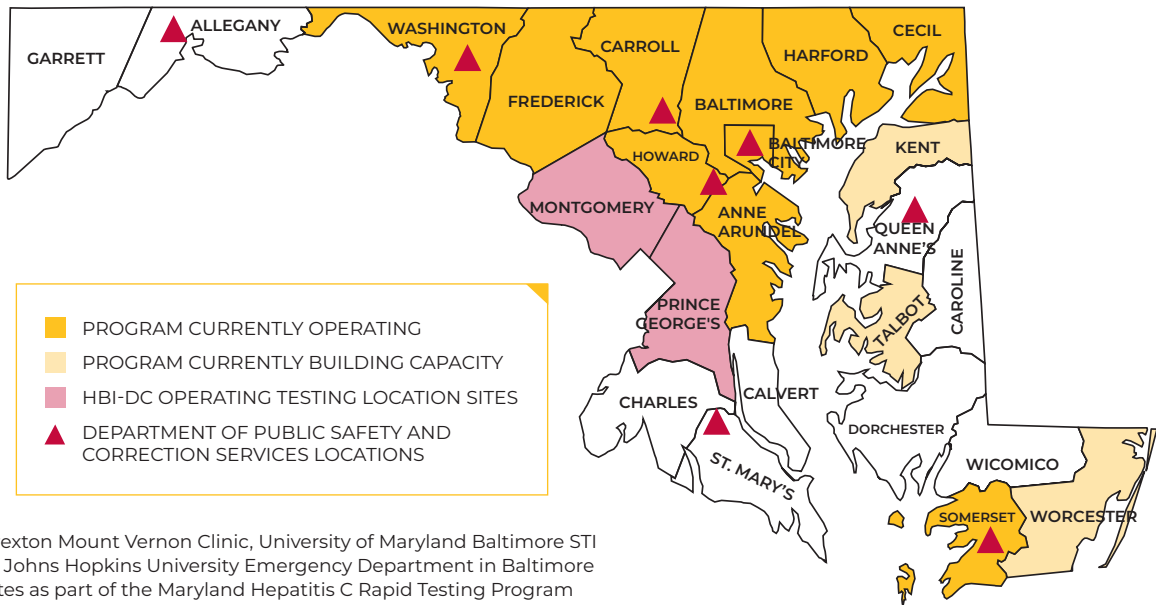
HEPATITIS C RAPID TESTING PROGRAM

The Hepatitis C Rapid Testing Program initiative focuses on increasing HCV screening and testing, diagnosis, and linkage to care in Maryland. Beginning in 2017, the Maryland Department of Health was identified as a beneficiary of the CDC- PS17- 1702 grant to improve hepatitis B and hepatitis C care cascades with a focus on increased hepatitis C testing and diagnosis. This grant has provided the opportunity to build the capacity of local health departments, community-based organizations, emergency departments and primary care providers to offer routine HCV screening, testing, and linkage to care for those infected



As of 2019, rapid HCV testing services has been developed in 15 of 24 Maryland jurisdictions and 27 locations across the state with several new jurisdictions and sites showing interest to participate. Although the Hepatitis C Rapid Testing Program is no longer CDC funded, the PHPA at MDH provides funding support for participating sites to continue to procure rapid HCV test kits and controls. In addition to test kits the program provides regular technical support in form of training, webinars, and peer program support to all participating sites.

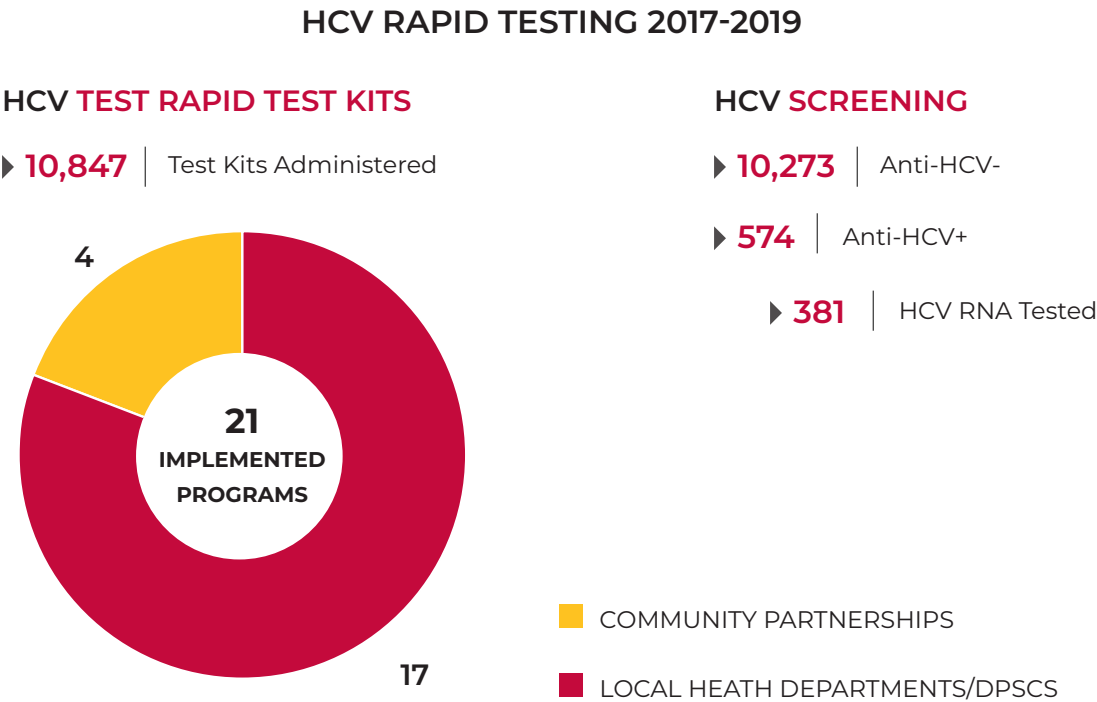
Figure 63. Maryland's Hepatitis C Rapid Testing Program Participating Local Health Departments, State Correctional Facilities and Community-Based Organization Testing Locations, 2017–2019



Source: Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services
Bureau Center for Viral Hepatitis Maryland HCV Rapid Testing Program, 2019

From 2017 to 2019, 10,847 HCV rapid test kits were administered through the HCV Rapid Testing Program. Of those screened for HCV 5.3% (574) tested HCV antibody positive. Among that HCV antibody positive, 66% (381) were currently infected with hepatitis C virus.

Figure 64. HCV Rapid Testing Program hepatitis C test kits and screening, 2017-2019

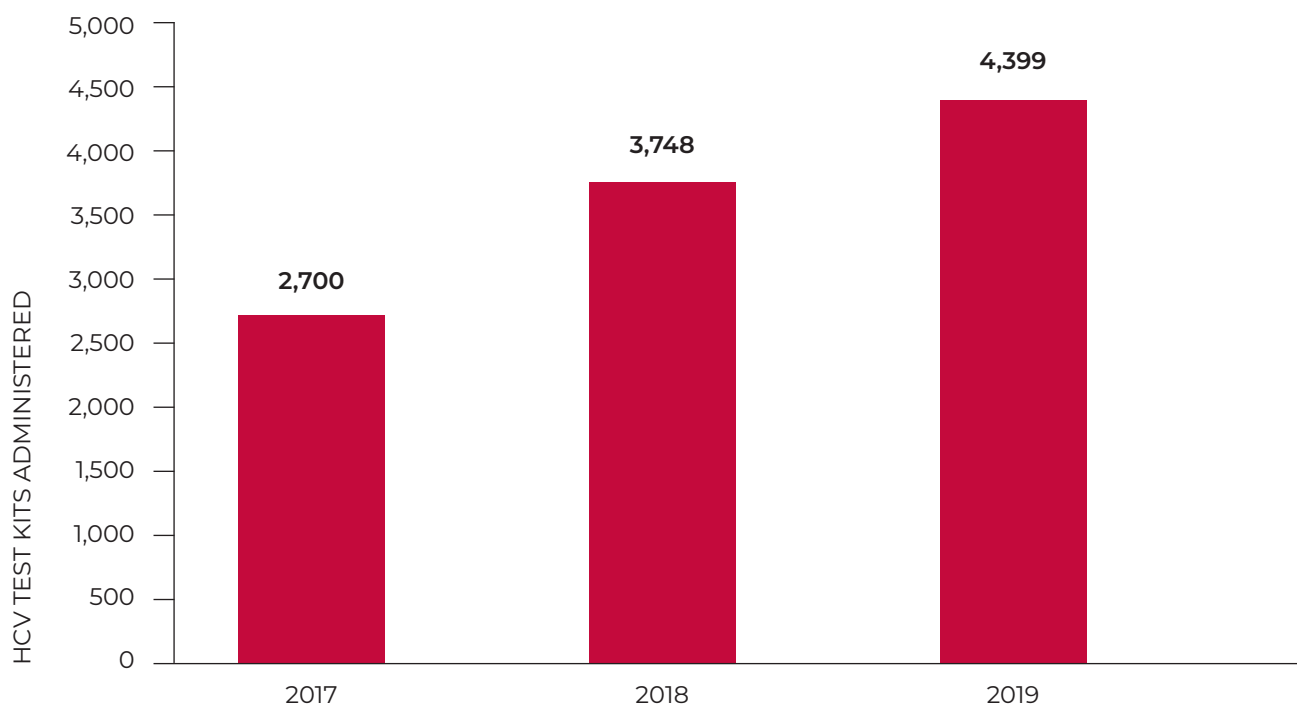


Source: Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services
Bureau Center for Viral Hepatitis Maryland HCV Rapid Testing Program, 2019

HEPATITIS C RAPID TESTING PROGRAM

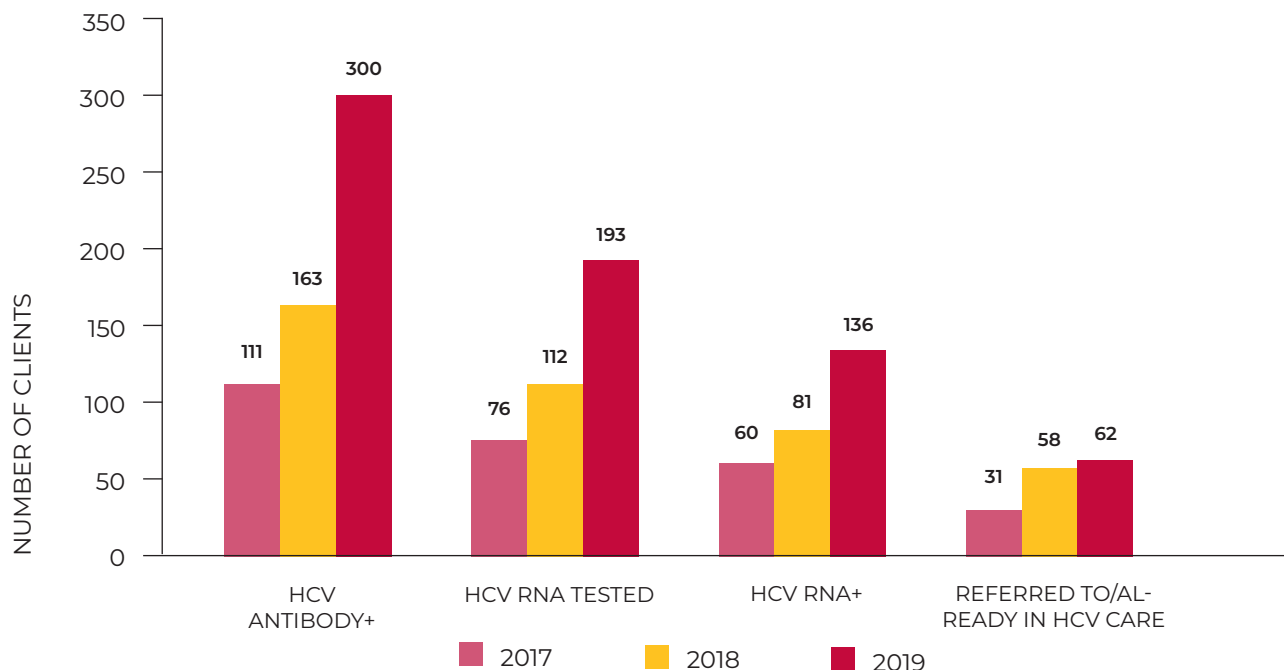
The number of HCV rapid test kits administered through the HCV Rapid Testing Program increased from 2,700 in 2017 to 4,399 in 2019. As the number of test kits administered through the HCV Rapid Testing Program increased from 2017 to 2019 the number of HCV antibody positive and HCV RNA clients also increased.

Figure 65. HCV Test Kits administered through Maryland's Hepatitis C Rapid Testing Program, 2017–2019



Source: Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services
Bureau Center for Viral Hepatitis Maryland HCV Rapid Testing Program, 2019

Figure 66. Maryland's Hepatitis C Rapid Testing Program HCV care cascade, 2017–2019



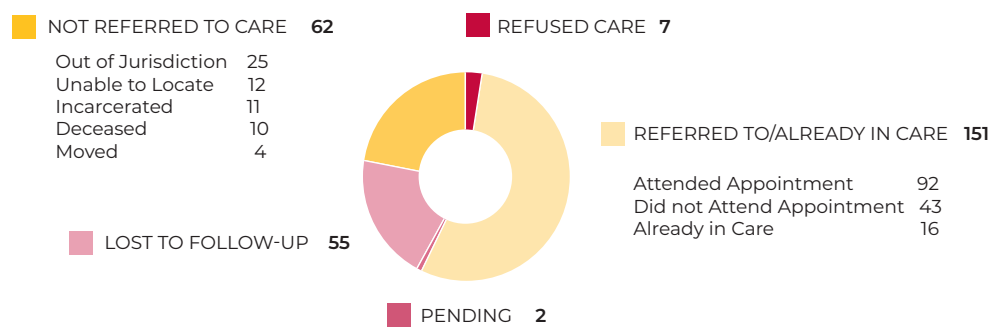
Source: Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services
Bureau Center for Viral Hepatitis Maryland HCV Rapid Testing Program, 2019

MARYLAND HEPATITIS C RAPID TESTING PROGRAM

LINKAGE TO CARE OUTCOMES

From 2017 to 2019, 151 clients were referred to or identified as already HCV care. Linkage to care was successfully completed for 92 clients who attended their first HCV medical appointment.

Figure 67. HCV Rapid Testing linkage to care outcomes by program year, 2017-2019



Source: Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services
Bureau Center for Viral Hepatitis Maryland HCV Rapid Testing Program, 2019

The Center for Viral Hepatitis hosts monthly virtual meetings for all participating sites of the HCV Rapid Testing Program across Maryland. Technical updates and best practices from partner’s programs are discussed during these meetings. The Center for Viral Hepatitis also uses an online workspace that allows partners to freely conduct and access threaded discussions in order to develop and implement strategies to improve and increase viral hepatitis prevention and coordination throughout Maryland.

MARYLAND COMMUNITY-BASED PROGRAMS TO TEST AND CURE HEPATITIS C

Maryland Community-based Programs to Test and Cure Hepatitis C Maryland initiative was established in September 2014 and continues to provide extensive training for primary care providers to learn current guidelines for HCV treatment and improve hepatitis C testing and treatment throughout Maryland. The overall goal of the program is to reduce HCV-related morbidity and mortality by strengthening healthcare capacity to diagnose and cure HCV infection originally in Baltimore City and Baltimore County, but has now expanded to several other jurisdictions Maryland. MDH collaborated with partners to achieve this goal through the following six strategies:

1. Increase the capacity of primary care providers to deliver HCV treatment and case management through the provision of provider training and ongoing telemedicine consultation
2. Increase HCV testing by primary care providers through provider and patient education
3. Increase linkage-to-care services available through the local health department to ensure HCV-infected persons are supported in adhering to their treatment regimen
4. Increase HCV surveillance infrastructure and data sharing to refine population-level estimates of HCV infection and health outcome
5. Increase utilization of electronic medical records by participating clinical sites in an effort to enhance HCV services, evaluate service outcomes, and inform quality improvement
6. Explore policy initiatives to improve client access to HCV testing, diagnosis, and treatment

Sharing the Cure Provider Training

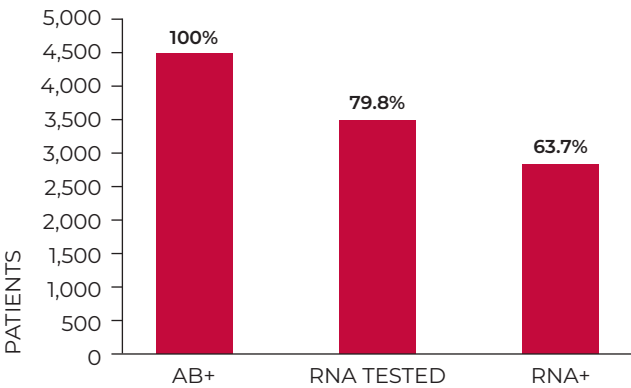
The Sharing the Cure (STC) provider training is a telemedicine provider education training & core component of the Maryland Community-based Program to Test and Cure Hepatitis C initially funded by CDC, but currently sustained with Maryland state government funding. The STC provider training is implemented and coordinated by the John Hopkins University (JHU) School of Medicine Division of Infectious Disease Viral Hepatitis Center. Providers participating in the STC provider training attend a 1-day in person HCV course on HCV evaluation, treatment, and cure, participate in mini-preceptorship where JHU provides clinical guidance and support on patient adherence and fibroscan training, a 14 to 22 weekly teleconference with JHU HCV experts on hepatitis C case testing and treatment decisions, additional primary care education sessions regarding viral hepatitis C, and a final exam to evaluate provider knowledge and ability to successfully test and treat HCV.

TEST AND CURE HEPATITIS C DATA

As a part of the Maryland Community-based Program to Test and Cure Hepatitis C all participating clinical agency sites submit electronic medical record data for all hepatitis C patients seen by a provider who has/or currently is participating in the STC provider training. Data elements include: demographics, insurance, injection drug use history/substance abuse history, additional comorbidities such as HIV and HBV, HCV diagnosis and lab test, and HCV treatment including: medication, regimen start and end date, treatment lab work, and sustained virologic response outcome.

From 2015 to 2019, 3,366 patients were seen by a STC provider related to hepatitis C. A total of 2,967 patients tested Anti-HCV+. Among those Anti-HCV+, 93% received HCV RNA testing, of which 80% tested HCV RNA+.

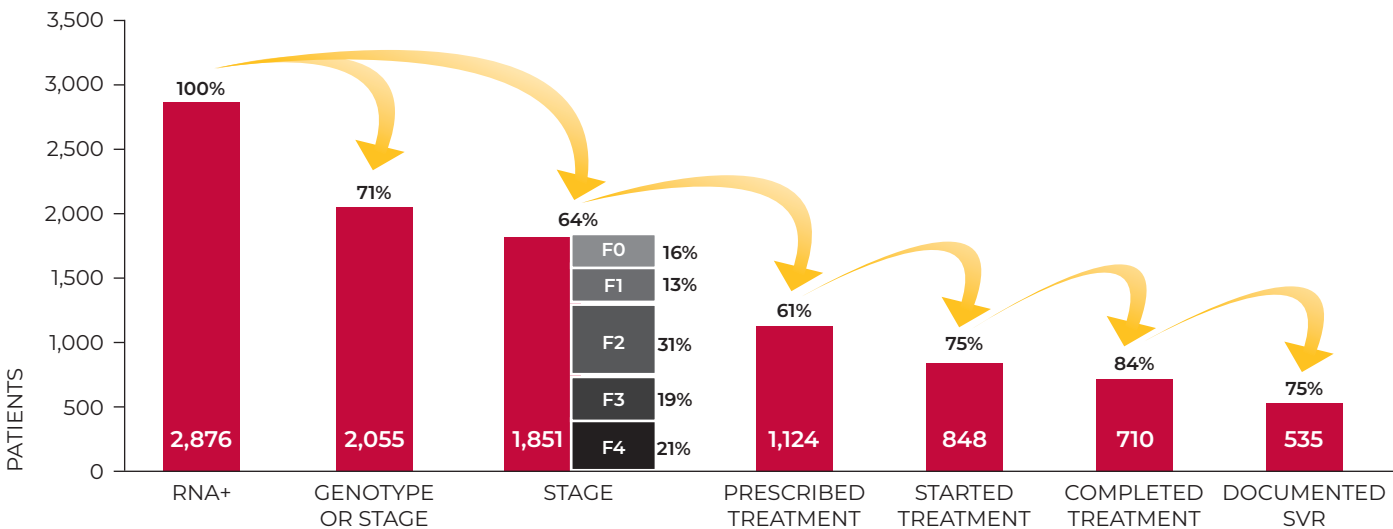
Figure 68. Maryland Community-based Programs to Test and Cure Hepatitis C clinical partner HCV testing, 2015-2019



Source: Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services Bureau Center for Viral Hepatitis Maryland Community-based Programs to Test and Cure HCV, 2019

In addition to receiving HCV testing and diagnosis, patients seen by a STC provider were worked up for hepatitis C treatment, which included additional labs such as HCV genotyping and liver fibrosis staging. Among the 2, 876 patients identified as chronically infected, 71% were worked up for treatment and 64% received liver fibrosis staging testing. More than half (61%) of those with liver fibrosis staging were prescribed HCV treatment. STC providers reported 84% of the patients who started HCV treatment successfully completed their regimens. Documented sustained virologic response (SVR) was obtained by 75% of patients who completed HCV treatment.

Figure 69. Maryland Community-based Programs to Test and Cure Hepatitis C clinical partner HCV care cascade, 2015-2019



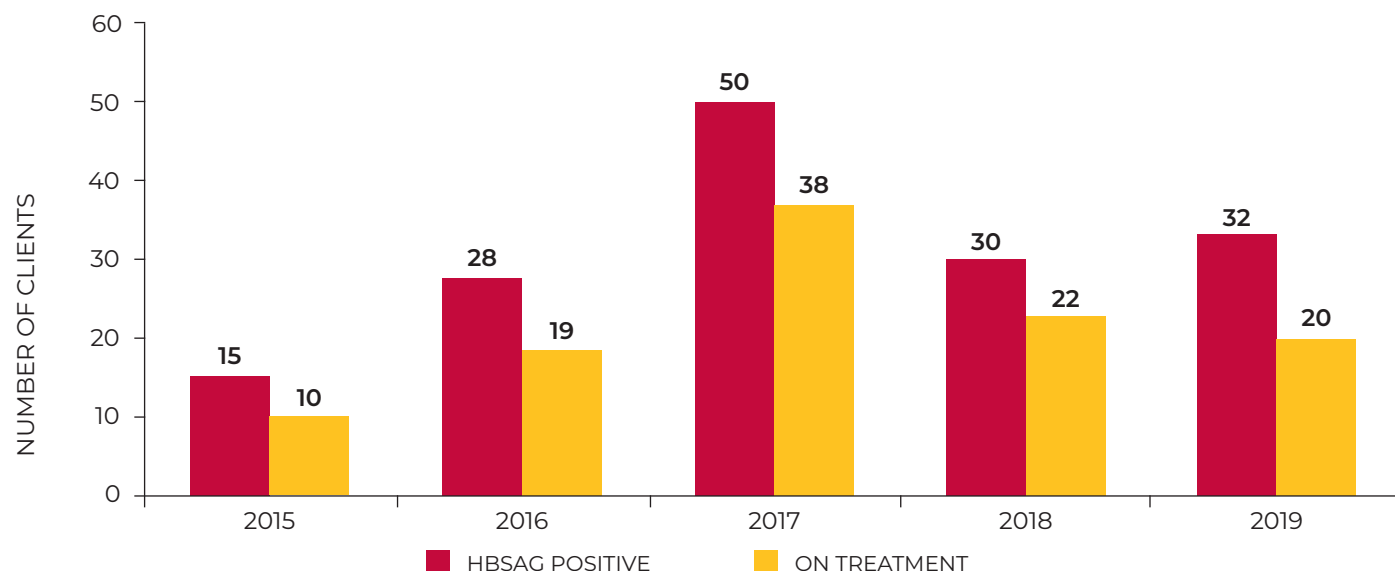
Source: Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services Bureau Center for Viral Hepatitis Maryland Community-based Programs to Test and Cure HCV, 2019

COMMUNITY ENGAGEMENT & ADVOCACY

Through the implementation of the Maryland Community based Program to Test and Cure Hepatitis C, the Department initiated collaboration with selected federally qualifying health centers especially in Baltimore City and Baltimore County to provide improved access to high quality HCV diagnosis and treatment services. This collaboration has been expanded to other FQHCs, local providers, and SUD treatment providers outside Baltimore to address increasing number of positive cases in sub-urban Maryland.

MDH Center for Viral Hepatitis has been partnering with Hepatitis B Initiative-Washington DC (HBI-DC), a community-based nonprofit organization that supports viral hepatitis B and C outreach throughout Washington DC, Maryland, and Northern Virginia, since 2017 to implement hepatitis B and hepatitis C prevention education, screening, and testing. HBI-DC through its outreach events throughout Maryland targets minority populations, particularly Asian and African immigrant populations in Montgomery County and Prince George's County to increase hepatitis B education, screening, diagnosis, and referral to care services. Hepatitis B vaccination services are also provided by HBI-DC for high risk individuals identified during outreach programs.

Figure 70. Unique patients who tested HbsAG positive and were successfully placed on treatment by Hepatitis B Initiative of Washington DC, 2015-2019



Source: Hepatitis B Initiative of Washington DC, 2019

The Maryland Department of Health participates in the Maryland Hepatitis Coalition, a multi-stakeholder group comprising of representatives of clinical providers, community groups, academic and research institutions, political advocates, and government agencies with a common interest of elimination of hepatitis C in Maryland bi-monthly meetings. Founded in 2008, the Maryland Hepatitis Coalition is a well-coordinated network of HCV advocates in Maryland that convenes bi-monthly to discuss and respond to viral hepatitis legislative and policy updates, as well as to share updates and resources. The mission of the Maryland Hepatitis Coalition is to raise awareness, promote primary and secondary prevention methods, and advocate to improve access to care and treatment for all populations and those with a higher risk for viral hepatitis. The coalition includes over 150 members from 40 unique organizations and agencies across all sectors. Members include representatives from local and state government agencies, academic

medical centers, health centers, pharmaceutical companies, advocacy groups and community-based organizations. The Maryland Hepatitis Coalition continues to push more towards collaboration, education, and awareness. The Maryland Hepatitis Coalition and its members have been one of the main advocates for the removal of Medicaid Fibrosis restrictions related to HCV treatment regimens.

In 2019, MDH Center for Viral Hepatitis co-hosted with Maryland Hepatitis Coalition the first Maryland Hepatitis Summit in collaboration with the University of Maryland School of Medicine, the John Hopkins University School of Medicine, Baltimore City Health Department, Sisters Together and Reaching Inc., and Patient Advocates. This summit was a 1-day conference focusing on the elimination of hepatitis in Maryland. Summit attendees heard directly from the Maryland Department of Health regarding its strategies to eliminate viral hepatitis in Maryland, discussed with clinicians Maryland specific barriers to viral hepatitis prevention and treatment, engaged in interactive break-out sessions regarding viral hepatitis, and mapped long-term plans and activities for the prevention and elimination of viral hepatitis in Maryland.

VIRAL HEPATITIS POLICIES

“MEDICAID FIBROSIS RESTRICTIONS”

Though a cure is available for HCV and treatment regimens have improved significantly since the development of DAAs, there remain several barriers to accessing treatment; chief among these is insurance coverage of treatment. Marylanders with private and public sources of coverage alike face restrictions to treatment. These payers can include criteria for approval to obtain treatment coverage, largely among restrictions related to degree of liver damage, sobriety, and prescriber specialty. Should the medication be approved, those with private coverage or Medicare/Medicare Advantage can also experience significant copays and coinsurances.

Up until July 2019 the following was Maryland Medicaid coverage of Hepatitis C treatment. Approval of HCV therapy requires prior authorization submission which is evaluated based on a set of clinical criteria.

Pre-Treatment Evaluation:

- *Must have chronic hepatitis C and HCV genotype and sub-genotype documented;*
- *HCV RNA quantitative within 90 days of application for therapy;*
- *Liver biopsy or the accepted test demonstrating liver fibrosis corresponding to a Metavir score of greater than or equal to 2*;*
- *Previous HCV treatment history and outcome;*
- *HIV status and, if HIV positive, current antiretroviral regimen and degree of viral suppression;*
- *Adherence evaluation: Providers must assess and document the patient's ability to adhere to therapy;*
- *Drug resistance testing as indicated; and*
- *Patient Treatment Plan*
 - *It is required that the patient have a treatment plan developed by, or in collaboration with, a provider with expertise in Hepatitis C management.*
 - *If the patient or their partner is of childbearing age, at least two (2) forms of contraception must be used (by the patient or their partner) if a RBV –containing regimen is prescribed throughout the duration of therapy and for 6 months after the regimen is complete.*

**As of July 1, 2019*

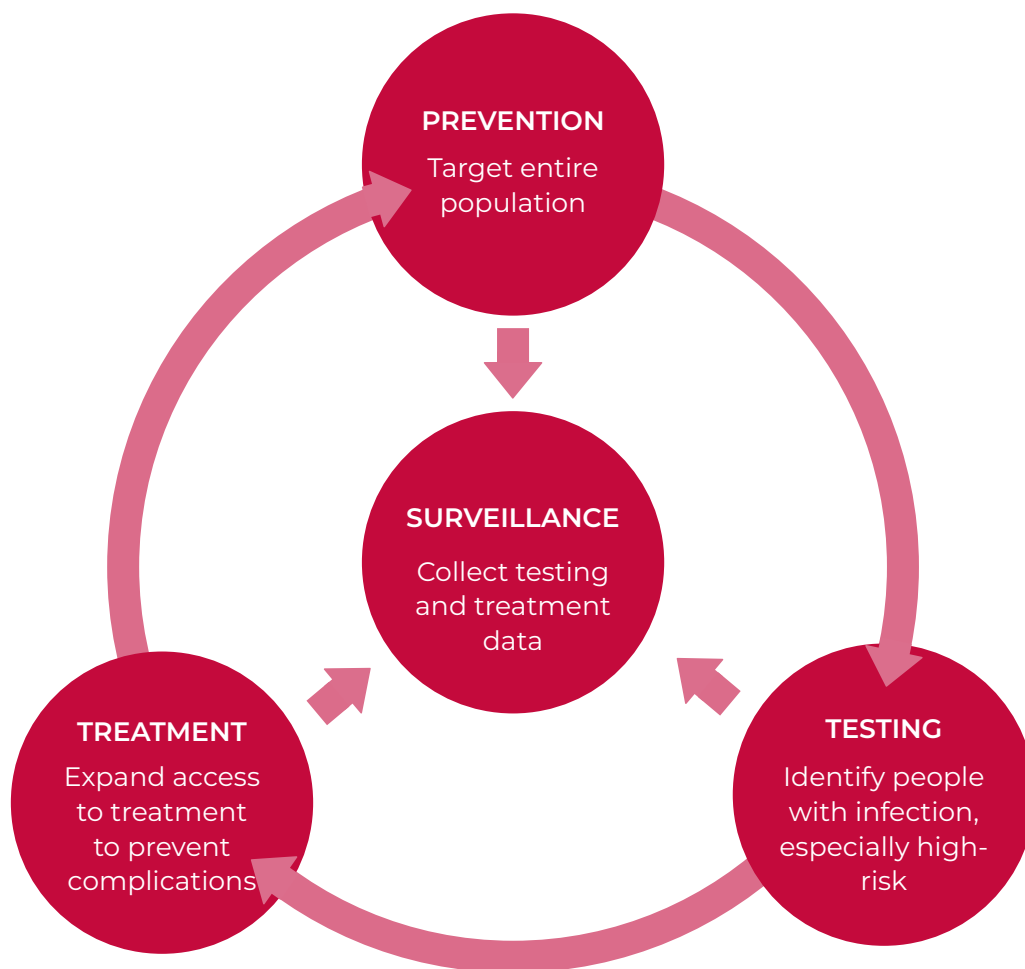
In 2019, the Maryland General Assembly passed Senate Bill 598, which became Chapter 451 of the Acts of 2019. The legislation directs the Maryland Medical Assistance Program to expand HCV treatment to all Medicaid recipients, regardless of liver damage. Prior to July 1, 2019, Medicaid patients with HCV infection having mild or no liver damage were not eligible for antiviral treatment. This constituted a treatment barrier and impacted hepatitis C elimination drive in the state, contributing in sustained transmission especially among persons who inject drugs.

Beginning in January 1, 2020, liver fibrosis restrictions were completely removed as a barrier to hepatitis C treatment for Medicaid recipients in Maryland. However, documentation of the stage of liver damage is still required as well as other pre-treatment evaluation requirements described above.

HEPATITIS C STRATEGIC PLAN

The Maryland Hepatitis C Strategic Plan articulates comprehensive, broad-based strategies that includes a four-pronged approach encompassing prevention of new infections, expanding HCV testing and linkage to care, improving access to treatment, and enhancing viral hepatitis surveillance.

Figure 71. Maryland Hepatitis C Strategic Plan: Four Pillars



Source: Maryland Department of Health Hepatitis C Strategic Plan, 2019

MARYLAND HEPATITIS C ELIMINATION INDICATORS

Maryland is working towards the elimination of hepatitis C disease as a public health threat by prioritizing the prevention of new infections, diagnosis and linkage to care, treatment of infections, and improved surveillance monitoring and evaluation. The Maryland Department of Health Center for Viral Hepatitis has utilized the four pillars of the Maryland Hepatitis C Strategic Plan to generate indicators and suggested measures in order to eliminate hepatitis C in Maryland:

HEPATITIS C STRATEGIC PLAN PILLAR	ELIMINATION INDICATOR	MEASURE
PREVENTION OF NEW INFECTION	<ul style="list-style-type: none"> Lower prevalence of acute and chronic hepatitis C cases in Maryland Increased HCV prevention education Integration of HCV education and services into HIV, STI, and harm reduction services Lower prevalence of acute and chronic HCV among injection drug users 	1.1 80% decrease in the number of new hepatitis C infections in Maryland 1.2 Decrease in the number of chronic hepatitis C cases reported in Maryland 1.3 Decrease in the number of persons who inject drugs (PWID) infected with HCV 1.4 Increase in the number of syringe service programs throughout Maryland
TESTING	<ul style="list-style-type: none"> Increase in the number of Marylanders who are aware of their acute and chronic HCV status Improved targeted HCV testing for high risk populations in Maryland including homeless individuals, PWID, and baby boomers 	2.1 Increase in the number of Marylanders screened for HCV in clinical and non-clinical settings 2.2 90% percent of HCV antibody positive Marylanders tested for HCV RNA 2.3 90% of HCV test results delivered to Marylanders tested
TREATMENT	<ul style="list-style-type: none"> Improved chronic HCV linkage to care services Targeted HCV treatment for Marylanders in earlier stages of liver disease Higher number of Marylanders achieving sustained virologic response (SVR) or cure 	3.1 Increase in the number of health care settings and providers offering HCV treatment 3.2 65% reduction in liver-related mortality 3.3 85% of HCV RNA positive Marylanders linked to HCV medical care 3.4 Increase in the number of currently infected HCV Marylanders who start direct acting antiviral (DAA) treatment 3.5 95% of Marylanders infected with HCV obtained SVR
SURVEILLANCE	<ul style="list-style-type: none"> Improved acute HCV case reporting in Maryland Increased acute HCV case investigation Completion of HCV case records reported in Maryland Integration of HCV treatment data reporting into testing data reporting 	4.1 80% or more of all hepatitis C test conducted by laboratories for Marylanders reported to local health departments in Maryland 4.2 Increase in HCV RNA negative test results reported to local health departments 4.3 Increase in clinical electronic medical record data reported to local health departments for Marylanders on HCV treatment

DATA SOURCES

SOURCES

Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services Bureau Center for Viral Hepatitis

Maryland National Electronic Disease Surveillance System

Maryland Enhanced HIV/AIDS Reporting System

Maryland Health Services Cost Review Commission

Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry

Maryland Department of Health Prevention and Health Promotion Administration Center for Immunization

Maryland Department of Public Safety and Correctional Services

Association of State and Territorial Health Officials

Center for Disease Analysis Foundation

Johns Hopkins University

Centers for Disease Control and Prevention

Substance Abuse and Mental Health Services Administration

Hepatitis B Initiative of Washington DC

US Census Bureau

American Community Survey

LIMITATIONS

Maryland National Electronic Disease Surveillance System:

Hepatitis A is severely under reported in surveillance and is primarily reported when there is a case associated with an outbreak. Therefore, demographic data of reported HAV cases in surveillance may be a misrepresentation and thus not presented here in this report.

As described, the surveillance definition of an acute HCV infection is dependent upon the presentation of symptoms or a serum level derived from a blood test. However, due to the often asymptomatic nature of HCV, many who become newly infected are not aware of their disease status. In addition, from 15-25% of acutely infected individuals will spontaneously clear the virus without intervention and will not go on to develop chronic HCV infection. It is thus difficult to make meaningful inferences about acute cases reported through surveillance because they are often vastly underestimated and not representative of true disease burden. Hepatitis C definition was different in 2015, resulting in inconsistencies classifying "confirmed" and "probable" cases (see data sources tab for further info on CDC case definitions). Reported cases of chronic hepatitis B and C are classified using the prevailing CDC surveillance case definition. The counts viewed over time reflect a reporting trend, but not the true prevalence. Note also that the case definition is periodically updated, so caution must be used in interpreting changes in counts over time. Additionally, changes in hepatitis C testing recommendations might also impact case counts over time.

Geographical distribution of cases is based on address of case at time of reporting and case investigation.

Maryland Enhanced HIV/AIDS Reporting System:

Surveillance is the ongoing systematic collection, analysis, interpretation, and dissemination of data. Data are only available for people that have been diagnosed with HIV by a health care provider, were residents of Maryland at the time of diagnosis or are current residents of Maryland as of December 31, 2019, are receiving medical care (often only at facilities in Maryland), and only includes information that has been reported to the Maryland Department of Health's Enhanced HIV/AIDS Reporting System (eHARS), as of June 30, 2019. Exposure data related to HIV exposure may not be how someone was infected with hepatitis.

Maryland Health Services Cost Review Commission

Data presented here excludes hospitalized non-Maryland residents. Inpatient hospitalizations with "any diagnosis" includes hospitalizations with any diagnosis of the respective infection/disease regardless of whether or not it was the primary or secondary diagnosis.

Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry

Case counts of 1-5 are suppressed per Maryland Department of Health/Maryland Cancer Registry Data Use Policy. Case counts are suppressed to prevent disclosure of data in other cell(s). Percentages for suppressed cell counts are suppressed.

Maryland Department of Public Safety and Correctional Services

Data for total population includes inmates detained and sentenced only excluding those in probation/parole-criminal and drunk driving monitoring program categories. Known positive is defined as inmates identified as positive upon entry into a Maryland Department of Public Safety and Correctional Services facility prior to any testing.

RESOURCES

LOCAL HEALTH DEPARTMENTS

Allegany County Health Department

12501-12503 Willowbrook Rd, Cumberland, MD 21501
301-759-5000

Anne Arundel County Health Department

Harry S. Truman Pwy, Annapolis, MD 21401
410-222-7095

Baltimore City Health Department

100 N. Holliday St, Baltimore, MD 21202
410-396-3100

Baltimore County Health Department

6401 York Rd, Third Floor Baltimore, MD 21212
410-887-2243

Calvert County Health Department

975 Solomons Island Rd North, Prince Frederick, MD 20678
410-535-5400

Caroline County Health Department

403 S 7th St, Denton, MD 21629
410-479-8030

Carroll County Health Department

290 South Center St, Westminster, MD 21157
410-876-2152

Cecil County Health Department

401 Bow St, Elkton, MD 21921
410-996-5550

Charles County Health Department

4545 Crain Hwy, White Plains, MD 20695
301-609-6900

Dorchester County Health Department

Cedar St, Cambridge, MD 21613
410-228-3223

Frederick County Health Department

350 Montevue Ln, Frederick, MD 21702
301-600-1029

Garrett County Health Department

1025 Memorial Dr, Oakland, MD 21550
301-334-7777

LOCAL HEALTH DEPARTMENTS (CONTINUED)

Harford County Health Department

120 South Hays St, Bel Air, MD 21014
410-838-1500

Howard County Health Department

8930 Stanford Blvd, Columbia, MD 21045
410-313-6300

Kent County Health Department

125 South Lynchburg St, Chestertown, MD 21620
410-778-1350

Montgomery County Department of Health and Human Services

1301 Piccard Dr., Rockville, MD 20850
240-777-0311

Prince George's County Health Department

3003 Hospital Dr, Cheverly MD 20785
301-883-7879

Queen Anne's County Health Department

206 North Commerce St, Centreville MD 21617
410-758-0720

St. Mary's County Health Department

21580 Peabody St, Leonardtown, MD 20650
301-475-4330

Somerset County Health Department

8928 Sign Post Rd, Suite 2, Westover, MD 21871
443-523-1700

Talbot County Health Department

100 South Hanson St, Easton, MD 21629
410-819-5600

Washington County Health Department

1302 Pennsylvania Ave, Hagerstown, MD 21742
240-313-3200

Wicomico County Health Department

108 E. Main Street, Salisbury, MD 21801
410-749-1244

Worcester County Health Department

6040 Public Landing Rd, Snow Hill, MD 21863
410-632-1100

HEPATITIS A

Hepatitis A is a liver disease caused by the hepatitis A virus (HAV). HAV can be prevented with a vaccine.

WHAT IS HEPATITIS A?

Hepatitis A is a contagious acute liver disease that causes inflammation of the liver. Hepatitis A can be cleared by the immune system when the infection is mild, however severe infections may require medical treatment.

HOW DOES HEPATITIS A SPREAD?

Hepatitis A is passed in a person's feces (stool). The infection is **mainly spread by person-to-person contact** by putting something in the mouth (even though it may look clean) that has been contaminated with the stool of a person infected with HAV. Hepatitis A is also spread by **eating food or water contaminated with HAV**. Having **sexual contact and sharing syringes or drug equipment with a person infected with HAV** can cause infection as well.

SYMPTOMS

- Yellow skin and eyes (jaundice)
- Brown, tea-colored urine
- Diarrhea or light-colored stool
- Fever
- Loss of appetite
- Stomach pain
- Nausea and/or vomiting
- Fatigue (tired)

Symptoms usually appear within 28 days after exposure to HAV and can last up to 2 weeks or longer in severe cases. Some people are asymptomatic or do not experience any symptoms of HAV. All people who are infected with HAV can spread it to others. **If you have any symptoms, please contact your health care provider.**

HEPATITIS A CAN BE PREVENTED WITH A VACCINE.



Vaccination is the best way to protect against hepatitis A.

A. The vaccine is routinely recommended for persons 12 months of age and older.

Other vaccine recommendations include:

- All children at age 1 year (i.e. 12-23 months)
- Travel to countries that have high rates of hepatitis A
- Men who have sex with men
- Users of injection and non-injection drugs
- Persons with chronic (lifelong) liver disease, such as hepatitis B & C
- People with clotting factor disorders, such as hemophilia
- Persons who work with HAV in a laboratory setting

WASH YOUR HANDS

Good personal hygiene is another prevention measure. Wash hands with soap and water:



- After using the toilet or changing diapers.
- Before preparing any food or drink and before eating.

The only way to know if you have HAV is to have a blood test. There is no special treatment for HAV, but doctors usually recommend rest, good diet, fluids, and avoiding alcohol. A few people may need to be hospitalized.

HEPATITIS B

Hepatitis B is a liver disease caused by the hepatitis B virus (HBV). HBV can be prevented with a vaccine.

WHAT IS HEPATITIS B?

Hepatitis B is a disease that attacks the liver. Hepatitis B can cause an acute, short-term illness or a chronic, life-long infection. Chronic HBV infection may go on to cause life-threatening cirrhosis (scarring of the liver), liver failure, or liver cancer. After acute HBV infection, the risk of developing chronic infection varies with age.

HOW DOES HEPATITIS B SPREAD?

Hepatitis B is spread by exposure to blood and body fluid from an acutely or chronically infected person. The hepatitis B virus (HBV) can be spread during unprotected sex, direct blood to blood contact for example, sharing syringes or drug equipment with a person infected with HBV or from a HBV infected mother to baby, usually at birth. HBV is not spread by sharing meals or utensils or casual contact, such as shaking hands, hugging, kissing, coughing, or sneezing.

SYMPTOMS

- Fatigue (tired)
- Nausea and/or vomiting
- Yellow skin and eyes (jaundice)
- Dark-colored urine
- Muscle aches/Joint Pain
- Loss of appetite
- Abdominal pain

Symptoms usually occur within 60 to 90 days after exposure to HBV. Some people are asymptomatic or do not experience any symptoms of HBV. An asymptomatic person infected with HBV also known as a carrier and can infect others. **If you have any symptoms, please contact your health care provider immediately for treatment/recommendations.**

HEPATITIS B IS A VACCINE PREVENTABLE DISEASE

Routine vaccination is recommended for all newborns prior to hospital discharge, all children and teens ages 0 through 18 years, and all persons who wish to be protected from hepatitis B virus infection. Persons who are considered at higher risk (listed above) and travelers to areas where the disease is common should also be immunized. Babies born to HBV infected mothers should get the vaccine and a shot called HBIG (hepatitis B immune globulin) within 12 hours of birth.



WHO SHOULD BE TESTED FOR HEPATITIS B?

A blood test is required for diagnosis of HBV. Anyone

who has not gotten the vaccine can become infected with hepatitis B, but there are people who may be at greater risk including:

- Infants born to HBV-infected mothers
- Men who have sex with men
- People who share syringes or drug equipment
- Sexual contacts or close household members of a person chronically infected with HBV
- Healthcare providers and emergency responders who have exposure to blood
- People born in regions with high HBV endemicity including: Asia, Africa, South America, Pacific Islands, Eastern Europe, and the Middle East

All pregnant women should be tested for HBV during early stages of pregnancy.

If you test positive you need to know if you have a new infection, have recovered from a past infection, or if you have a chronic infection.



TREATMENT

Limited treatment is available for hepatitis B. There are no special treatments for someone who has acute HBV, however rest and avoiding alcohol and certain drugs are advised. For chronic hepatitis B medical evaluation for liver disease progression every 6-12 months is recommended and antiviral drugs are available.

HEPATITIS C

Hepatitis C is a liver disease caused by the hepatitis C virus (HCV). HCV is one of the most common bloodborne infections.

WHAT IS HEPATITIS C?

Hepatitis C is a blood-borne disease that infects the liver. Hepatitis C can cause an acute, short-term illness or a chronic, life-long infection. An estimated 75-85% of HCV infected persons will develop chronic infection. Chronic HCV infection can cause life-threatening cirrhosis (scarring of the liver), liver failure, liver cancer, and in severe cases death.

HOW DOES HEPATITIS C SPREAD?

Hepatitis C is spread mainly by exposure to blood and blood products when the blood of a HCV infected person enters the body of a person who is not infected with HCV. Mainly this involves direct passage of blood through the skin through sharing syringes or drug equipment with a person infected with HCV. Much less often, sexual contact, birth to an infected mother, unregulated tattooing, or needle-sticks can lead to HCV infection. HCV is not spread by sharing meals or utensils, breastfeeding, or casual contact, such as shaking hands, hugging, kissing, coughing, or sneezing.

SYMPTOMS

- Yellow skin and eyes (jaundice)
- Loss of appetite
- Nausea and/or vomiting
- Abdominal pain
- Fatigue (tired)
- Dark-colored urine
- Joint pain
- Clay-colored stool

Many persons have no symptoms of HCV infection. Symptoms may not occur until after the development of liver complications including cirrhosis, liver failure, and/or liver cancer. **If you have any symptoms, please contact your health care provider immediately for treatment/recommendations.**

DIFFERENT TYPES OF HEPATITIS C VIRUS

There are 7 distinct HCV genotypes or genetic make-up.

PREVENTION

Hepatitis C can be prevented by avoiding exposure and practicing good hygiene. People currently injecting drugs should not share needles or drug equipment with others. The use of latex condoms may decrease the risk of catching or passing HCV through sex.

WHO SHOULD BE TESTED FOR HEPATITIS C?



A blood test is required for diagnosis of HCV. It is recommended all adults aged 18 years or older receive one-time hepatitis C testing. In addition, people at greater risk including the following should receive hepatitis C testing:

- People who currently inject drugs, share syringes, or drug equipment
- People with a history of injection drug use
- People born between 1945 to 1965
- People with HIV
- People who receive or received hemodialysis
- Infants born to HCV-infected mothers
- Healthcare providers and emergency responders who have exposure to blood

All pregnant women should be tested for HCV during pregnancy.

There are two standard blood tests that diagnose hepatitis C:

- **Hepatitis C antibody testing** confirms exposure to HCV
- **Hepatitis C RNA testing** searches the blood for HCV and confirms the presence of HCV infection

HEPATITIS C IS CURABLE

Hepatitis C has a cure. Direct-acting antiviral (DAA) oral medications are available to treat HCV. DAAs are very effective at targeting HCV and achieving a sustained virologic response. Hepatitis C DAA treatment regimens range from 8-12 (up to 24) weeks.



APPENDIX: SUPPORTING DATA TABLES

TABLE 1. REPORTED NUMBER OF HEPATITIS A IN MARYLAND BY DEMOGRAPHICS, 2015-2019

	YEAR											
	2015		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
OVERALL												
Total	20	0.3	34	0.6	31	0.5	52	0.9	96	1.6	233	3.9
SEX AT BIRTH												
Male	8	0.3	22	0.8	23	0.8	36	1.2	60	2.0	149	5.1
Female	12	0.4	12	0.4	8	0.3	16	0.5	36	1.2	84	2.7
Unknown	0	---	0	---	0	---	0	---	0	---	0	0.0
Missing	0	---	0	---	0	---	0	---	0	---	0	0.0
RACE												
American Indian or Alaskan Native	1	2.9	0	0.0	2	5.6	0	0.0	0	0.0	3	8.4
Asian	0	0.0	1	0.3	1	0.3	2	0.5	2	0.5	6	1.5
Black/African American	4	0.2	10	0.5	7	0.4	18	1.0	18	1.0	57	3.1
Native Hawaiian or Other Pacific Islander	1	15.7	0	0.0	0	0.0	2	29.6	0	0.0	3	45.5
White	10	0.3	20	0.6	18	0.5	27	0.8	64	1.8	139	3.9
Other	0	---	0	0.0	0	---	0	---	0	---	0	---
Unknown	4	---	3	---	3	---	3	---	12	---	25	---
Missing	0	---	0	---	0	---	0	---	0	---	0	---

Data subject to change.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019

TABLE 2. REPORTED NUMBER OF HEPATITIS A IN MARYLAND BY COUNTY, 2015-2019

	YEAR											
	2015		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
MARYLAND												
Overall	20	0.3	34	0.6	31	0.5	52	0.9	96	1.6	233	3.9
COUNTY												
Allegany	0	0.0	0	0.0	0	0.0	0	0.0	1	1.4	1	1.4
Anne Arundel	1	0.2	6	1.1	3	0.5	2	0.3	1	0.2	13	2.3
Baltimore City	2	0.3	3	0.5	10	1.6	6	1.0	5	0.8	26	4.3
Baltimore	1	0.1	0	0.0	2	0.2	5	0.6	11	1.3	19	2.3
Calvert	1	1.1	2	2.2	0	0.0	4	4.3	0	0.0	7	7.7
Caroline	0	0.0	0	0.0	0	0.0	0	0.0	1	3.0	1	3.0
Carroll	1	0.6	1	0.6	0	0.0	1	0.6	1	0.6	4	2.4
Cecil	0	0.0	1	1.0	0	0.0	2	1.9	27	26.3	30	29.3
Charles	0	0.0	6	3.8	0	0.0	1	0.6	2	1.2	9	5.6
Dorchester	0	0.0	0	0.0	0	0.0	0	0.0	2	6.3	2	6.2
Frederick	0	0.0	0	0.0	1	0.4	0	0.0	1	0.4	2	0.8
Garrett	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Harford	1	0.4	0	0.0	5	2.0	0	0.0	5	2.0	11	4.4
Howard	1	0.3	2	0.6	1	0.3	2	0.6	1	0.3	7	2.2
Kent	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Montgomery	5	0.5	6	0.6	5	0.5	7	0.7	14	1.3	37	3.5
Prince George's	2	0.2	5	0.6	4	0.4	12	1.3	15	1.6	38	4.2
Queen Anne's	0	0.0	0	0.0	0	0.0	0	0.0	1	2.0	1	2.0
Somerset	0	0.0	0	0.0	0	0.0	0	0.0	1	3.9	1	3.9
St. Mary's	4	3.6	2	1.8	0	0.0	0	0.0	0	0.0	6	5.3
Talbot	1	2.7	0	0.0	0	0.0	1	2.7	0	0.0	2	5.4
Washington	0	0.0	0	0.0	0	0.0	9	6.0	2	1.3	11	7.3
Wicomico	0	0.0	0	0.0	0	0.0	0	0.0	2	1.9	2	2.0
Worcester	0	0.0	0	0.0	0	0.0	0	0.0	3	5.7	3	5.8

Data subject to change.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
 U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019

TABLE 3. REPORTED NUMBER OF ACUTE HEPATITIS B IN MARYLAND BY DEMOGRAPHICS, 2015-2019

	YEAR											
	2015		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
OVERALL												
Total	40	0.7	27	0.4	34	0.6	53	0.9	41	0.7	195	3.2
SEX AT BIRTH												
Male	24	0.8	13	0.4	23	0.8	38	1.3	13	0.4	111	3.8
Female	16	0.5	14	0.5	11	0.4	15	0.5	28	0.9	84	2.7
Unknown	0	---	0	---	0	---	0	---	0	---	0	---
Missing	0	---	0	---	0	---	0	---	0	---	0	---
AGE GROUP (YEARS)												
14 to 29	4	0.3	5	0.4	2	0.2	3	0.2	4	0.3	18	1.4
30 to 39	10	1.3	7	0.9	12	1.5	14	1.7	15	1.8	58	7.1
40 to 49	13	1.6	5	0.6	9	1.2	21	2.7	10	1.3	58	7.5
50 to 59	9	1.0	7	0.8	6	0.7	8	0.9	10	1.2	40	4.6
60 to 69	2	0.3	3	0.4	4	0.6	3	0.4	1	0.1	13	1.9
70+	2	0.4	0	0	1	0.2	4	0.6	1	0.2	8	1.3
Unknown	0	---	0	---	0	---	0	---	0	---	0	---
Missing	0	---	0	---	0	---	0	---	0	---	0	---
RACE												
American Indian or Alaskan Native	1	2.9	0	0.0	0	0.0	0	0.0	0	0.0	1	2.8
Asian	0	0.0	0	0.0	0	0.0	1	0.2	1	0.2	2	0.5
Black/African American	17	1.0	10	0.5	11	0.6	15	0.8	6	0.3	59	3.2
Native Hawaiian or Other Pacific Islander	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0
White	19	0.5	15	0.4	17	0.5	32	0.9	26	0.7	109	3.1
Mixed Race *	0	0.0	0	0.0	0	0.0	0	0.0	1	0.6	1	0.6
Other	0	---	0	---	0	---	0	---	0	---	0	---
Unknown	3	---	2	---	5	---	5	---	4	---	19	---
Missing	0	---	0	---	1	---	0	---	3	---	4	---
ETHNICITY												
Non Hispanic or Latino	34	0.6	21	0.4	26	0.5	42	0.8	31	0.6	154	2.8
Hispanic or Latino	1	0.2	3	0.5	1	0.2	1	0.2	5	0.8	11	1.8
Unknown	0	---	0	---	0	---	0	---	0	---	0	---
Missing	5	---	3	---	7	---	10	---	5	---	30	---

* Mixed race defined as belonging to more than one race category.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019

TABLE 4. REPORTED NUMBER OF ACUTE HEPATITIS B IN MARYLAND BY COUNTY, 2015-2019

	YEAR											
	2015		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
MARYLAND												
Overall	40	0.7	27	0.4	34	0.6	53	0.9	41	0.7	195	3.2
COUNTY												
Allegany	1	1.4	0	0.0	0	0.0	3	4.2	1	1.4	5	7.0
Anne Arundel	3	0.5	4	0.7	2	0.3	4	0.7	2	0.3	15	2.6
Baltimore City	8	1.3	3	0.5	8	1.3	9	1.5	11	1.9	39	6.4
Baltimore	7	0.8	9	1.1	5	0.6	10	1.2	9	1.1	40	4.8
Calvert	0	0.0	0	0.0	0	0.0	1	1.1	0	0.0	1	1.1
Caroline	0	0.0	2	6.1	0	0.0	1	3.0	1	3.0	4	12.1
Carroll	0	0.0	0	0.0	0	0.0	3	1.8	1	0.6	4	2.4
Cecil	0	0.0	0	0.0	1	1.0	5	4.9	9	8.8	15	14.6
Charles	0	0.0	0	0.0	2	1.3	1	0.6	2	1.2	5	3.1
Dorchester	2	6.1	0	0.0	1	3.1	0	0.0	1	3.1	4	12.5
Frederick	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Garrett	1	3.4	1	3.4	1	3.4	0	0.0	0	0.0	3	10.3
Harford	2	0.8	0	0.0	1	0.4	4	1.6	0	0.0	7	2.8
Howard	2	0.6	2	0.6	2	0.6	1	0.3	2	0.6	9	2.8
Kent	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Montgomery	3	0.3	0	0.0	6	0.6	6	0.6	1	0.1	16	1.5
Prince George's	5	0.5	4	0.4	4	0.4	3	0.3	0	0.0	16	1.8
Queen Anne's	0	0.0	0	0.0	0	0.0	0	0.0	1	2.0	1	2.0
Somerset	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
St. Mary's	0	0.0	1	0.9	1	0.9	0	0.0	0	0.0	2	1.8
Talbot	1	2.7	0	0.0	0	0.0	0	0.0	0	0.0	1	2.7
Washington	3	2.0	1	0.7	0	0.0	0	0.0	0	0.0	4	2.7
Wicomico	2	2.0	0	0.0	0	0.0	1	1.0	0	0.0	3	2.9
Worcester	0	0.0	0	0.0	0	0.0	1	1.9	0	0.0	1	1.9

Data subject to change.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019

TABLE 5. REPORTED NUMBER OF CHRONIC HEPATITIS B IN MARYLAND BY DEMOGRAPHICS, 2015-2019

	YEAR											
	2015		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
OVERALL												
Total	1,561	26.1	1,956	32.6	1,786	29.6	1,864	30.9	1,746	28.9	8,913	148.0
SEX AT BIRTH												
Male	862	29.6	1,094	37.5	952	32.4	1,057	36.1	930	31.8	4,895	166.8
Female	695	22.5	851	27.4	833	26.7	807	25.9	813	26.1	3,999	128.3
Unknown	3	---	4	---	1	---	0	---	2	---	10	---
Missing	1	---	7	---	0	---	0	---	1	---	9	---
AGE GROUP (YEARS)												
0 to 19	30	2.0	26	1.7	26	1.7	41	2.7	35	3.3	158	10.6
20 to 29	232	28.5	245	30.4	217	27.1	225	28.3	216	27.2	1,135	141.6
30 to 39	453	57.1	545	67.8	460	56.5	503	61.1	491	59.6	2,452	301.2
40 to 49	312	39.2	479	61.3	398	51.6	416	54.5	361	47.3	1,966	245.8
50 to 59	307	35.0	352	40.3	339	39.2	333	39.0	301	35.3	1,632	188.7
60 to 69	145	22.3	208	31.1	230	34.0	207	30.1	208	30.2	998	147.5
70+	81	14.6	99	17.3	115	19.2	138	22.1	132	21.2	565	94.3
Unknown	0	---	0	---	0	---	0	---	0	---	0	---
Missing	1	---	2	---	1	---	1	---	2	---	7	---
RACE												
American Indian or Alaskan Native	2	5.9	0	0.0	6	16.9	7	19.3	2	5.5	17	47.9
Asian	167	43.7	201	51.6	165	41.4	153	37.7	133	32.8	819	205.7
Black/African American	288	16.3	356	19.3	291	15.7	362	19.4	337	18.0	1,634	88.1
Native Hawaiian or Other Pacific Islander	0	0.0	2	30.5	0	0.0	2	29.6	1	14.8	5	75.8
White	108	3.0	130	3.6	116	3.3	163	4.6	152	4.3	669	18.8
Mixed Race *	3	1.8	2	1.2	1	0.6	4	2.3	2	1.1	12	7
Other	0	---	0	---	0	---	0	---	0	---	0	---
Unknown	892	---	1,088	---	1,027	---	926	---	819	---	4,752	---
Missing	101	---	177	---	180	---	247	---	300	---	1,005	---
ETHNICITY												
Non Hispanic or Latino	395	7.3	559	10.3	479	8.8	595	11.0	601	11.1	2,629	48.5
Hispanic or Latino	19	3.3	21	3.6	24	3.9	22	3.5	25	4.0	111	18.3
Unknown	0	---	0	---	0	---	0	---	0	---	0	---
Missing	1,147	---	1,376	---	1,283	---	1,247	---	1,120	---	6,173	---

* Mixed race defined as belonging to more than one race category.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019

TABLE 6. REPORTED NUMBER OF CHRONIC HEPATITIS B IN MARYLAND BY COUNTY, 2015-2019

	YEAR											
	2015		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
MARYLAND												
Overall	1,561	26.1	1,956	32.6	1,786	29.6	1,864	30.9	1,746	28.9	8,913	148.0
COUNTY												
Allegany	18	24.8	9	12.5	10	14.0	5	7.0	8	11.4	50	70.1
Anne Arundel	77	13.7	88	15.5	93	16.3	103	17.9	90	15.5	451	78.9
Baltimore City	219	35.2	251	40.7	225	36.9	244	40.5	252	42.5	1,191	195.1
Baltimore	155	18.7	277	33.4	181	21.8	225	27.2	184	22.2	1,022	123.3
Calvert	9	9.9	8	8.8	7	7.7	9	9.8	6	6.5	39	42.7
Caroline	3	9.2	2	6.1	4	12.1	10	30.0	9	26.9	28	84.6
Carroll	17	10.2	12	7.2	17	10.1	16	9.5	18	10.7	80	47.7
Cecil	13	12.7	17	16.6	13	12.7	13	12.7	10	9.7	66	64.5
Charles	18	11.6	27	17.2	35	22.0	27	16.7	26	15.9	133	83.4
Dorchester	5	15.4	2	6.2	7	21.8	1	3.1	3	9.4	18	56.1
Frederick	32	13.1	42	17.0	38	15.2	44	17.3	54	20.8	210	83.8
Garrett	0	0.0	1	3.4	1	3.4	2	6.9	2	6.9	6	20.5
Harford	29	11.6	46	18.4	46	18.3	29	11.4	35	13.7	185	73.5
Howard	100	32.1	127	40.3	81	25.4	113	35.0	109	33.5	530	166.0
Kent	0	0.0	1	5.1	1	5.1	3	15.4	1	5.1	6	30.9
Montgomery	487	47.2	583	56.1	504	48.1	533	50.8	473	45.0	2,580	246.5
Prince George's	312	34.4	393	43.3	458	50.3	417	45.8	386	42.4	1,966	216.1
Queen Anne's	0	0.0	8	16.3	4	8.1	6	12.0	3	6.0	21	42.4
Somerset	7	27.3	4	15.5	6	23.2	6	23.4	2	7.8	25	96.5
St. Mary's	16	14.4	10	8.9	12	10.7	11	9.8	14	12.3	63	56.0
Talbot	5	13.4	4	10.8	2	5.4	2	5.4	3	8.1	16	43.2
Washington	16	10.7	20	13.4	21	14.0	23	15.3	37	24.5	117	77.9
Wicomico	21	20.6	21	20.6	14	13.7	20	19.4	17	16.4	93	91.0
Worcester	2	3.9	3	5.8	6	11.6	2	3.8	4	7.7	17	32.9

Data subject to change.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
 U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019

TABLE 7. HBSAG POSITIVE PREGNANT WOMEN ENROLLED IN MARYLAND'S PERINATAL HEPATITIS B PROGRAM, 2015-2017

	YEAR OF DELIVERY							
	2015		2016		2017		2015-2017	
	N	PERCENT	N	PERCENT	N	PERCENT	N	PERCENT
ENROLLED								
HBsAg-positive pregnant women	154	100%	197	100%	162	100%	513	100%
INSURANCE STATUS								
Private (include separate CHIP programs)	55	36%	74	38%	62	38%	191	37%
Public (Medicaid)	68	44%	89	45%	74	46%	231	45%
Uninsured (no health insurance)	14	9%	13	7%	10	6%	37	7%
Unknown	17	11%	21	11%	16	10%	54	11%

Percent values may not add up to 100 due to rounding error.

Source: Center for Disease Control and Prevention - National Center for Immunization and Respiratory Diseases Annual Immunization Progress Report Annual Assessment of Progress Towards Goals to Prevent Perinatal Hepatitis B Transmission, Maryland Calendar Year 2015-2017

TABLE 8. HEPATITIS B IMMUNIZATION AMONG INFANTS REPORTED TO AND CASE MANAGED BY MARYLAND'S PERINATAL HEPATITIS B PROGRAM, 2015-2017

	YEAR OF BIRTH							
	2015		2016		2017		2015-2017	
	N	PERCENT	N	PERCENT	N	PERCENT	N	PERCENT
INFANTS								
Infants born to hepatitis B infected women who were case managed	249	100%	303	100%	257	100%	809	100%
PERINATAL HEPATITIS B IMMUNIZATION								
Infants given post-exposure prophylaxis (PEP)*	230	92%	292	96%	243	95%	765	95%
Infants who completed HBV vaccine series by 12 months of age	178	71%	233	77%	198	77%	609	75%
Infants given PEP and completed post-vaccination serologic testing (PVST)	141	57%	179	59%	161	63%	481	59%
Unknown	17	11%	21	11%	16	10%	54	11%

Post-exposure prophylaxis defined as receiving hepatitis B vaccine birth dose and hepatitis B immunoglobulin within 1 calendar day of birth.

Source: Center for Disease Control and Prevention - National Center for Immunization and Respiratory Diseases Annual Immunization Progress Report Annual Assessment of Progress Towards Goals to Prevent Perinatal Hepatitis B Transmission, Maryland Calendar Year 2015-2017

TABLE 9. POST-EXPOSURE PROPHYLAXIS AMONG INFANTS REPORTED TO AND CASE MANAGED BY MARYLAND'S PERINATAL HEPATITIS B PROGRAM, 2015-2017

	YEAR OF BIRTH							
	2015		2016		2017		2015-2017	
	N	PERCENT	N	PERCENT	N	PERCENT	N	PERCENT
INFANTS								
Reported infants born to hepatitis B infected women	249	100%	303	100%	257	100%	809	100%
RECEIPT OF RECOMMENDED POST-EXPOSURE PROPHYLAXIS (PEP)								
Infants given PEP	230	92.4%	292	96.4%	243	94.6%	765	94.6%
Infants given only HBIG and no Hep B-1 within 1 calendar day of birth	0	0.0%	1	0.3%	0	0.0%	1	0.1%
Infants given Hep B-1 only and no HBIG within 1 calendar day of birth	6	2.4%	6	2.0%	5	1.9%	17	2.1%
Infants who did not receive Hep B-1 only and no HBIG within 1 calendar day of birth or unknown	13	5.2%	4	1.3%	9	3.5%	26	3.2%

Hepatitis B vaccine birth dose (Hep B-1)
Hepatitis B immunoglobulin (HBIG)

Post-exposure prophylaxis defined as receiving Hep B-1 and HBIG within 1 calendar day of birth).
Percent values may not add up to 100 due to rounding error.

Source: Center for Disease Control and Prevention - National Center for Immunization and Respiratory Diseases Annual Immunization Progress Report Annual Assessment of Progress Towards Goals to Prevent Perinatal Hepatitis B Transmission, Maryland Calendar Year 2015-2017

TABLE 10. POST-VACCINATION SEROLOGIC TESTING AMONG INFANTS REPORTED TO AND CASE MANAGED BY MARYLAND'S PERINATAL HEPATITIS B PROGRAM, 2015-2017

	YEAR OF BIRTH							
	2015		2016		2017		2015-2017	
	N	PERCENT	N	PERCENT	N	PERCENT	N	PERCENT
INFANTS								
Infants given PEP and completed post-vaccination serologic testing (PVST)	141	57%	179	59%	161	63%	481	100%
POST-VACCINATION SEROLOGIC TESTING RESULTS								
PVST tested & HBsAG-positive	0	0%	0	0%	0	0%	0	0%
PVST tested & protected	132	94%	168	94%	155	96%	455	95%
PVST tested & susceptible	2	1%	2	1%	3	2%	7	1%
PVST Test results indeterminate	7	5%	9	5%	3	2%	19	4%

Percent values may not add up to 100 due to rounding error.

Source: Center for Disease Control and Prevention - National Center for Immunization and Respiratory Diseases Annual Immunization Progress Report Annual Assessment of Progress Towards Goals to Prevent Perinatal Hepatitis B Transmission, Maryland Calendar Year 2015-2017

TABLE 11. REPORTED NUMBER OF PROBABLE ACUTE HEPATITIS C IN MARYLAND BY DEMOGRAPHICS, 2015-2019

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
OVERALL												
Total	---	---	9	0.6	9	0.5	7	0.6	6	0.5	31	0.5
SEX AT BIRTH												
Male	---	---	2	0.1	4	0.1	4	0.1	4	0.1	14	0.5
Female	---	---	7	0.2	5	0.2	3	0.1	2	0.1	17	0.5
Unknown	---	---	0	---	0	---	0	---	0	---	0	---
Missing	---	---	0	---	0	---	0	---	0	---	0	---
AGE GROUP (YEARS)												
0 to 19	---	---	1	0.1	0	0.0	0	0.0	0	0.0	1	0.1
20 to 29	---	---	5	0.6	2	0.2	2	0.3	2	0.3	11	1.4
30 to 39	---	---	2	0.2	6	0.7	1	0.1	3	0.4	12	1.5
40 to 49	---	---	1	0.1	1	0.1	3	0.4	0	0.0	5	0.6
50 to 59	---	---	0	0.0	0	0.0	1	0.1	1	0.1	2	0.2
60 to 69	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
70+	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Unknown	---	---	0	---	0	---	0	---	0	---	0	---
Missing	---	---	0	---	0	---	0	---	0	---	0	---
BIRTH COHORT												
1900 to 1944	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
1945 to 1965	---	---	0	0.0	0	0.0	1	0.1	1	0.1	2	0.1
1966 to 1988	---	---	4	0.2	7	0.4	4	0.2	3	0.2	18	1.0
1989 to 2019	---	---	5	0.2	2	0.1	2	0.1	2	0.1	11	0.5
Missing	---	---	0	---	0	---	0	---	0	---	0	---
RACE												
American Indian or Alaskan Native	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Asian	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Black/African American	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Native Hawaiian or Other Pacific Islander	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
White	---	---	8	0.2	7	0.2	6	0.2	5	0.1	26	0.7
Mixed Race †	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Other	---	---	0	---	0	---	0	---	0	---	0	---
Unknown	---	---	0	---	2	---	1	---	0	---	3	---
Missing	---	---	1	---	0	---	0	---	1	---	2	---

TABLE 11A. REPORTED NUMBER OF PROBABLE ACUTE HEPATITIS C IN MARYLAND BY DEMOGRAPHICS, 2015-2019 (CONTINUED)

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
ETHNICITY												
Non Hispanic or Latino	--	--	5	0.1	6	0.1	4	0.1	5	0.1	20	0.4
Hispanic or Latino	--	--	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Unknown	--	--	0	--	0	--	0	--	0	--	0	--
Missing	--	--	4	--	3	--	3	--	1	--	11	--

* "Probable" was not included in 2015 Hepatitis C Acute Case Definition.

† Mixed race defined as belonging to more than one race category.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019
MDH Vital Statistics Annual Reports: <https://health.maryland.gov/vsa/Pages/reports.aspx>

TABLE 12. REPORTED NUMBER OF PROBABLE ACUTE HEPATITIS C IN MARYLAND BY COUNTY, 2015-2019

	YEAR											
	2015*		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
MARYLAND												
Overall	---	---	9	0.6	9	0.5	7	0.6	6	0.5	31	0.5
COUNTY												
Allegany	---	---	0	0.0	1	1.4	0	0.0	0	0.0	1	1.4
Anne Arundel	---	---	2	0.4	2	0.4	3	0.5	0	0.0	7	1.2
Baltimore City	---	---	0	0.0	0	0.0	1	0.2	0	0.0	1	0.2
Baltimore	---	---	1	0.1	0	0.0	0	0.0	0	0.0	1	0.1
Calvert	---	---	1	1.1	1	1.1	0	0.0	0	0.0	2	2.2
Caroline	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Carroll	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Cecil	---	---	2	2.0	2	2.0	1	1.0	0	0.0	5	4.9
Charles	---	---	0	0.0	0	0.0	1	0.6	0	0.0	1	0.6
Dorchester	---	---	0	0.0	1	3.1	0	0.0	0	0.0	1	3.1
Frederick	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Garrett	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Harford	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Howard	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Kent	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Montgomery	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	0.2
Prince George's	---	---	1	0.1	0	0.0	0	0.0	0	0.0	1	0.5
Queen Anne's	---	---	1	2.0	0	0.0	0	0.0	0	0.0	1	6.1
Somerset	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	7.7
St. Mary's	---	---	0	0.0	0	0.0	1	0.9	3	2.6	4	6.2
Talbot	---	---	0	0.0	1	2.7	0	0.0	1	2.7	2	2.7
Washington	---	---	0	0.0	0	0.0	0	0.0	1	0.7	1	4.0
Wicomico	---	---	1	1.0	1	1.0	0	0.0	1	1.0	3	7.8
Worcester	---	---	0	0.0	0	0.0	0	0.0	0	0.0	0	9.7

* "Probable" was not included in 2015 Hepatitis C Acute Case Definition.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
 U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019
 MDH Vital Statistics Annual Reports: <https://health.maryland.gov/vsa/Pages/reports.aspx>

TABLE 13. REPORTED NUMBER OF PROBABLE CHRONIC HEPATITIS C IN MARYLAND BY DEMOGRAPHICS, 2015-2019

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
OVERALL												
Total	310	5.2	2,833	47.2	2,703	44.9	2,237	37.1	2,478	41.0	10,561	175.3
SEX AT BIRTH												
Male	181	6.2	1,575	54.0	1,508	51.4	1,277	43.6	1,363	46.5	5,904	201.2
Female	129	4.2	1,245	40.1	1,186	38.0	960	30.8	1,103	35.4	4,623	148.3
Unknown	0	---	8	---	7	---	0	---	12	---	27	---
Missing	0	---	5	---	2	---	0	---	0	---	7	---
AGE GROUP (YEARS)												
0 to 19	7	0.5	50	3.3	51	3.4	40	2.7	40	2.7	188	12.6
20 to 29	65	8.0	443	54.9	459	57.3	351	44.2	360	45.3	1,678	209.4
30 to 39	45	5.7	499	62.1	464	57.0	432	52.5	498	60.5	1,938	238.0
40 to 49	35	4.4	372	47.6	311	40.3	228	29.9	316	41.4	1,262	163.6
50 to 59	79	9.0	724	82.9	634	73.3	484	56.7	478	56.0	2,399	277.4
60 to 69	59	9.1	566	84.6	619	91.5	518	75.3	589	85.6	2,351	347.4
70+	20	3.6	175	30.7	162	27.0	180	28.9	186	29.8	723	120.6
Unknown	0	---	4	---	3	---	4	---	11	---	22	---
Missing	0	---	0	---	0	---	0	---	0	---	0	---
BIRTH COHORT												
1900 to 1944	19	5.4	136	37.8	105	28.3	84	21.8	86	22.3	430	116.0
1945 to 1965	136	9.9	1,297	92.6	1,238	86.8	1,013	70.0	1,029	71.1	4,713	330.4
1966 to 1988	110	5.9	1,031	55.5	924	50.0	768	41.8	924	50.3	3,757	203.5
1989 to 2019	45	1.9	365	15.3	433	18.2	368	15.5	428	18.0	1,639	68.8
Missing	0	---	4	---	3	---	4	---	11	---	22	---
RACE												
American Indian or Alaskan Native	0	0.0	4	11.5	1	2.8	1	2.8	5	13.8	11	31.0
Asian	8	2.1	22	5.6	14	3.5	12	3.0	21	5.2	77	19.3
Black/African American	61	3.4	447	24.3	511	27.5	379	20.3	374	20.0	1,772	95.5
Native Hawaiian or Other Pacific Islander	1	15.7	1	15.3	0	0.0	1	14.8	0	0.0	3	45.5
White	135	3.8	778	21.8	808	22.7	640	18.0	656	18.5	3,017	84.8
Mixed Race †	0	0.0	0	0.0	6	3.5	6	3.4	3	1.7	15	8.8
Other	0	---	0	---	0	---	0	---	0	---	0	---
Unknown	95	---	1,400	---	1,212	---	1,015	---	1,087	---	4,809	---
Missing	10	---	181	---	151	---	183	---	332	---	857	---

TABLE 13A. REPORTED NUMBER OF PROBABLE CHRONIC HEPATITIS C IN MARYLAND BY DEMOGRAPHICS, 2015-2019 (CONTINUED)

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
ETHNICITY												
Non Hispanic or Latino	116	2.1	784	14.5	1,007	18.6	887	16.4	944	17.4	3,738	69.0
Hispanic or Latino	3	0.5	40	6.8	45	7.4	33	5.3	33	5.3	154	25.3
Unknown	0	-- --	0	-- --	0	-- --	0	-- --	0	-- --	0	-- --
Missing	191	-- --	2,009	-- --	1,651	-- --	1,317	-- --	1,501	-- --	6,669	-- --

2012 HepC Case Definition was used to classify 2015 cases.

† Mixed race defined as belonging to more than one race category.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019
MDH Vital Statistics Annual Reports: <https://health.maryland.gov/vsa/Pages/reports.aspx>

TABLE 14. REPORTED NUMBER OF PROBABLE CHRONIC HEPATITIS C IN MARYLAND BY COUNTY, 2015-2019

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
MARYLAND												
Overall	310	5.2	2,833	47.2	2,703	44.9	2,237	37.1	2,478	41.0	10,561	175.3
COUNTY												
Allegany	1	1.4	22	30.5	25	35.0	24	33.8	41	58.2	113	158.4
Anne Arundel	66	11.7	242	42.7	198	34.7	179	31.1	215	37.1	900	157.5
Baltimore City	84	13.5	639	103.7	701	114.8	454	75.4	492	82.9	2,370	388.2
Baltimore	65	7.9	418	50.4	465	56.1	378	45.7	396	47.9	1,722	207.8
Calvert	4	4.4	32	35.1	25	27.3	20	21.7	13	14.1	94	102.8
Caroline	0	0.0	14	42.6	11	33.2	12	36.0	6	18.0	43	129.9
Carroll	5	3.0	68	40.7	59	35.2	52	30.9	47	27.9	231	137.9
Cecil	1	1.0	179	174.7	125	122.1	106	103.3	97	94.3	508	496.1
Charles	4	2.6	40	25.4	49	30.7	24	14.9	32	19.6	149	93.4
Dorchester	0	0.0	26	80.6	28	87.2	21	65.7	6	18.8	81	252.3
Frederick	9	3.7	85	34.4	86	34.3	87	34.1	82	31.6	349	139.3
Garrett	0	0.0	6	20.4	9	30.8	1	3.4	14	48.3	30	102.6
Harford	3	1.2	107	42.7	78	31.0	78	30.7	84	32.9	350	139.0
Howard	12	3.9	94	29.8	83	26.0	74	22.9	92	28.2	355	111.2
Kent	2	10.1	13	66.1	22	113.2	23	118.3	8	41.2	68	349.8
Montgomery	15	1.5	289	27.8	210	20.1	191	18.2	281	26.7	986	94.2
Prince George's	9	1.0	298	32.8	255	28.0	289	31.8	310	34.1	1,161	127.6
Queen Anne's	4	8.2	20	40.8	25	50.4	14	27.9	15	29.8	78	157.3
Somerset	1	3.9	25	96.8	23	88.8	14	54.7	7	27.3	70	270.3
St. Mary's	0	0.0	43	38.5	33	29.3	24	21.3	31	27.3	131	116.5
Talbot	1	2.7	19	51.2	16	43.2	16	43.2	5	13.4	57	153.9
Washington	23	15.4	88	58.8	100	66.6	96	63.7	130	86.1	437	291.0
Wicomico	0	0.0	49	48.0	54	52.8	44	42.7	47	45.4	194	189.7
Worcester	1	1.9	17	33.0	23	44.5	16	30.8	27	51.6	84	162.6

* 2012 HepC Case Definition used to classify 2015 cases.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019
MDH Vital Statistics Annual Reports: <https://health.maryland.gov/vsa/Pages/reports.aspx>

TABLE 15. REPORTED NUMBER OF CONFIRMED ACUTE HEPATITIS C IN MARYLAND BY DEMOGRAPHIC, 2015-2019

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
OVERALL												
Total	38	0.6	36	0.6	33	0.5	38	0.6	33	0.5	178	3.0
SEX AT BIRTH												
Male	22	0.8	19	0.7	17	0.6	21	0.7	21	0.7	100	3.4
Female	16	0.5	17	0.5	16	0.5	17	0.5	12	0.4	78	2.5
Unknown	0	---	0	---	0	---	0	---	0	---	0	---
Missing	0	---	0	---	0	---	0	---	0	---	0	---
AGE GROUP (YEARS)												
0 to 19	2	0.1	1	0.1	1	0.1	0	0.0	0	0.0	4	0.3
20 to 29	12	1.5	14	1.7	22	2.7	10	1.3	8	1.0	66	8.2
30 to 39	14	1.8	12	1.5	6	0.7	13	1.6	10	1.2	55	6.8
40 to 49	5	0.6	7	0.9	2	0.3	6	0.8	6	0.8	26	3.4
50 to 59	4	0.5	1	0.1	0	0.0	4	0.5	3	0.4	12	1.4
60 to 69	1	0.2	0	0.0	1	0.1	3	0.4	5	0.7	10	1.5
70+	0	0.0	1	0.2	1	0.2	2	0.3	1	0.2	5	0.8
Unknown	0	---	0	---	0	---	0	---	0	---	0	---
Missing	0	---	0	---	0	---	0	---	0	---	0	---
BIRTH COHORT												
1900 to 1944	0	0.0	1	0.3	1	0.3	1	0.3	0	0.0	3	0.8
1945 to 1965	6	0.4	1	0.1	1	0.1	6	0.4	9	0.6	23	1.6
1966 to 1988	22	1.2	23	1.2	16	0.9	21	1.1	16	0.9	98	5.3
1989 to 2019	10	0.4	11	0.5	15	0.6	10	0.4	8	0.3	54	2.3
Missing	0	---	0	---	0	---	0	---	0	---	0	---
RACE												
American Indian or Alaskan Native	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Asian	1	0.3	0	0.0	0	0.0	1	0.2	0	0.0	2	0.5
Black/African American	4	0.2	4	0.2	4	0.2	2	0.1	4	0.2	18	1.0
Native Hawaiian or Other Pacific Islander	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
White	31	0.9	27	0.8	27	0.8	31	0.9	22	0.6	138	3.0
Mixed Race †	0	0.0	1	0.6	0	0.0	0	0.0	0	0.0	1	0.6
Other	0	---	0	---	0	---	0	---	0	---	0	---
Unknown	2	---	4	---	2	---	3	---	4	---	15	---
Missing	0	---	0	---	0	---	1	---	3	---	4	---

TABLE 15A. REPORTED NUMBER OF CONFIRMED ACUTE HEPATITIS C IN MARYLAND BY DEMOGRAPHIC, 2015-2019 (CONTINUED)

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
ETHNICITY												
Non Hispanic or Latino	27	0.5	29	0.5	25	0.5	29	0.5	25	0.5	135	2.5
Hispanic or Latino	1	0.2	0	0.0	0	0.0	1	0.2	3	0.5	5	0.8
Unknown	0	-- --	0	-- --	0	-- --	0	-- --	0	-- --	0	-- --
Missing	10	-- --	7	-- --	8	-- --	8	-- --	5	-- --	38	-- --

* 2012 HepC Case Definition used to classify 2015 cases.

† Mixed race defined as belonging to more than one race category.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019
MDH Vital Statistics Annual Reports: <https://health.maryland.gov/vsa/Pages/reports.aspx>

TABLE 16. REPORTED NUMBER OF CONFIRMED ACUTE HEPATITIS C IN MARYLAND BY COUNTY, 2015-2019

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
MARYLAND												
Overall	38	0.6	36	0.6	33	0.5	38	0.6	33	0.5	178	3.0
COUNTY												
Allegany	1	1.4	0	0.0	6	8.4	2	2.8	0	0.0	9	12.6
Anne Arundel	6	1.1	10	1.8	6	1.1	4	0.7	4	0.7	30	5.3
Baltimore City	3	0.5	1	0.2	0	0.0	1	0.2	2	0.3	7	1.1
Baltimore	0	0.0	4	0.5	4	0.5	7	0.8	6	0.7	21	2.5
Calvert	3	3.3	1	1.1	4	4.4	8	8.7	2	2.2	18	19.7
Caroline	2	6.1	0	0.0	0	0.0	1	3.0	0	0.0	3	9.1
Carroll	0	0.0	0	0.0	1	0.6	2	1.2	3	1.8	6	3.6
Cecil	9	8.8	5	4.9	4	3.9	5	4.9	5	4.9	28	27.3
Charles	2	1.3	1	0.6	0	0.0	0	0.0	1	0.6	4	2.5
Dorchester	0	0.0	1	3.1	0	0.0	0	0.0	0	0.0	1	3.1
Frederick	0	0.0	3	1.2	0	0.0	0	0.0	0	0.0	3	1.2
Garrett	1	3.4	0	0.0	0	0.0	1	3.4	1	3.4	3	10.3
Harford	1	0.4	2	0.8	1	0.4	0	0.0	1	0.4	5	2.0
Howard	0	0.0	1	0.3	0	0.0	0	0.0	0	0.0	1	0.3
Kent	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Montgomery	0	0.0	0	0.0	1	0.1	0	0.0	1	0.1	2	0.2
Prince George's	0	0.0	1	0.1	0	0.0	2	0.2	2	0.2	5	0.5
Queen Anne's	1	2.0	1	2.0	0	0.0	0	0.0	1	2.0	3	6.1
Somerset	0	0.0	1	3.9	1	3.9	0	0.0	0	0.0	2	7.7
St. Mary's	4	3.6	1	0.9	0	0.0	1	0.9	1	0.9	7	6.2
Talbot	0	0.0	0	0.0	0	0.0	0	0.0	1	2.7	1	2.7
Washington	1	0.7	1	0.7	3	2.0	1	0.7	0	0.0	6	4.0
Wicomico	2	2.0	1	1.0	2	2.0	3	2.9	0	0.0	8	7.8
Worcester	2	3.9	1	1.9	0	0.0	0	0.0	2	3.8	5	9.7

* 2012 HepC Case Definition used to classify 2015 cases.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019
MDH Vital Statistics Annual Reports: <https://health.maryland.gov/vsa/Pages/reports.aspx>

TABLE 17. REPORTED NUMBER OF CONFIRMED CHRONIC HEPATITIS C IN MARYLAND BY DEMOGRAPHIC, 2015-2019

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
OVERALL												
Total	7,641	127.7	5,002	83.3	4,779	79.3	4,018	66.6	3,140	51.9	24,580	408.0
SEX AT BIRTH												
Male	4,629	159.0	3,134	107.5	2,993	102.0	2,554	87.2	2,010	68.6	15,320	522.1
Female	3,001	97.0	1,862	60.0	1,776	57.0	1,463	47.0	1,126	36.2	9,228	296.0
Unknown	6	---	3	---	9	---	1	---	4	---	23	---
Missing	5	---	3	---	1	---	0	---	0	---	9	---
AGE GROUP (YEARS)												
0 to 19	51	3.4	37	2.5	39	2.6	20	1.3	16	1.1	163	10.9
20 to 29	738	90.7	552	68.4	637	79.5	578	72.7	455	57.2	2,960	369.4
30 to 39	780	98.4	609	75.8	673	82.7	696	84.5	627	76.1	3,385	415.8
40 to 49	939	117.9	536	68.6	539	69.9	446	58.4	362	47.4	2,822	365.8
50 to 59	2,746	312.9	1,621	185.5	1,325	153.2	999	117.0	719	84.2	7,410	856.8
60 to 69	1,987	306.0	1,378	205.9	1,284	189.7	1,012	147.2	741	107.8	6,402	945.9
70+	393	70.7	268	47.0	280	46.7	257	41.2	211	33.8	1,409	235.1
Unknown	7	---	1	---	2	---	10	---	9	---	29	---
Missing	0	---	0	---	0	---	0	---	0	---	0	---
BIRTH COHORT												
1900 to 1944	319	90.9	192	53.3	177	47.7	136	35.3	89	23.1	913	246.2
1945 to 1965	4,806	350.7	2,997	214.1	2,554	179.1	1,966	135.8	1,377	95.1	13,700	960.5
1966 to 1988	1,995	106.8	1,372	73.9	1,479	80.1	1,348	73.4	1,147	62.5	7,341	397.6
1989 to 2019	514	21.4	440	18.4	567	23.8	558	23.5	518	21.8	2,597	109.0
Missing	7	---	1	---	2	---	10	---	9	---	29	---
RACE												
American Indian or Alaskan Native	6	17.6	3	8.6	4	11.3	6	16.6	5	13.8	24	67.6
Asian	25	6.5	14	3.6	22	5.5	16	3.9	11	2.7	88	22.1
Black/African American	1,637	92.6	918	49.8	918	49.5	734	39.3	488	26.1	4,695	253.0
Native Hawaiian or Other Pacific Islander	1	15.7	1	15.3	2	30.3	0	0.0	0	0.0	4	60.6
White	1,536	43.0	1,104	31.0	1,240	34.9	1,045	29.4	838	23.6	5,763	162.0
Mixed Race †	9	5.5	3	1.8	6	3.5	4	2.3	11	6.3	33	19.3
Other	0	---	0	---	0	---	0	---	0	---	0	---
Unknown	4,190	---	2,675	---	2,391	---	1,986	---	1,489	---	12,731	---
Missing	237	---	284	---	196	---	227	---	298	---	1,242	---

TABLE 17A. REPORTED NUMBER OF CONFIRMED CHRONIC HEPATITIS C IN MARYLAND BY DEMOGRAPHIC, 2015-2019 (CONTINUED)

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
ETHNICITY												
Non Hispanic or Latino	1,708	31.5	1,511	27.9	1,838	33.9	1,636	30.2	1,190	22.0	7,883	145.5
Hispanic or Latino	28	4.9	31	5.3	35	5.8	26	4.1	22	3.5	142	23.4
Unknown	0	-- --	0	-- --	0	-- --	0	-- --	0	-- --	0	-- --
Missing	5,905	-- --	3,460	-- --	2,906	-- --	2,356	-- --	1,928	-- --	16,555	-- --

* 2012 HepC Case Definition used to classify 2015 cases.

† Mixed race defined as belonging to more than one race category.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019
MDH Vital Statistics Annual Reports: <https://health.maryland.gov/vsa/Pages/reports.aspx>

TABLE 18. REPORTED NUMBER OF CONFIRMED CHRONIC HEPATITIS C IN MARYLAND BY COUNTY, 2015-2019

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
MARYLAND												
Overall	7,641	127.7	5,002	83.3	4,779	79.3	4,018	66.6	3,140	51.9	24,580	408.0
COUNTY												
Allegany	114	157.3	106	147.1	115	161.2	140	197.3	88	125.0	563	789.0
Anne Arundel	470	83.5	348	61.3	331	57.9	319	55.4	235	40.6	1,703	298.1
Baltimore City	2,965	476.3	1,637	265.6	1,521	249.1	1,174	194.9	867	146.1	8,164	1337.3
Baltimore	980	118.4	693	83.6	668	80.6	554	66.9	460	55.6	3,355	404.9
Calvert	95	105.0	56	61.5	60	65.6	62	67.3	48	51.9	321	351.1
Caroline	40	122.7	30	91.4	25	75.5	24	72.1	24	71.8	143	432.1
Carroll	138	82.6	137	82.0	116	69.2	81	48.1	58	34.4	530	316.3
Cecil	229	223.7	122	119.0	130	127.0	124	120.8	116	112.8	721	704.1
Charles	106	68.1	77	49.0	94	59.0	62	38.4	54	33.1	393	246.5
Dorchester	70	215.9	43	133.2	27	84.1	26	81.4	12	37.6	178	554.4
Frederick	169	69.0	127	51.4	142	56.7	119	46.7	79	30.4	636	253.8
Garrett	26	88.4	19	64.7	21	71.8	7	24.0	15	51.7	88	300.9
Harford	211	84.5	152	60.7	152	60.4	114	44.9	134	52.5	763	302.9
Howard	138	44.3	112	35.5	78	24.4	76	23.6	66	20.3	470	147.2
Kent	26	131.9	20	101.7	18	92.6	13	66.9	11	56.6	88	452.6
Montgomery	471	45.6	297	28.6	287	27.4	251	23.9	182	17.3	1,488	142.1
Prince George's	690	76.1	473	52.1	447	49.1	389	42.8	314	34.5	2,313	254.3
Queen Anne's	43	87.8	27	55.0	28	56.5	23	45.9	17	33.7	138	278.3
Somerset	57	221.9	60	232.2	67	258.7	54	210.9	47	183.5	285	1100.6
St. Mary's	96	86.5	81	72.5	73	64.9	62	55.0	41	36.1	353	313.8
Talbot	34	90.9	18	48.5	19	51.3	23	62.0	13	35.0	107	288.9
Washington	258	173.1	228	152.4	229	152.5	210	139.4	177	117.2	1,102	733.8
Wicomico	165	162.2	107	104.9	95	92.9	82	79.6	58	56.0	507	495.8
Worcester	50	97.2	32	62.2	36	69.7	29	55.8	24	45.9	171	331.0

* 2012 HepC Case Definition used to classify 2015 cases.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019
MDH Vital Statistics Annual Reports: <https://health.maryland.gov/vsa/Pages/reports.aspx>

TABLE 19. REPORTED NUMBER OF PROBABLE AND CONFIRMED ACUTE HEPATITIS C IN MARYLAND BY DEMOGRAPHIC, 2015-2019

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
OVERALL												
Total	38	0.6	45	0.7	42	0.7	45	0.7	39	0.6	209	3.5
SEX AT BIRTH												
Male	22	0.8	21	0.7	21	0.7	25	0.9	25	0.9	114	3.9
Female	16	0.5	24	0.8	21	0.7	20	0.6	14	0.4	95	3.0
Unknown		---		---		---		---		---	0	---
Missing		---		---		---		---		---	0	---
AGE GROUP (YEARS)												
0 to 19	2	0.1	2	0.1	1	0.1	0	0.0	0	0.0	5	0.3
20 to 29	12	1.5	19	2.4	24	3.0	12	1.5	10	1.3	77	9.6
30 to 39	14	1.8	14	1.7	12	1.5	14	1.7	13	1.6	67	8.2
40 to 49	5	0.6	8	1.0	3	0.4	9	1.2	6	0.8	31	4.0
50 to 59	4	0.5	1	0.1	0	0.0	5	0.6	4	0.5	14	1.6
60 to 69	1	0.2	0	0.0	1	0.1	3	0.4	5	0.7	10	1.5
70+	0	0.0	1	0.2	1	0.2	2	0.3	1	0.2	5	0.8
Unknown	1	---	0	---	1	---	3	---	5	---	10	---
Missing	0	---	1	---	1	---	2	---	1	---	5	---
BIRTH COHORT												
1900 to 1944	0	0.0	1	0.3	1	0.3	1	0.3	0	0.0	3	0.8
1945 to 1965	6	0.4	1	0.1	1	0.1	7	0.5	10	0.7	25	1.8
1966 to 1988	22	1.2	27	1.5	23	1.2	25	1.4	19	1.0	116	6.3
1989 to 2019	10	0.4	16	0.7	17	0.7	12	0.5	10	0.4	65	2.7
Missing	0	---	0	---	0	---	0	---	0	---	0	---
RACE												
American Indian or Alaskan Native	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Asian	1	0.3	0	0.0	0	0.0	1	0.2	0	0.0	2	0.5
Black/African American	4	0.2	4	0.2	4	0.2	2	0.1	4	0.2	18	1.0
Native Hawaiian or Other Pacific Islander	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
White	31	0.9	35	1.0	34	1.0	37	1.0	27	0.8	164	4.6
Mixed Race †	0	0.0	1	0.6	0	0.0	0	0.0	0	0.0	1	0.6
Other	0	---	0	---	0	---	0	---	0	---	0	---
Unknown	2	---	4	---	4	---	4	---	4	---	18	---
Missing	0	---	1	---	0	---	1	---	4	---	6	---

TABLE 19A. REPORTED NUMBER OF PROBABLE AND CONFIRMED ACUTE HEPATITIS C IN MARYLAND BY DEMOGRAPHIC, 2015-2019 (CONTINUED)

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
ETHNICITY												
Non Hispanic or Latino	27	0.5	34	0.6	31	0.6	33	0.6	30	0.6	155	2.9
Hispanic or Latino	1	0.2	0	0.0	0	0.0	1	0.2	3	0.5	5	0.8
Unknown	0	-- --	0	-- --	0	-- --	0	-- --	0	-- --	0	-- --
Missing	10	-- --	11	-- --	11	-- --	11	-- --	6	-- --	49	-- --

* Only includes confirmed cases. "Probable" was not included in 2015 Hepatitis C Acute Case Definition.

† Mixed race defined as belonging to more than one race category.

Data subject to change overtime.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019
MDH Vital Statistics Annual Reports: <https://health.maryland.gov/vsa/Pages/reports.aspx>

TABLE 20. REPORTED NUMBER OF PROBABLE AND CONFIRMED ACUTE HEPATITIS C IN MARYLAND BY COUNTY, 2015-2019

	YEAR											
	2015*		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
MARYLAND												
Overall	38	0.6	45	0.7	42	0.7	45	0.7	39	0.6	209	3.5
COUNTY												
Allegany	1	1.4	0	0.0	7	9.8	2	2.8	0	0.0	10	14.0
Anne Arundel	6	1.1	12	2.1	8	1.4	7	1.2	4	0.7	37	6.5
Baltimore City	3	0.5	1	0.2	0	0.0	2	0.3	2	0.3	8	1.3
Baltimore	0	0.0	5	0.6	4	0.5	7	0.8	6	0.7	22	2.7
Calvert	3	3.3	2	2.2	5	5.5	8	8.7	2	2.2	20	21.9
Caroline	2	6.1	0	0.0	0	0.0	1	3.0	0	0.0	3	9.1
Carroll	0	0.0	0	0.0	1	0.6	2	1.2	3	1.8	6	3.6
Cecil	9	8.8	7	6.8	6	5.9	6	5.8	5	4.9	33	32.2
Charles	2	1.3	1	0.6	0	0.0	1	0.6	1	0.6	5	3.1
Dorchester	0	0.0	1	3.1	1	3.1	0	0.0	0	0.0	2	6.2
Frederick	0	0.0	3	1.2	0	0.0	0	0.0	0	0.0	3	1.2
Garrett	1	3.4	0	0.0	0	0.0	1	3.4	1	3.4	3	10.3
Harford	1	0.4	2	0.8	1	0.4	0	0.0	1	0.4	5	2.0
Howard	0	0.0	1	0.3	0	0.0	0	0.0	0	0.0	1	0.3
Kent	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Montgomery	0	0.0	0	0.0	1	0.1	0	0.0	1	0.1	2	0.2
Prince George's	0	0.0	2	0.2	0	0.0	2	0.2	2	0.2	6	0.7
Queen Anne's	1	2.0	2	4.1	0	0.0	0	0.0	1	2.0	4	8.1
Somerset	0	0.0	1	3.9	1	3.9	0	0.0	0	0.0	2	7.7
St. Mary's	4	3.6	1	0.9	0	0.0	2	1.8	4	3.5	11	9.8
Talbot	0	0.0	0	0.0	1	2.7	0	0.0	2	5.4	3	8.1
Washington	1	0.7	1	0.7	3	2.0	1	0.7	1	0.7	7	4.7
Wicomico	2	2.0	2	2.0	3	2.9	3	2.9	1	1.0	11	10.8
Worcester	2	3.9	1	1.9	0	0.0	0	0.0	2	3.8	5	9.7

* Only includes confirmed cases. "Probable" was not included in 2015 Hepatitis C Acute Case Definition
Data subject to change overtime

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019
MDH Vital Statistics Annual Reports: <https://health.maryland.gov/vsa/Pages/reports.aspx>

TABLE 21. REPORTED NUMBER OF PROBABLE AND CONFIRMED CHRONIC HEPATITIS C IN MARYLAND BY DEMOGRAPHIC, 2015-2019

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
OVERALL												
Total	7,951	132.8	7,835	130.5	7,482	124.2	6,255	103.6	5,618	92.9	35,141	583.4
SEX AT BIRTH												
Male	4,810	165.2	4,709	161.6	4,501	153.4	3,831	130.8	3,373	115.2	21,224	723.3
Female	3,130	101.1	3,107	100.2	2,962	95.0	2,423	77.8	2,229	71.6	13,851	444.2
Unknown	6	---	11	---	16	---	1	---	16	---	50	---
Missing	5	---	8	---	3	---	0	---	0	---	16	---
AGE GROUP (YEARS)												
0 to 19	58	3.9	87	5.8	90	6.0	60	4.0	56	3.7	351	23.4
20 to 29	803	98.7	995	123.3	1,096	136.8	929	116.9	815	102.5	4,638	578.7
30 to 39	825	104.0	1,108	137.9	1,137	139.7	1,128	137.0	1,125	136.6	5,323	653.8
40 to 49	974	122.3	908	116.2	850	110.2	674	88.2	678	88.8	4,084	529.4
50 to 59	2,825	321.9	2,345	268.4	1,959	226.5	1,483	173.7	1,197	140.2	9,809	1134.2
60 to 69	2,046	315.1	1,944	290.4	1,903	281.2	1,530	222.5	1,330	193.4	8,753	1293.2
70+	413	74.3	443	77.6	442	73.8	437	70.0	397	63.6	2,132	355.7
Unknown	0	---	0	---	0	---	0	---	0	---	0	---
Missing	7	---	5	---	5	---	14	---	20	---	51	---
BIRTH COHORT												
1900 to 1944	338	96.3	328	91.1	282	76.1	220	57.0	175	45.4	1,343	362.2
1945 to 1965	4,942	360.6	4,294	306.7	3,792	265.9	2,979	205.8	2,406	166.2	18,413	1290.9
1966 to 1988	2,105	112.7	2,403	129.5	2,403	130.2	2,116	115.2	2,071	112.8	11,098	601.1
1989 to 2019	559	23.3	805	33.7	1,000	42.0	926	39.0	946	39.9	4,236	177.9
Missing	7	---	5	---	5	---	14	---	20	---	51	---
RACE												
American Indian or Alaskan Native	6	17.6	7	20.1	5	14.1	7	19.3	10	27.6	35	98.6
Asian	33	8.6	36	9.2	36	9.0	28	6.9	32	7.9	165	41.4
Black/African American	1,698	96.0	1,365	74.1	1,429	77.0	1,113	59.6	862	46.2	6,467	348.5
Native Hawaiian or Other Pacific Islander	2	31.3	2	30.5	2	30.3	1	14.8	0	0.0	7	106.1
White	1,671	46.8	1,882	52.8	2,048	57.6	1,685	47.4	1,494	42.1	8,780	246.8
Mixed Race †	9	5.5	3	1.8	12	7.0	10	5.7	14	8.0	48	28.1
Other	0	---	0	---	0	---	0	---	0	---	0	---
Unknown	4,285	---	4,075	---	3,603	---	3,001	---	2,576	---	17,540	---
Missing	247	---	465	---	347	---	410	---	630	---	2,099	---

TABLE 21A. REPORTED NUMBER OF PROBABLE AND CONFIRMED CHRONIC HEPATITIS C IN MARYLAND BY DEMOGRAPHIC, 2015-2019 (CONTINUED)

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
ETHNICITY												
Non Hispanic or Latino	1,824	33.7	2,295	42.4	2,845	52.5	2,523	46.6	2,134	39.4	11,621	214.5
Hispanic or Latino	31	5.4	71	12.1	80	13.2	59	9.4	55	8.8	296	48.7
Unknown	6,096	-- --	5,469	-- --	4,557	-- --	3,673	-- --	3,429	-- --	23,224	-- --
Missing	0	-- --	0	-- --	0	-- --	0	-- --	0	-- --	0	-- --

* Only includes confirmed cases. "Probable" was not included in 2015 Hepatitis C Acute Case Definition.

† Mixed race defined as belonging to more than one race category.

Data subject to change overtime.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019
MDH Vital Statistics Annual Reports: <https://health.maryland.gov/vsa/Pages/reports.aspx>

TABLE 22. REPORTED NUMBER OF PROBABLE AND CONFIRMED CHRONIC HEPATITIS C IN MARYLAND BY COUNTY, 2015-2019

	YEAR											
	2015 *		2016		2017		2018		2019		2015-2019	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	COUNT	RATE PER 100,000
MARYLAND												
Overall	7,951	132.8	7,835	130.5	7,482	124.2	6,255	103.6	5,618	92.9	35,141	583.4
COUNTY												
Allegany	115	158.7	128	177.6	140	196.2	164	231.2	129	183.2	676	947.4
Anne Arundel	536	95.2	590	104.0	529	92.6	498	86.5	450	77.7	2,603	455.6
Baltimore City	3,049	489.8	2,276	369.3	2,222	364.0	1,628	270.2	1,359	229.0	10,534	1725.5
Baltimore	1,045	126.3	1,111	134.1	1,133	136.7	932	112.6	856	103.5	5,077	612.7
Calvert	99	109.4	88	96.6	85	93.0	82	89.1	61	65.9	415	453.9
Caroline	40	122.7	44	134.0	36	108.8	36	108.1	30	89.8	186	562.0
Carroll	143	85.6	205	122.7	175	104.4	133	79.0	105	62.3	761	454.2
Cecil	230	224.6	301	293.7	255	249.0	230	224.1	213	207.1	1,229	1200.3
Charles	110	70.7	117	74.4	143	89.7	86	53.3	86	52.7	542	339.9
Dorchester	70	215.9	69	213.8	55	171.3	47	147.1	18	56.4	259	806.7
Frederick	178	72.7	212	85.8	228	91.0	206	80.8	161	62.0	985	393.0
Garrett	26	88.4	25	85.2	30	102.6	8	27.5	29	100.0	118	403.5
Harford	214	85.8	259	103.4	230	91.3	192	75.6	218	85.3	1,113	441.9
Howard	150	48.2	206	65.3	161	50.4	150	46.5	158	48.5	825	258.4
Kent	28	142.0	33	167.8	40	205.7	36	185.2	19	97.8	156	802.4
Montgomery	486	47.1	586	56.4	497	47.5	442	42.2	463	44.1	2,474	236.3
Prince George's	699	77.1	771	84.9	702	77.2	678	74.5	624	68.6	3,474	381.9
Queen Anne's	47	95.9	47	95.8	53	106.9	37	73.8	32	63.5	216	435.6
Somerset	58	225.8	85	329.0	90	347.5	68	265.6	54	210.8	355	1370.9
St. Mary's	96	86.5	124	111.0	106	94.2	86	76.3	72	63.4	484	430.3
Talbot	35	93.6	37	99.6	35	94.5	39	105.2	18	48.4	164	442.8
Washington	281	188.5	316	211.2	329	219.1	306	203.1	307	203.2	1,539	1024.8
Wicomico	165	162.2	156	152.9	149	145.7	126	122.3	105	101.3	701	685.6
Worcester	51	99.1	49	95.2	59	114.2	45	86.6	51	97.6	255	493.6

* Only includes confirmed cases. "Probable" was not included in 2015 Hepatitis C Acute Case Definition.
Data subject to change overtime.

Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015 to 2019
U.S. Census Bureau Population Estimates by Age, Race and Gender April 1, 2010 to July 1, 2019
MDH Vital Statistics Annual Reports: <https://health.maryland.gov/vsa/Pages/reports.aspx>

TABLE 23. CHARACTERISTICS OF PEOPLE LIVING WITH DIAGNOSED HIV AND EVER DIAGNOSED WITH HEPATITIS B OR HEPATITIS C, 2019

	MARYLAND POPULATION AGED 13+	PEOPLE LIVING WITH DIAGNOSED HIV											
		TOTAL PEOPLE LIVING WITH DIAGNOSED HIV	NO REPORTED HEPATITIS DIAGNOSIS ‡		EVER DIAGNOSED WITH HCV			EVER DIAGNOSED WITH HBV			EVER DIAGNOSED WITH HCV AND HBV		
			N	PERCENT	N	PERCENT	RATE	N	PERCENT	RATE	N	PERCENT	RATE
MARYLAND													
Overall	5,080,666	31,621	27,109	100.0%	3,768	100.0%	76.5	651	100.0%	14.7	93	100.0%	14.7
AGE ON DECEMBER 31, 2018													
0 to 19	532,906	250	246	0.9%	1	0.0%	0.2	3	0.4%	0.6	0	0.4%	0.6
20 to 29	794,984	2,939	2,876	10.6%	46	1.2%	5.8	17	2.3%	2.1	0	2.3%	2.1
30 to 39	823,580	5,860	5,556	20.5%	202	5.2%	24.5	98	13.1%	11.9	4	13.1%	11.9
40 to 49	763,740	6,818	6,139	22.6%	480	12.3%	62.8	178	23.8%	23.3	21	23.8%	23.3
50 to 59	853,899	9,604	7,713	28.5%	1,601	41.2%	187.5	246	32.8%	28.8	44	32.8%	28.8
60+	1,311,557	6,150	4,579	16.9%	1,438	37.0%	109.6	109	14.6%	10.1	24	14.6%	10.1
Unknown	--	--	--	--	--	--	--	--	--	--	--	--	--
Missing	--	--	--	--	--	--	--	--	--	--	--	--	--
SEX AT BIRTH													
Male	2,437,974	20,894	17,786	66%	2,516	64.7%	103.2	516	68.9%	21.2	76	68.9%	21.2
Female	2,642,693	10,727	9,323	34%	1,252	32.2%	47.4	135	18.0%	5.1	17	18.0%	5.1
RACE/ETHNICITY													
Hispanic	465,711	2,134	1,976	7.3%	122	3.1%	26.2	33	4.4%	7.1	1	4.4%	7.1
Non-Hispanic Black	1,507,995	23,492	20,008	73.8%	2,901	74.6%	192.4	481	64.2%	31.9	42	64.2%	31.9
Non-Hispanic White	2,658,002	3,999	3,444	12.7%	454	11.7%	17.1	89	11.9%	3.3	3	11.9%	3.3
Non-Hispanic Other	448,959	1,996	1,681	6.2%	291	7.5%	64.8	48	6.4%	10.7	47	6.4%	10.7
REPORTED OR ESTIMATED EXPOSURE CATEGORY													
MSM	--	10,994	10,233	37.7%	437	11.2%	--	309	41.3%	--	15	41.3%	--
IDU	--	4,790	2,372	8.7%	2,284	58.7%	--	77	10.3%	--	57	10.3%	--
MSM/IDU	--	1,062	730	2.7%	288	7.4%	--	35	4.7%	--	8	4.7%	--
HET	--	9,901	9,222	34.0%	505	13.0%	--	166	22.2%	--	9	22.2%	--
Perinatal Transmission	--	453	445	1.6%	5	0.1%	--	3	0.4%	--	0	0.4%	--
Other	--	44	33	0.1%	10	0.3%	--	1	0.1%	--	0	0.1%	--
No Reported Risk	--	4,377	4,074	15.0%	239	6.1%	--	60	8.0%	--	4	8.0%	--
COUNTRY OF BIRTH *													
United States	4,171,682	27,131	22,846	84.3%	3,656	94.0%	87.6	537	71.7%	12.9	92	71.7%	12.9
Foreign-Born	854,039	3,589	3,416	12.6%	70	1.8%	8.2	102	13.6%	11.9	1	13.6%	11.9
HIV CARE OUTCOMES †													
Retained in Care	--	25,203	21,173	78.1%	3,359	86.4%	--	584	78.0%	--	87	78.0%	--
Virologically Suppressed	--	21,306	17,938	66.2%	2,799	72.0%	--	496	66.2%	--	73	66.2%	--

TABLE 23. CHARACTERISTICS OF PEOPLE LIVING WITH DIAGNOSED HIV AND EVER DIAGNOSED WITH HEPATITIS B OR HEPATITIS C, 2019

Only confirmed cases of hepatitis are described.

Percent values may not add up to 100 due to rounding error.

¥ People living with diagnosed HI+J11:J40V that have tested negative for hepatitis, have not been tested for hepatitis, or have been tested and the hepatitis test results were not reported.

* Excludes 847 people living with diagnosed HIV without a reported hepatitis diagnosis, 42 ever diagnosed with HCV, and 12 ever diagnosed with HBV for which country of birth was not reported.

† Excludes 6,545 people living with diagnosed HIV without a reported hepatitis diagnosis, 530 ever diagnosed with HCV, and 80 ever diagnosed with HBV for which no viral load test collected during 2018 was reported.

Source: Enhanced HIV/AIDS Reporting System (eHARS), Maryland Department of Health, Data reported through 6/30/2019 Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland

TABLE 24. DEATHS AMONG PEOPLE WITH DIAGNOSED HIV (PWDH) EVER DIAGNOSED WITH HEPATITIS C, 2019

	PEOPLE DIAGNOSED WITH HIV						TOTAL DEATHS	PERCENT HIV/ HCV AMONG TOTAL DEATHS
	NO REPORTED HCV DIAGNOSIS			EVER DIAGNOSED WITH HCV				
	DEATHS	PWDH *	PERCENT DECEASED	DEATHS	PWDH *	PERCENT DECEASED		
YEAR OF DEATH								
2010	680	23,373	2.9%	112	4,735	2.4%	792	14.1%
2011	645	24,175	2.7%	107	4,474	2.4%	752	14.2%
2012	629	24,964	2.5%	155	4,742	3.3%	784	19.8%
2013	594	25,736	2.3%	181	4,693	3.9%	775	23.4%
2014	531	26,506	2.0%	201	4,616	4.4%	732	27.5%
2015	559	27,257	2.1%	225	4,504	5.0%	784	28.7%
2016	611	27,939	2.2%	238	4,361	5.5%	849	28.0%
2017	560	28,524	2.0%	245	4,205	5.8%	805	30.4%

Percent values may not add up to 100 due to rounding error.

*Persons with diagnosed HIV are estimated based on the number of people alive at the previous year-end in addition to the new diagnoses. These estimates will not be consistent with estimates of people living with diagnosed HIV

Source: Enhanced HIV/AIDS Reporting System (eHARS), Maryland Department of Health, Data reported through 6/30/2019 Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland

TABLE 25. NUMBER OF PEOPLE LIVING WITH DIAGNOSED HIV AND EVER DIAGNOSED WITH HEPATITIS B OR HEPATITIS C BY JURISDICTION, 2019

	MARYLAND POPULATION AGED 13+	PEOPLE LIVING WITH DIAGNOSED HIV												
		TOTAL PEOPLE LIVING WITH DIAGNOSED HIV	NO REPORTED HEPATITIS DIAGNOSIS †			EVER DIAGNOSED WITH HCV			EVER DIAGNOSED WITH HBV			EVER DIAGNOSED WITH HCV AND HBV		
			N	PERCENT	RATE	N	PERCENT	RATE	N	PERCENT	RATE	N	PERCENT	RATE
MARYLAND														
Overall	6,042,718	31,621	27,109	100%	448.6	3,768	100%	62.4	646	100%	10.7	93	100%	1.5
JURISDICTION *														
Allegany	70,975	100	85	0.3%	119.8	12	0.3%	16.9	3	0.5%	4.2	0	0.0%	0.0
Anne Arundel	576,031	1,359	1,205	4.4%	209.2	123	3.3%	21.4	26	4.0%	4.5	5	5.4%	0.9
Baltimore City	828,431	11,049	8,434	31.1%	1,018.1	2,362	62.7%	285.1	194	30.0%	23.4	59	63.4%	7.1
Baltimore	602,495	3,604	3,096	11.4%	513.9	420	11.1%	69.7	78	12.1%	12.9	10	10.8%	1.7
Calvert	92,003	133	121	0.4%	131.5	8	0.2%	8.7	4	0.6%	4.3	0	0.0%	0.0
Caroline	33,304	59	53	0.2%	159.1	5	0.1%	15.0	1	0.2%	3.0	0	0.0%	0.0
Carroll	168,429	160	130	0.5%	77.2	25	0.7%	14.8	3	0.5%	1.8	2	2.2%	1.2
Cecil	102,826	146	121	0.4%	117.7	20	0.5%	19.5	3	0.5%	2.9	2	2.2%	1.9
Charles	161,503	570	535	2.0%	331.3	20	0.5%	12.4	14	2.2%	8.7	1	1.1%	0.6
Dorchester	31,998	149	130	0.5%	406.3	18	0.5%	56.3	1	0.2%	3.1	0	0.0%	0.0
Frederick	255,648	442	407	1.5%	159.2	22	0.6%	8.6	13	2.0%	5.1	0	0.0%	0.0
Garrett	29,163	18	16	0.1%	54.9	2	0.1%	6.9	0	0.0%	0.0	0	0.0%	0.0
Harford	253,956	518	456	1.7%	179.6	51	1.4%	20.1	10	1.5%	3.9	1	1.1%	0.4
Howard	323,196	682	629	2.3%	194.6	33	0.9%	10.2	19	2.9%	5.9	1	1.1%	0.3
Kent	19,383	41	38	0.1%	196.0	1	0.0%	5.2	2	0.3%	10.3	0	0.0%	0.0
Montgomery	1,052,567	3,498	3,276	12.1%	311.2	129	3.4%	12.3	91	14.1%	8.6	2	2.2%	0.2
Prince George's	909,308	7,825	7,315	27.0%	804.5	352	9.3%	38.7	152	23.5%	16.7	6	6.5%	0.7
Queen Anne's	50,251	48	46	0.2%	91.5	2	0.1%	4.0	0	0.0%	0.0	0	0.0%	0.0
Somerset	25,675	69	61	0.2%	237.6	4	0.1%	15.6	4	0.6%	15.6	0	0.0%	0.0
St. Mary's	112,664	162	147	0.5%	130.5	10	0.3%	8.9	5	0.8%	4.4	0	0.0%	0.0
Talbot	36,968	77	64	0.2%	173.1	10	0.3%	27.1	3	0.5%	8.1	0	0.0%	0.0
Washington	150,926	350	298	1.1%	197.4	42	1.1%	27.8	9	1.4%	6.0	1	1.1%	0.7
Wicomico	103,195	249	214	0.8%	207.4	25	0.7%	24.2	8	1.2%	7.8	2	2.2%	1.9
Worcester	51,823	87	73	0.3%	140.9	10	0.3%	19.3	3	0.5%	5.8	1	1.1%	1.9

Only confirmed cases of hepatitis are described.

Percent values may not add up to 100 due to rounding error.

† People living with diagnosed HIV that have tested negative for hepatitis, have not been tested for hepatitis, or have been tested and the hepatitis test results were not reported.

* Excludes 159 people living with diagnosed HIV without a reported hepatitis diagnosis, 62 ever diagnosed with HCV, and 5 ever diagnosed with HBV residing at a state or federal correctional facility.

Source: Enhanced HIV/AIDS Reporting System (eHARS), Maryland Department of Health, Data reported through 6/30/2019
Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland

TABLE 26. PAST-YEAR SUBSTANCE USE DISORDER AMONG YOUNG ADULTS AGED 18 - 25 IN REGION 3 (ANNUAL AVERAGES, 2015 - 2017) *

	2015 TO 2017
	ANNUAL AVERAGE †
GEOGRAPHY	
National	15.1%
Region 3 ‡	16.1%
Maryland	17.5%
Pennsylvania	16.8%
West Virginia	13.8%
Delaware	15.7%
District of Columbia	19.5%
Virginia	14.4%

* Substance use disorder is defined as dependence on or abuse of alcohol, illicit drugs (e.g., marijuana, cocaine, hallucinogens, heroin, or inhalants), or psychotherapeutics (e.g., prescription pain relievers, sedatives, tranquilizers, or stimulants) in the past 12 months based on assessments of individual diagnostic criteria from the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which include such symptoms as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past year. For details, see American Psychiatric Association (1994).

† Estimates are annual averages based on combined 2013-2017 National Survey on Drug Use and Health (NSDUH) data or NSDUH data for other combined years as indicated.

‡ Region 3 is a combined geographical area including the following states combined Maryland, Pennsylvania, West Virginia, Delaware, District of Columbia, and Virginia.

Source: Behavioral Health Barometer Region 3, Volume 5. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013-2017

TABLE 27. PAST-YEAR SUBSTANCE USE DISORDER AMONG PEOPLE AGED 12 OR OLDER IN REGION 3 (ANNUAL AVERAGES, 2015 - 2017)

	2015 TO 2017
	ANNUAL AVERAGE †
GEOGRAPHY	
National	7.5%
Region 3 ‡	7.5%
Maryland	7.8%
Pennsylvania	7.4%
West Virginia	5.8%
Delaware	9.1%
District of Columbia	11.7%
Virginia	7.2%

TABLE 28. SUBSTANCE USE DISORDER IN THE PAST YEAR, BY AGE GROUP AND STATE: ESTIMATED NUMBERS (IN THOUSANDS), ANNUAL AVERAGES BASED ON 2016 AND 2017 - NATIONAL SURVEY ON DRUG USE AND HEALTH * †

	AGE GROUP											
	12+			12 TO 17			18 TO 25			26+		
	ESTIMATE	95% CI		ESTIMATE	95% CI		ESTIMATE	95% CI		ESTIMATE	95% CI	
AGE GROUP (YEARS)												
US	19,906	19,372	20,454	1,028	964	1,096	5,156	4,979	5,339	13,722	13,234	14,227
Maryland	378	323	441	16	12	20	103	86	122	260	212	317

CI = Confidence Interval

* Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

† State and census region estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the "Total U.S." row, design-based (direct) estimates and corresponding 95 percent confidence intervals are given.

Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017.

TABLE 29. NEEDING BUT NOT RECEIVING TREATMENT AT A SPECIALTY FACILITY FOR SUBSTANCE USE IN THE PAST YEAR, BY AGE GROUP AND STATE: ESTIMATED NUMBERS (IN THOUSANDS), ANNUAL AVERAGES BASED ON 2016 AND 2017 - NATIONAL SURVEY ON DRUG USE AND HEALTH * †

	AGE GROUP											
	12+			12 TO 17			18 TO 25			26+		
	ESTIMATE	95% CI		ESTIMATE	95% CI		ESTIMATE	95% CI		ESTIMATE	95% CI	
AGE GROUP (YEARS)												
US	18,453	17,936	18,984	969	907	1,035	4,845	4,672	55,023	12,640	12,166	13,130
Maryland	343	292	403	15	11	20	92	77	109	237	192	290

CI = Confidence Interval

* Needing But Not Receiving Substance Use Treatment refers to respondents who are classified as needing illicit drug or alcohol treatment, but who did not receive illicit drug or alcohol treatment at a specialty facility.

Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

† State and census region estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the "Total U.S." row, design-based (direct) estimates and corresponding 95 percent confidence intervals are given.

Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017.

TABLE 30. CHANGES IN NUMBER OF PEOPLE ENROLLED IN SUBSTANCE USE TREATMENT PROGRAMS IN REGION 3 (SINGLE-DAY COUNTS, 2013 AND 2017) * †

	2013	2017	CHANGE ‡
	N	N	
GEOGRAPHY			
Region 3 ‡	141,524	163,986	Higher
Maryland	42,128	48,654	Higher
Pennsylvania	57,687	64,303	Higher
West Virginia	9,990	18,115	Higher
Delaware	5,197	7,738	Higher
District of Columbia	3,684	2,763	Lower
Virginia	22,838	22,413	Lower

* Number of individuals enrolled in substance use treatment refers to the number of clients in treatment at alcohol and drug abuse facilities (public and private) throughout the 50 states, the District of Columbia, and other U.S. jurisdictions.

† Single-day counts reflect the number of individuals who were enrolled in substance use treatment on March 31, 2013 and March 31, 2017.

‡ Significance testing was not conducted on these data. Conducting statistical significance tests is not necessary because these are counts of people enrolled at all treatment facilities (rather than estimates from a sample of treatment facilities).

§ Region 3 is a combined geographical area including the following states combined Maryland, Pennsylvania, West Virginia, Delaware, District of Columbia, and Virginia.

Source: Behavioral Health Barometer Region 3, Volume 5. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2017

TABLE 31. CHANGES IN NUMBER OF PEOPLE ENROLLED IN SUBSTANCE USE TREATMENT PROGRAMS IN REGION 3 RECEIVING METHADONE (SINGLE-DAY COUNTS, 2013 AND 2017) * †

	2013	2017	CHANGE ‡
	N	N	
GEOGRAPHY			
Region 3 ‡	18,136	7,815	Higher
Maryland	2,622	5,443	Higher
Pennsylvania	2,308	4,659	Higher
West Virginia	1,134	3,539	Lower
Delaware	380	1,827	Higher
District of Columbia	93	67	Lower
Virginia	1,278	2,601	Higher

* Number of individuals enrolled in substance use treatment refers to the number of clients in treatment at alcohol and drug abuse facilities (public and private) throughout the 50 states, the District of Columbia, and other U.S. jurisdictions. These counts reflect only individuals who were receiving these specific medication-assisted therapies as part of their opioid treatment in specialty substance abuse treatment programs; they do not include counts of individuals who were receiving other types of treatment (such as those who received MAT from private physicians) for their opioid addiction on the reference dates.

† Single-day counts reflect the number of individuals who were enrolled in substance use treatment on March 31, 2013 and March 31, 2017.

‡ Significance testing was not conducted on these data. Conducting statistical significance tests is not necessary because these are counts of people enrolled at all treatment facilities (rather than estimates from a sample of treatment facilities).

§ Region 3 is a combined geographical area including the following states combined Maryland, Pennsylvania, West Virginia, Delaware, District of Columbia, and Virginia.

Physicians who obtain specialized training per the Drug Addiction Treatment Act of 2000 (DATA 2000) may prescribe buprenorphine to treat opioid addiction. Some physicians are in private, office-based practices; others are affiliated with substance abuse treatment facilities or programs and may prescribe buprenorphine to clients at those facilities. Additionally, opioid treatment programs (OTPs) may also prescribe and/or dispense buprenorphine. The buprenorphine single-day counts include only those clients who received/were prescribed buprenorphine by physicians affiliated with substance abuse treatment facilities; they do not include clients from private practice physicians.

Source: Behavioral Health Barometer Region 3, Volume 5. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2017

TABLE 32. PAST-YEAR ILLICIT DRUG USE AMONG YOUNG ADULTS AGED 18 - 25 IN REGION 3 (ANNUAL AVERAGES, 2015 - 2017) *

GEOGRAPHY	2015 TO 2017
	ANNUAL AVERAGE †
National	7.2%
Region 3 ‡	6.9%
Maryland	8.8%
Pennsylvania	6.6%
West Virginia	6.6%
Delaware	8.1%
District of Columbia	7.4%
Virginia	6.1%

TABLE 33. PAST-YEAR ILLICIT DRUG USE AMONG YOUNG ADULTS AGED 12 OR OLDER IN REGION 3 (ANNUAL AVERAGES, 2015 - 2017)

GEOGRAPHY	2015 TO 2017
	ANNUAL AVERAGE †
National	7.5%
Region 3 ‡	7.5%
Maryland	7.8%
Pennsylvania	7.4%
West Virginia	5.8%
Delaware	9.1%
District of Columbia	11.7%
Virginia	7.2%

* Illicit drug use disorder are defined using diagnostic criteria specified within the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which include such symptoms as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past year. For details, see American Psychiatric Association (1994).

† Estimates are annual averages based on combined 2013-2017 National Survey on Drug Use and Health (NSDUH) data or NSDUH data for other combined years as indicated.

‡ Region 3 is a combined geographical area including the following states combined Maryland, Pennsylvania, West Virginia, Delaware, District of Columbia, and Virginia.

Source: Behavioral Health Barometer Region 3, Volume 5. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013-2017

TABLE 34. ILLICIT DRUG USE IN THE PAST YEAR, BY AGE GROUP AND STATE: ESTIMATED NUMBERS (IN THOUSANDS), ANNUAL AVERAGES BASED ON 2016 AND 2017 - NATIONAL SURVEY ON DRUG USE AND HEALTH * †

AGE GROUP (YEARS)	AGE GROUP											
	12+			12 TO 17			18 TO 25			26+		
	ESTIMATE	95% CI		ESTIMATE	95% CI		ESTIMATE	95% CI		ESTIMATE	95% CI	
US	7,463	7,174	7,763	765	710	825	2,470	2,342	2,605	4,228	3,982	4,488
Maryland	141	113	175	12	9	17	49	38	62	79	58	109

CI = Confidence Interval

* Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.

† State and census region estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the "Total U.S." row, design-based (direct) estimates and corresponding 95 percent confidence intervals are given.

Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017.

TABLE 35. NEEDING BUT NOT RECEIVING TREATMENT AT A SPECIALTY FACILITY FOR ILLICIT DRUG USE IN THE PAST YEAR, BY AGE GROUP AND STATE: ESTIMATED NUMBERS (IN THOUSANDS), ANNUAL AVERAGES BASED ON 2016 AND 2017 - NATIONAL SURVEY ON DRUG USE AND HEALTH * †

	AGE GROUP											
	12+			12 TO 17			18 TO 25			26+		
	ESTIMATE	95% CI		ESTIMATE	95% CI		ESTIMATE	95% CI		ESTIMATE	95% CI	
AGE GROUP (YEARS)												
US	6,635	6,364	6,918	727	673	785	2,265	2,141	2,395	3,644	3,414	3,888
Maryland	123	98	154	12	9	16	43	32	56	69	51	94

CI = Confidence Interval

* Respondents were classified as needing illicit drug treatment if they met the criteria for an illicit drug use disorder as defined in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or received treatment for illicit drug use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center). Needing But Not Receiving Illicit Drug Treatment refers to respondents who are classified as needing illicit drug treatment, but who did not receive illicit drug treatment at a specialty facility. Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.

† State and census region estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the "Total U.S." row, design-based (direct) estimates and corresponding 95 percent confidence intervals are given.

Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017.

TABLE 36. PAST-YEAR OPIOID USE DISORDER AMONG YOUNG ADULTS AGED 18 - 25 IN REGION 3 (ANNUAL AVERAGES, 2015 - 2017) *

	2013 TO 2017
	ANNUAL AVERAGE †
GEOGRAPHY	
National	1.3%
Region 3 ‡	1.4%
Maryland	1.6%
Pennsylvania	1.5%
West Virginia	2.0%
Delaware	1.9%
District of Columbia	--
Virginia	1.0%

* Opioid use disorder is defined as heroin use disorder or prescription pain reliever use disorder using diagnostic criteria specified within the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which include such symptoms as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past year. For details, see American Psychiatric Association (1994).

† Estimates are annual averages based on combined 2013-2017 National Survey on Drug Use and Health (NSDUH) data or NSDUH data for other combined years as indicated.

‡ Region 3 is a combined geographical area including the following states combined Maryland, Pennsylvania, West Virginia, Delaware, District of Columbia, and Virginia.

Source: Behavioral Health Barometer Region 3, Volume 5. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013-2017

TABLE 37. PAST-YEAR ILLICIT DRUG USE AMONG YOUNG ADULTS AGED 12 OR OLDER IN REGION 3 (ANNUAL AVERAGES, 2015 - 2017)

	2015 TO 2017
	ANNUAL AVERAGE †
GEOGRAPHY	
National	0.8%
Region 3 ‡	0.9%
Maryland	0.9%
Pennsylvania	0.9%
West Virginia	1.2%
Delaware	1.6%
District of Columbia	0.3%
Virginia	0.8%

TABLE 38. CHANGES IN NUMBER OF PEOPLE ENROLLED IN OPIOID TREATMENT PROGRAMS IN REGION 3 RECEIVING METHADONE (SINGLE-DAY COUNTS, 2013 AND 2017) * †

	2013	2017	CHANGE ¥
	N	N	
GEOGRAPHY			
Region 3 ‡	62,212	53,891	Higher
Maryland	19,488	25,026	Higher
Pennsylvania	20,606	22,136	Higher
West Virginia	4,299	3,109	Lower
Delaware	2,420	3,555	Higher
District of Columbia	1,760	1,736	Lower
Virginia	5,318	6,650	Higher

* These counts reflect only individuals who were receiving these specific medication-assisted therapies as part of their opioid treatment in specialty substance abuse treatment programs; they do not include counts of individuals who were receiving other types of treatment (such as those who received MAT from private physicians) for their opioid addiction on the reference dates.

† Single-day counts reflect the number of individuals who were enrolled in substance use treatment on March 31, 2013 and March 31, 2017.

¥ Significance testing was not conducted on these data. Conducting statistical significance tests is not necessary because these are counts of people enrolled at all treatment facilities (rather than estimates from a sample of treatment facilities).

‡ Region 3 is a combined geographical area including the following states combined Maryland, Pennsylvania, West Virginia, Delaware, District of Columbia, and Virginia.

Source: Behavioral Health Barometer Region 3, Volume 5. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015-2017

TABLE 39. PAST-YEAR HEROIN DRUG USE AMONG YOUNG ADULTS AGED 12 OR OLDER IN REGION 3 (ANNUAL AVERAGES, 2015 - 2017)

	2013 TO 2017
	ANNUAL AVERAGE †
GEOGRAPHY	
National	0.33%
Region 3 ‡	0.63%
Maryland	0.75%
Pennsylvania	0.65%
West Virginia	0.66%
Delaware	1.28%
District of Columbia	0.40%
Virginia	1.0%

† Estimates are annual averages based on combined 2013-2017 National Survey on Drug Use and Health (NSDUH) data or NSDUH data for other combined years as indicated

‡ Region 3 is a combined geographical area including the following states combined Maryland, Pennsylvania, West Virginia, Delaware, District of Columbia, and Virginia..

Source: Behavioral Health Barometer Region 3, Volume 5. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2017

TABLE 40. HEROIN USE IN THE PAST YEAR, BY AGE GROUP AND STATE: ESTIMATED NUMBERS (IN THOUSANDS), ANNUAL AVERAGES BASED ON 2016 AND 2017 - NATIONAL SURVEY ON DRUG USE AND HEALTH * †

	AGE GROUP											
	12+			12 TO 17			18 TO 25			26+		
	ESTIMATE	95% CI		ESTIMATE	95% CI		ESTIMATE	95% CI		ESTIMATE	95% CI	
AGE GROUP (YEARS)												
US	29,519	28,818	30,236	1,962	1,872	2,056	8,156	7,940	8,378	19,400	18,784	20,035
Maryland	599	523	685	41	33	51	172	149	197	386	320	464

CI = Confidence Interval

* Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.

† State and census region estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the "Total U.S." row, design-based (direct) estimates and corresponding 95 percent confidence intervals are given. .

Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017.

TABLE 41. CHANGES IN PAST-YEAR HEROIN DRUG USE AMONG PEOPLE AGED 12 OR OLDER IN REGION 3 (ANNUAL AVERAGES, 2002 - 2005 AND 2014 - 2017)

	2002 TO 2005	2012 TO 2017	SIGNIFICANT CHANGE ‡
	N	N	
GEOGRAPHY			
Region 3 ‡	0.24%	0.63%	Increased
Maryland	0.23%	0.75%	No Change
Pennsylvania	0.27%	0.65%	Increased
West Virginia	0.10%	0.66%	Increased
Delaware	0.29%	1.28%	Increased
District of Columbia	1.02%	0.40%	No Change
Virginia	0.44%	0.44%	Increased

† Estimates are annual averages based on combined 2013-2017 National Survey on Drug Use and Health (NSDUH) data or NSDUH data for other combined years as indicated.

‡ Region 3 is a combined geographical area including the following states combined Maryland, Pennsylvania, West Virginia, Delaware, District of Columbia, and Virginia.

Source: Behavioral Health Barometer Region 3, Volume 5. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015-2017

TABLE 42. PAST-YEAR PRESCRIPTION PAIN RELIEVERS AMONG YOUNG ADULTS AGED 12 OR OLDER IN REGION 3 (ANNUAL AVERAGES, 2015 - 2017)

	2013 TO 2017
	ANNUAL AVERAGE †
GEOGRAPHY	
National	4.3%
Region 3	3.1%
Maryland	3.9%
Pennsylvania	4.5%
West Virginia	3.9%
Delaware	4.4%
District of Columbia	4.3%
Virginia	3.7%

Prescription pain relievers include the following subcategories of pain relievers: hydrocodone products (Vicodin®, Lortab®, Norco®, Zohydro® ER, or generic hydrocodone); oxycodone products (OxyContin®, Percocet®, Percodan®, Roxicet®, Roxicodone®, or generic oxycodone); tramadol products (Ultram®, Ultram® ER, Ultracet®, generic tramadol, or generic extended-release tramadol); codeine products (Tylenol® with codeine 3 or 4 or generic codeine pills); morphine products (Avinza®, Kadian®, MS Contin®, generic morphine, or generic extended-release morphine); fentanyl products (Actiq®, Duragesic®, Fentora®, or generic fentanyl); buprenorphine products (Suboxone® or generic buprenorphine); oxymorphone products (Opana®, Opana® ER, generic oxymorphone, or generic extended-release oxymorphone); Demerol®; hydromorphone products (Dilaudid® or generic hydromorphone, or Exalgo® or generic extended-release hydromorphone); methadone; or any other prescription pain reliever.

Prescription pain reliever misuse is defined as prescription pain reliever use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor.

† Estimates are annual averages based on combined 2013-2017 National Survey on Drug Use and Health (NSDUH) data or NSDUH data for other combined years as indicated.

‡ Region 3 is a combined geographical area including the following states combined Maryland, Pennsylvania, West Virginia, Delaware District of Columbia, and Virginia.

Source: Behavioral Health Barometer Region 3, Volume 5. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2017

TABLE 43. PAIN RELIEVER MISUSE IN THE PAST YEAR, BY AGE GROUP AND STATE: ESTIMATED NUMBERS (IN THOUSANDS), ANNUAL AVERAGES BASED ON 2016 AND 2017

	AGE GROUP											
	12+			12 TO 17			18 TO 25			26+		
	ESTIMATE	95% CI		ESTIMATE	95% CI		ESTIMATE	95% CI		ESTIMATE	95% CI	
AGE GROUP (YEARS)												
US	1,715	1,570	1,874	124	103	153	315	274	362	1,275	1,140	1,426
Maryland	30	21	41	2	1	3	5	3	7	23	15	34

CI = Confidence Interval

* Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

† State and census region estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the "Total U.S." row, design-based (direct) estimates and corresponding 95 percent confidence intervals are given.

Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017.

TABLE 44. SUBSTANCE ABUSE TREATMENT FACILITIES REPORTED IN MARYLAND'S NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES STATE PROFILE, 2018 *

	FACILITIES	
	N	PERCENT
SUBSTANCE ABUSE TREATMENT FACILITIES		
Total Surveyed †	413	100%
HEPATITIS TESTING SERVICES		
Screening for hepatitis B	129	31%
Screening for hepatitis C	152	37%
PHARMACOTHERPY SERVICES		
Naltrexone (oral)	116	28%
Extended-release, injectable naltrexone (e.g., Vivitrol®)	131	32%
Methadone	78	19%
Buprenorphine with naloxone (e.g., Suboxone®, Bunavail®, Zubsolv®)	202	49%
Buprenorphine without naloxone	128	31%
Buprenorphine sub-dermal implant (Probuphine®)	8	2%
Buprenorphine extended release, injectable (e.g., Sublocade®)	20	5%
HEPATITIS COUNSELING SERVICES		
Education, counseling, or support for hepatitis	229	55%
OPIOID TREATMENT PROGRAMS (OTPS)		
Facilities with OTPs	84	20%

Percent values may not add up to 100 due to rounding error.

* Data in this profile are from facilities that reported to the N-SSATS and are based on the survey's reference date, March 30, 2018.

†The survey response rate in Maryland was 85.9 percent.

Source: Substance Abuse and Mental Health Services Administration National Survey of Substance Abuse Treatment Services 2018 Annual Report.
Released September 16, 2019.

TABLE 45. HEPATITIS VACCINATION AMONG INCARCERATED INDIVIDUALS IN MARYLAND DEPARTMENT OF PUBLIC SAFETY AND CORRECTION SERVICES FACILITIES, 2016-2019

	YEAR				
	2016	2017	2018	2019	2016-2019
	N	N	N	N	N
HEPATITIS A					
Inmates who received hepatitis A vaccination while incarcerated	446	457	360	521	1,784
HEPATITIS B					
Inmates who received hepatitis B vaccination while incarcerated	445	451	367	509	1,772

Source: Maryland Department of Public Safety and Correction Services

TABLE 46. KNOWN HEPATITIS B AND C POSITIVES * AMONG INCARCERATED INDIVIDUALS IN MARYLAND DEPARTMENT OF PUBLIC SAFETY AND CORRECTION SERVICES FACILITIES, 2016-2019

	YEAR				
	2016	2017	2018	2019	2016-2019
	N	N	N	N	N
CARCERAL POPULATION ¥					
Inmates	25,104	22,203	21,640	22,142	91,089
HEPATITIS B					
Inmates known to be hepatitis B virus positive	22	13	9	5	49
HEPATITIS C					
Inmates known to be hepatitis C virus positive	2,304	2,083	1,950	1,951	8,288

* Known positive is defined as inmates identified as positive upon entry into a Maryland Department of Public Safety and Correctional Services facility prior to any testing. Hepatitis B virus positive is defined as being hepatitis B surface antigen positive. Hepatitis C virus positive is defined as being hepatitis C antibody positive.

¥ Population number includes inmates detained and sentenced only, excludes those in probation/parole-criminal and drunk driving monitoring program categories.

Source: Maryland Department of Public Safety and Correction Services

TABLE 47. TREATMENT AMONG HEPATITIS C VIRUS INFECTED INDIVIDUALS INCARCERATED IN MARYLAND DEPARTMENT OF PUBLIC SAFETY AND CORRECTION SERVICES FACILITIES, 2016-2019

	YEAR EXCLUDES HOSPITALIZED NON-MARYLAND RESIDENTS.									
	2016		2017		2018		2019		2016-2019	
	N	PERCENT	N	PERCENT	N	PERCENT	N	PERCENT	N	PERCENT
TREATMENT ELIGIBLE†										
Hepatitis C virus (HCV) infected inmates presented to panel	N/A	N/A	325	100%	735	100%	644	100%	1704	100%
TREATMENT INITIATION										
Inmates eligible for HCV treatment who received direct acting antiviral treatment (DAA)	231	N/A	285	88%	321	44%	489	76%	1326	78%
TREATMENT COMPLETION										
Inmates who initiated HCV treatment that successfully completed	221	96%	283	99%	311	97%	426	87%	1241	94%
SUSTAINED VIROLOGIC RESPONSE (SVR) ‡										
Inmates who completed HCV treatment that achieved SVR	204	92%	263	93%	262	84%	107	25%	836	67%
Inmates who completed HCV treatment that did not achieve SVR	9	4%	7	2%	8	3%	2	0%	26	2%
Inmates who completed HCV treatment whose SVR status pending	8	4%	13	5%	41	13%	317	74%	379	31%
TREATMENT INCOMPLETION										
Inmates who initiated HCV treatment who were non-compliant	1	0.4%	1	0.4%	2	1%	2	0.4%	6	0.5%
Inmates who initiated HCV treatment released from incarceration while on treatment	9	4%	4	1%	8	2%	2	0.4%	23	2%
HCV REINFECTION ¶										
Inmates that achieved sustained virologic cure who were reinfected	2	1%	1	0.4%	1	0.4%	--	--	4	0.5%

† In 2016/2017, DPSCS implemented a policy that incorporated a direct acting antiviral (DAA) treatment prioritization policy for hepatitis C treatment based on the guidance of Federal Bureau of Prisons and American Association of the Study of Liver Diseases. Eligible inmates were presented to a multidisciplinary panel that determined treatment urgency based on patient HCV infection. In 2018/2019, DPSCS hepatitis C treatment policy changed now relying on the DPSCS primary care team to identify and treat inmates at risk of HCV.

‡ Sustained virologic response is defined as a recorded lab result with undetectable viral load 12 weeks post treatment completion.

¶ HCV reinfection is defined as the reoccurrence of detectable hepatitis C virus viremia after obtaining sustained virologic response.

Source: Maryland Department of Public Safety and Correction Services

TABLE 48. NUMBER OF INPATIENT HOSPITALIZATIONS FOR HEPATITIS A INFECTION IN MARYLAND, 2015-2019

	ALL HOSPITALIZATIONS		NO DIAGNOSIS OF HAV		PRIMARY DIAGNOSIS OF HAV		ANY DIAGNOSIS OF HAV	
	N	PERCENT *	N	PERCENT *	N	PERCENT*	N	PERCENT *
YEAR								
2015	578,066	22%	578,063	22%	3	5%	138	19%
2016	570,099	22%	570,091	22%	8	14%	160	22%
2017	559,777	21%	559,768	21%	9	16%	146	20%
2018	547,969	21%	547,953	21%	16	28%	185	25%
2019	401,254	15%	401,233	15%	21	37%	106	14%
2015 to 2019	2,657,165	100%	2,657,108	100%	57	100%	735	100%

* Percent values may not add up to 100 due to rounding error.
Excludes hospitalized non-Maryland residents.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

TABLE 49. NUMBER OF INPATIENT HOSPITALIZATIONS FOR HEPATITIS B INFECTION IN MARYLAND, 2015-2019

	ALL HOSPITALIZATIONS		NO DIAGNOSIS OF HBV		PRIMARY DIAGNOSIS OF HBV		ANY DIAGNOSIS OF HBV	
	N	PERCENT *	N	PERCENT *	N	PERCENT *	N	PERCENT *
YEAR								
2015	578,066	22%	578,012	22%	54	32%	1,578	35%
2016	570,099	22%	570,065	22%	34	20%	686	15%
2017	559,777	21%	559,747	21%	30	18%	848	19%
2018	547,969	21%	547,939	21%	30	18%	804	18%
2019	401,254	15%	401,232	15%	22	13%	627	14%
2015 to 2019	2,657,165	100%	2,656,995	100%	170	100%	4,543	100%

* Percent values may not add up to 100 due to rounding error.
Excludes hospitalized non-Maryland residents.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

TABLE 50. NUMBER OF INPATIENT HOSPITALIZATIONS FOR ANY HEPATITIS C INFECTION IN MARYLAND, 2015-2019

	ALL HOSPITALIZATIONS		NO HCV DIAGNOSIS		PRIMARY DIAGNOSIS OF HCV		ANY DIAGNOSIS OF HCV	
	N	PERCENT *	N	PERCENT *	N	PERCENT *	N	PERCENT *
YEAR								
2015	578,066	22%	577,531	22%	535	71%	15,742	22%
2016	570,099	22%	569,971	22%	128	17%	15,722	22%
2017	559,777	21%	559,737	21%	40	5%	15,750	22%
2018	547,969	21%	547,935	21%	34	5%	14,763	21%
2019	401,254	15%	401,236	15%	18	2%	10,202	14%
2015 to 2019	2,657,165	100%	2,656,410	100%	755	100%	72,179	100%

* Percent values may not add up to 100 due to rounding error.
Excludes hospitalized non-Maryland residents.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

TABLE 51A. NUMBER OF INPATIENT HOSPITALIZATIONS BY LIVER DISEASE CATEGORY IN MARYLAND, 2015-2019

YEAR	ALL HOSPITALIZATIONS		LIVER DISEASE CATEGORY					
			PRIMARY DIAGNOSIS OF CIRRHOSIS		PRIMARY DIAGNOSIS OF DECOMPENSATED CIRRHOSIS		PRIMARY DIAGNOSIS OF OTHER CHRONIC LIVER DISEASE	
	N	PERCENT *	N	PERCENT *	N	PERCENT*	N	PERCENT *
2015	578,066	22%	966	47%	1182	26%	694	14%
2016	570,099	22%	325	16%	833	18%	1103	20%
2017	559,777	21%	270	13%	890	20%	1159	17%
2018	547,969	21%	253	12%	908	20%	1156	15%
2019	401,254	15%	228	11%	722	16%	925	13%
2015 to 2019	2,657,165	100%	2,042	100%	4535	100%	5037	100%

* Percent values may not add up to 100 due to rounding error.

Includes hospitalizations with any diagnosis of the respective infection/disease regardless of whether or not it was the primary or secondary diagnosis.

Excludes hospitalized non-Maryland residents.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

TABLE 51B. NUMBER OF INPATIENT HOSPITALIZATIONS BY LIVER DISEASE CATEGORY IN MARYLAND, 2015-2019

YEAR	ALL HOSPITALIZATIONS		LIVER DISEASE CATEGORY					
			PRIMARY DIAGNOSIS OF LIVER TRANSPLANTS		PRIMARY DIAGNOSIS OF LIVER CANCER		ALL LIVER DISEASES	
	N	PERCENT *	N	PERCENT *	N	PERCENT*	N	PERCENT *
2015	578,066	22%	151	21%	652	20.5	3,645	24%
2016	570,099	22%	83	24%	775	24.3	3,119	21%
2017	559,777	21%	73	21%	671	21.1	3,063	20%
2018	547,969	21%	61	20%	649	20.4	3,027	20%
2019	401,254	15%	53	14%	436	13.7	2,364	16%
2015 to 2019	2,657,165	100%	421	100%	3,183	100%	15,218	100%

* Percent values may not add up to 100 due to rounding error.

Includes hospitalizations with any diagnosis of the respective infection/disease regardless of whether or not it was the primary or secondary diagnosis.

Excludes hospitalized non-Maryland residents.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

TABLE 52. NUMBER OF INPATIENT HOSPITALIZATIONS FOR ANY HEPATITIS C INFECTION AND ANY LIVER DISEASE BY CATEGORY IN MARYLAND, 2015-2019

	ALL HOSPITALIZATIONS		ANY DIAGNOSIS OF HCV		ANY DIAGNOSIS OF HCV AND ANY LIVER DISEASE CATEGORY:			
					CIRRHOSIS		DECOMPENSATED CIRRHOSIS	
	N	PERCENT *	N	PERCENT *	N	PERCENT*	N	PERCENT *
YEAR								
2015	578,066	22%	15,742	22%	2,593	30%	1,464	21%
2016	570,099	22%	15,722	22%	1,671	19%	1,478	22%
2017	559,777	21%	15,750	22%	1,643	19%	1,519	22%
2018	547,969	21%	14,763	21%	1,563	18%	1,351	20%
2019	401,254	15%	10,202	14%	1,265	15%	1,042	15%
2015 to 2019	2,657,165	100%	72,179	100%	8,735	100%	6,854	100%

* Percent values may not add up to 100 due to rounding error.

Includes hospitalizations with any diagnosis of the respective infection/disease regardless of whether or not it was the primary or secondary diagnosis.

Excludes hospitalized non-Maryland residents.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

TABLE 53. NUMBER OF INPATIENT HOSPITALIZATIONS BY LIVER DISEASE CATEGORY IN MARYLAND, 2015-2019

	ALL HOSPITALIZATIONS		ANY DIAGNOSIS OF HCV		ANY DIAGNOSIS OF HCV AND ANY LIVER DISEASE CATEGORY:					
					OTHER CHRONIC LIVER DISEASE		LIVER TRANSPLANTS		LIVER CANCER	
	N	PERCENT *	N	PERCENT *	N	PERCENT *	N	PERCENT*	N	PERCENT *
YEAR										
2015	578,066	22%	15,742	22%	1,032	20%	170	25%	437	19%
2016	570,099	22%	15,722	22%	1,017	20%	159	24%	507	22%
2017	559,777	21%	15,750	22%	1,186	23%	145	22%	550	24%
2018	547,969	21%	14,763	21%	1,145	22%	121	18%	466	20%
2019	401,254	15%	10,202	14%	844	16%	75	11%	338	15%
2015 to 2019	2,657,165	100%	72,179	100%	5,224	100%	670	100%	2,298	100%

* Percent values may not add up to 100 due to rounding error.

Includes hospitalizations with any diagnosis of the respective infection/disease regardless of whether or not it was the primary or secondary diagnosis.

Excludes hospitalized non-Maryland residents.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data, 2015-2019

TABLE 54. DEMOGRAPHICS AMONG HOSPITAL INPATIENT HEPATITIS C HOSPITALIZATIONS AND HOSPITALIZATIONS BY LIVER DISEASE CATEGORY IN MARYLAND, 2015-2019

	2015 TO 2019					
	HCV		CIRRHOSIS		DECOMPENSATED CIRRHOSIS	
	N	PERCENT*	N	PERCENT*	N	PERCENT*
OVERALL						
Total	755	100%	2,042	100.00%	4,535	100.00%
SEX AT BIRTH						
Male	521	69%	1,186	58%	2,525	56%
Female	234	31%	852	42%	1,982	44%
Missing	0	0%	4	0%	28	1%
SEX AT BIRTH						
18 to 29	9	1%	27	1%	45	1%
30 to 39	28	4%	110	5%	164	4%
40 to 49	84	11%	287	14%	400	9%
50 to 59	342	45%	655	32%	1,369	30%
60 to 69	250	33%	533	26%	1,495	33%
70 to 79	32	4%	272	13%	698	15%
80+	10	1%	154	8%	336	7%
Missing	0	0%	4	0%	28	1%
BIRTH COHORT						
1900 to 1944	40	5%	350	17%	840	19%
1945 to 1965	599	79%	1,252	61%	2,994	66%
1966 to 1988	110	15%	424	21%	656	15%
1989 to 2019	6	1%	16	1%	45	1%
Missing	0	0%	0	0%	0	0%
RACE						
American Indian or Alaskan Native	3	0%	8	0%	17	0%
Asian/Native Hawaiian or Other Pacific Islander	8	1%	41	2%	63	1%
Black/African American	302	40%	459	23%	1,133	25%
White	386	51%	1,258	62%	2,895	64%
Other	41	5%	106	5%	135	3%
Missing	0	0%	4	0%	28	1%
ETHNICITY						
Non Hispanic or Latino	15	2%	166	8%	264	6%
Hispanic or Latino	689	91%	1,783	87%	4,108	91%
Declined to Answer	6	1%	9	0%	5	0%
Unknown	45	6%	84	4%	158	4%
PRIMARY PAYER						
Medicaid	309	41%	650	32%	1,082	24%
Medicare	288	38%	840	41%	2,303	51%
Private insurance	128	17%	442	22%	973	22%
Self-pay	5	1%	32	2%	45	1%
Charity	1	0%	3	0%	7	0%
Other government sponsored patients	13	2%	39	2%	78	2%
Other	11	2%	36	2%	47	1%
Unknown	0	0%	0	0%	0	0%

TABLE 55. DEMOGRAPHICS AMONG HOSPITAL INPATIENT HEPATITIS C HOSPITALIZATIONS AND HOSPITALIZATIONS BY LIVER DISEASE CATEGORY IN MARYLAND, 2015-2019 (CONTINUED)

	2015 TO 2019							
	OTHER CHRONIC LIVER DISEASE		LIVER TRANSPLANTS		LIVER CANCER		TOTAL	
	N	PERCENT*	N	PERCENT*	N	PERCENT*	N	PERCENT*
OVERALL								
Total	5,037	100.00%	421	100.00%	3,183	100.00%	15,973	100%
SEX AT BIRTH								
Male	2,684	53%	234	56%	1,787	56%	8,937	56%
Female	2,301	46%	151	36%	1,388	44%	6,908	43%
Missing	52	1%	36	9%	8	0%	128	1%
SEX AT BIRTH								
18 to 29	155	3%	25	6%	22	1%	283	2%
30 to 39	431	9%	52	12%	75	2%	860	5%
40 to 49	607	12%	55	13%	221	7%	1,654	10%
50 to 59	1,394	28%	141	34%	744	23%	4,645	29%
60 to 69	1,428	28%	106	25%	1,086	34%	4,898	31%
70 to 79	693	14%	6	1%	666	21%	2,367	15%
80+	277	6%	0	0%	361	11%	1,138	7%
Missing	52	1%	36	9%	8	0%	128	1%
BIRTH COHORT								
1900 to 1944	751	15%	3	1%	861	27%	2,845	18%
1945 to 1965	2,950	59%	241	57%	1,950	61%	9,986	63%
1966 to 1988	1,194	24%	125	30%	351	11%	2,860	18%
1989 to 2019	140	3%	52	12%	21	1%	280	2%
Missing	2	0%	0	0%	0	0%	2	0%
RACE								
American Indian or Alaskan Native	15	0%	1	0%	15	1%	59	0%
Asian/Native Hawaiian or Other Pacific Islander	105	2%	8	2%	115	4%	340	2%
Black/African American	1,377	27%	121	29%	1,139	36%	4,531	28%
White	3,039	60%	226	54%	1,675	53%	9,479	59%
Other	167	3%	19	5%	114	4%	582	4%
Missing	52	1%	36	9%	8	0%	128	1%
ETHNICITY								
Non Hispanic or Latino	285	6%	14	3%	117	4%	861	5%
Hispanic or Latino	4,589	91%	401	95%	2,964	93%	14,534	91%
Declined to Answer	17	0%	2	1%	13	0%	52	0%
Unknown	146	3%	4	1%	89	3%	526	3%
PRIMARY PAYER								
Medicaid	1,413	28%	124	30%	486	15%	4,064	25%
Medicare	2,155	43%	141	34%	1,592	50%	7,319	46%
Private insurance	1,237	25%	124	30%	989	31%	3,893	24%
Self-pay	85	2%	1	0%	25	1%	193	1%
Charity	10	0%	0	0%	3	0%	24	0%
Other government sponsored patients	92	2%	26	6%	34	1%	282	2%
Other	45	1%	5	1%	52	2%	196	1%
Unknown	0	0%	0	0%	2	0%	2	0%

TABLE 56. LENGTH OF STAY AND TOTAL CHARGES WITH RELATED HEPATITIS A INFECTION HOSPITAL INPATIENT DISCHARGE IN MARYLAND, 2015-2019

	LENGTH OF STAY (DAYS)					CHARGES		
	MEAN (SD)		MEDIAN (RANGE)		TOTAL LENGTH OF STAY	MEAN	MEDIAN	TOTAL CHARGES (US DOLLARS)
YEAR								
2015	4	0	4	0	12	\$8,056.16	\$8,202.13	\$24,168.48
2016	3	1.5	3	4	22	\$7,030.01	\$6,973.02	\$56,240.07
2017	3	2.1	2	6	28	\$9,094.45	\$7,479.39	\$81,850.04
2018	3	1.6	3	6	46	\$7,406.16	\$6,736.79	\$118,498.50
2019	3	1.9	3	7	66	\$8,362.67	\$7,689.52	\$167,253.38
AVERAGE								
5 Year Average	3	1.7	3	7	174	\$8,000.19	\$7,214.95	\$448,010.47

Excludes hospitalized non-Maryland residents.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data 2015-2019

TABLE 57. LENGTH OF STAY AND TOTAL CHARGES WITH RELATED HEPATITIS B INFECTION HOSPITAL INPATIENT DISCHARGE IN MARYLAND, 2015-2019

	LENGTH OF STAY (DAYS)					CHARGES		
	MEAN (SD)		MEDIAN (RANGE)		TOTAL LENGTH OF STAY	MEAN	MEDIAN	TOTAL CHARGES (US DOLLARS)
YEAR								
2015	5	5.7	4	27	273	\$25,126.22	\$10,865.05	\$1,306,563.48
2016	5	3.9	4	22	148	\$12,066.81	\$10,087.29	\$386,138.03
2017	4	3.4	3	15	126	\$12,248.22	\$9,113.77	\$367,446.50
2018	3	2.1	3	9	101	\$13,425.53	\$8,718.56	\$389,340.28
2019	9	13.6	4	58	177	\$23,580.69	\$11,664.13	\$471,613.75
AVERAGE								
5 Year Average	5	6.3	3	59	825	\$17,920.87	\$10,255.98	\$2,921,102.04

Excludes hospitalized non-Maryland residents.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data 2015-2019

TABLE 58. LENGTH OF STAY AND TOTAL CHARGES WITH RELATED HEPATITIS C INFECTION HOSPITAL INPATIENT DISCHARGE IN MARYLAND, 2015-2019

	LENGTH OF STAY (DAYS)					CHARGES		
	MEAN (SD)		MEDIAN (RANGE)		TOTAL LENGTH OF STAY	MEAN	MEDIAN	TOTAL CHARGES (US DOLLARS)
YEAR								
2015	7	9.0	4	106	3,497	\$25,518.26	\$11,066.85	\$13,473,640.69
2016	6	8.6	4	77	790	\$26,668.09	\$11,220.68	\$3,360,179.77
2017	17	53.8	5	325	602	\$102,910.55	\$14,927.14	\$3,704,779.79
2018	5	2.9	4	10	153	\$32,752.63	\$13,791.94	\$1,113,589.54
2019	5	6.3	3	22	97	\$26,119.38	\$11,303.96	\$470,148.83
AVERAGE								
5 Year Average	7	14.6	4	325	5,139	\$29,814.47	\$11,370.25	\$22,122,338.62

Excludes hospitalized non-Maryland residents.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data 2015-2019

**TABLE 59A. LENGTH OF STAY AND TOTAL CHARGES WITH A RELATED HEPATITIS C INFECTION
HOSPITAL INPATIENT DISCHARGE BY LIVER DISEASE CATEGORY IN MARYLAND, 2015-2019**

	LENGTH OF STAY (DAYS)					CHARGES		
	MEAN (SD)		MEDIAN (RANGE)		TOTAL LENGTH OF STAY	MEAN	MEDIAN	TOTAL CHARGES (US DOLLARS)
CIRRHOSIS								
YEAR								
2015	6	7.3	4	59	5,860	\$24,954.81	\$12,475.59	\$23,482,477.52
2016	7	10.5	4	133	2,176	\$36,073.65	\$12,206.49	\$11,507,495.62
2017	9	25.4	4	313	2,362	\$46,985.90	\$13,545.57	\$12,357,292.40
2018	7	10.5	4	83	1,760	\$36,041.89	\$13,628.50	\$8,938,387.93
2019	6	5.4	4	32	1,240	\$21,370.37	\$14,377.21	\$4,722,852.60
AVERAGE (2015 TO 2019)								
5 Year Average	7	12	4	313	13,398	\$30,626.76	\$12,967.63	\$61,008,506.07
DECOMPENSATED CIRRHOSIS								
YEAR								
2015	6	8	4	148	6,926	\$17,674.83	\$10,240.84	\$20,714,900.95
2016	6	7.5	4	110	4,584	\$17,786.77	\$9,902.01	\$14,567,363.64
2017	5	5.9	4	52	4,774	\$19,636.71	\$10,985.03	\$17,123,207.05
2018	5	6	4	98	4,670	\$19,894.02	\$10,438.66	\$17,785,251.29
2019	6	11	4	240	4,386	\$23,746.39	\$12,013.70	\$16,717,459.12
AVERAGE (2015 TO 2019)								
5 Year Average	6	7.8	4	240	25,340	\$19,481.77	\$10,594.39	\$86,908,182.05
OTHER CHRONIC LIVER DISEASE								
YEAR								
2015	5	6.1	4	73	3,613	\$16,182.65	\$9,898.99	\$11,036,568.40
2016	5	5.8	4	93	5,660	\$15,289.61	\$9,365.57	\$16,619,805.79
2017	5	5.3	4	55	6,001	\$18,137.12	\$10,523.50	\$20,603,767.39
2018	5	5.4	4	59	5,945	\$18,654.82	\$10,244.81	\$21,247,842.47
2019	6	9.9	4	240	5,259	\$20,964.10	\$11,195.50	\$18,993,477.79
AVERAGE (2015 TO 2019)								
5 Year Average	5	6.6	4	240	26,478	\$17,879.08	\$10,193.31	\$88,501,461.84
LIVER TRANSPLANTS								
YEAR								
2015	12	20.6	6	156	1,843	\$56,622.09	\$19,488.78	\$8,436,691.61
2016	11	11.7	7	57	918	\$48,602.78	\$20,333.66	\$3,985,428.22
2017	10	12.8	7	100	696	\$49,418.52	\$21,955.65	\$3,558,133.28
2018	10	9.7	7	43	590	\$40,562.13	\$23,232.77	\$2,433,727.61
2019	14	25.7	5	132	728	\$65,210.12	\$16,931.73	\$3,456,136.44
AVERAGE (2015 TO 2019)								
5 Year Average	11	17.4	6	156	4,775	\$52,572.40	\$20,674.09	\$21,870,117.16

**TABLE 59B. LENGTH OF STAY AND TOTAL CHARGES WITH A RELATED HEPATITIS C INFECTION
HOSPITAL INPATIENT DISCHARGE BY LIVER DISEASE CATEGORY IN MARYLAND, 2015-2019
(CONTINUED)**

	LENGTH OF STAY (DAYS)					CHARGES		
	MEAN (SD)		MEDIAN (RANGE)		TOTAL LENGTH OF STAY	MEAN	MEDIAN	TOTAL CHARGES (US DOLLARS)
LIVER CANCER								
YEAR								
2015	6	4.8	5	44	3,709	\$24,720.25	\$15,234.55	\$15,796,241.36
2016	6	5.9	4	59	4,303	\$22,970.28	\$13,913.63	\$17,319,591.59
2017	5	5.2	4	76	3,529	\$22,338.14	\$14,096.55	\$14,564,470.31
2018	6	5.6	4	66	3,703	\$22,498.48	\$15,850.27	\$14,264,038.71
2019	6	5.6	5	39	2,679	\$28,262.76	\$18,707.52	\$11,926,885.75
AVERAGE (2015 TO 2019)								
5 Year Average	6	5.4	4	76	17,923	\$23,821.74	\$15,302.17	\$73,871,227.72

Excludes hospitalized non-Maryland residents.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data 2015-2019

TABLE 60. LENGTH OF STAY AND TOTAL CHARGES WITH RELATED HIV HOSPITAL INPATIENT DISCHARGE IN MARYLAND, 2015-2019

	LENGTH OF STAY (DAYS)					CHARGES		
	MEAN (SD)		MEDIAN (RANGE)		TOTAL LENGTH OF STAY	MEAN	MEDIAN	TOTAL CHARGES (US DOLLARS)
YEAR								
2015	9	10.7	6	106	9,200	\$26,713.34	\$15,538.65	\$26,472,924.29
2016	9	13.7	6	188	6,926	\$30,884.26	\$15,231.08	\$23,101,429.81
2017	9	11.6	5	99	6,680	\$29,344.66	\$16,906.10	\$21,656,362.75
2018	9	9.2	6	95	6,219	\$28,653.34	\$17,344.89	\$20,830,981.10
2019	9	10.6	6	99	3,999	\$29,989.29	\$18,397.22	\$13,105,319.50
AVERAGE								
5 Year Average	9	11.3	6	188	33,024	\$28,884.10	\$16,456.39	\$105,167,017.45

Excludes hospitalized non-Maryland residents.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data 2015-2019

TABLE 61. COMORBIDITIES AMONG HOSPITAL INPATIENT HOSPITALIZATIONS WITH ANY DIAGNOSIS OF HEPATITIS C IN MARYLAND, 2015-2019

	YEAR										TOTAL	
	2015		2016		2017		2018		2019			
	COUNT	PERCENT	COUNT	PERCENT	COUNT	PERCENT	COUNT	PERCENT	COUNT	PERCENT	COUNT	PERCENT *
ANY DIAGNOSIS												
Hepatitis C Infection	15,742	22%	15,722	22%	15,750	22%	14,763	21%	10,202	14%	72,179	100%
SEX AT BIRTH												
Hepatitis B infection	5	25%	3	15%	5	25%	4	20%	3	15%	20	100%
HIV	230	28%	174	21%	177	21%	173	21%	78	9%	832	100%
Cirrhosis	282	44%	130	20%	99	16%	63	10%	63	10%	637	100%
Decompensated cirrhosis	113	11%	214	21%	274	27%	227	23%	176	18%	1,004	100%
Liver Transplants	33	40%	19	23%	12	15%	12	15%	6	7%	82	100%
Liver Cancer	153	24%	164	26%	130	20%	117	18%	79	12%	643	100%
Diabetes	40	21%	45	24%	45	24%	34	18%	26	14%	190	100%

Excludes hospitalized non-Maryland residents.

Source: Maryland Department of Health Health Services Cost Review Commission Public Use Statewide Inpatient and Outpatient Data 2015-2019

TABLE 62. NUMBER OF DEATHS FOR VIRAL HEPATITIS B AND C IN MARYLAND, 2009-2018

	HBV	HCV
OVERALL		
2009 to 2018	75	1,019
YEAR		
2009	6	115
2010	7	108
2011	13	115
2012	7	105
2013	12	99
2014	8	113
2015	6	109
2016	3	94
2017	5	86
2018	8	75

Source: Maryland Department of Health Vital Statistics Administration, 2019

TABLE 63. CRUDE MORTALITY RATES FOR VIRAL HEPATITIS B IN MARYLAND, 2009-2018

	CRUDE MORTALITY RATE PER 100,000	AGE-ADJUSTED * MORTALITY RATE PER 100,000
YEAR		
2009	0.11	***
2010	0.12	***
2011	0.22	***
2012	0.12	***
2013	0.20	***
2014	0.13	***
2015	0.10	***
2016	**	***
2017	0.08	***
2018	0.13	***

* Age-adjusted to the 2000 U.S. standard population.

**Rates based on <5 events in the numerator are not presented since such rates are subject to instability.

***Rates based on <20 events in the numerator are not presented since such rates are subject to instability.

Source: Maryland Department of Health Vital Statistics Administration, 2019

TABLE 64. CRUDE AND AGE-ADJUSTED MORTALITY RATES FOR VIRAL HEPATITIS C IN MARYLAND, 2009-2018

	CRUDE MORTALITY RATE PER 100,000	AGE-ADJUSTED * MORTALITY RATE PER 100,000
YEAR		
2009	2.02	1.74
2010	1.87	1.56
2011	1.97	1.62
2012	1.78	1.46
2013	1.67	1.33
2014	1.89	1.49
2015	1.81	1.44
2016	1.56	1.27
2017	1.42	1.11
2018	1.24	0.96

* Age-adjusted to the 2000 U.S. standard population.

Source: Source: Maryland Department of Health Vital Statistics Administration, 2019

TABLE 65. AGGREGATE CRUDE AND AGE-ADJUSTED MORTALITY RATES FOR VIRAL HEPATITIS B AND C IN MARYLAND FOR 2009 TO 2018 AND 2014 TO 2018

	HCV		HBV	
	CRUDE MORTALITY RATE PER 100,000	AGE-ADJUSTED * MORTALITY RATE PER 100,000	CRUDE MORTALITY RATE PER 100,000	AGE-ADJUSTED* MORTALITY RATE PER 100,000
YEAR				
2009 to 2018	0.13	***	1.72	1.40
2014 to 2018	0.10	***	1.59	1.25

* Age-adjusted to the 2000 U.S. standard population.
***Rates based on <20 events in the numerator are not presented since such rates are subject to instability.

Source: Source: Maryland Department of Health Vital Statistics Administration, 2019

TABLE 66. HEPATITIS B-RELATED DEATHS BY AGE, SEX AT BIRTH, RACE AND ETHNICITY IN MARYLAND, 2014-2018

	YEAR		
	2014 TO 2018		
	N	PERCENT	CRUDE MORTALITY RATE PER 100,000
OVERALL			
Total	30	100.0%	0.10
SEX AT BIRTH			
Male	23	76.7%	0.16
Female	7	23.3%	*
Unknown	0	0.0%	*
Missing	0	0.0%	*
AGE GROUP (YEARS)			
0 to 19	0	0.0%	*
20 to 29	0	0.0%	*
30 to 39	1	3.3%	*
40 to 49	6	20.0%	*
50 to 59	9	30.0%	*
60 to 69	10	33.3%	*
70 to 79	4	13.3%	*
80+	0	0.0%	*
Unknown	0	0.0%	*
Missing	0	0.0%	*
RACE			
American Indian or Alaskan Native	0	0.0%	*
Asian	6	20.0%	*
Black/African American	14	46.7%	*
Native Hawaiian or Other Pacific Islander	0	0.0%	*
White	9	30.0%	*
Other	1	3.3%	*
Unknown	0	0.0%	*
Missing	0	0.0%	*
ETHNICITY			
Non Hispanic or Latino	29	96.7%	0.11
Hispanic or Latino	1	3.3%	*
Unknown	0	0.0%	*
Missing	0	0.0%	*

*Rates based on <5 events on an annual basis are not presented since such rates are subject to instability.

Source: Maryland Department of Health Vital Statistics Administration, 2019

TABLE 67. HEPATITIS C-RELATED DEATHS BY AGE, SEX AT BIRTH, RACE AND ETHNICITY IN MARYLAND, 2014-2018

	YEAR		
	2014 TO 2018		
	N	PERCENT	CRUDE MORTALITY RATE PER 100,000
OVERALL			
Total	477	100.0%	1.59
SEX AT BIRTH			
Male	329	69.0%	2.26
Female	148	31.0%	0.95
Unknown	0	0.0%	*
Missing	0	0.0%	*
AGE GROUP (YEARS)			
0 to 19	0	0.0%	*
20 to 29	2	0.4%	*
30 to 39	10	2.1%	*
40 to 49	29	6.1%	0.74
50 to 59	193	40.5%	4.42
60 to 69	180	37.7%	5.39
70 to 79	39	8.2%	2.19
80+	23	4.8%	2.13
Unknown	1	0.2%	*
Missing	0	0.0%	*
RACE			
American Indian or Alaskan Native	1	0.2%	*
Asian	6	1.3%	*
Black/African American	227	47.6%	2.38
Native Hawaiian or Other Pacific Islander	2	0.4%	*
White	240	50.3%	1.32
Other	1	0.2%	*
Unknown	0	0.0%	*
Missing	0	0.0%	*
ETHNICITY			
Non Hispanic or Latino	471	98.7%	1.73
Hispanic or Latino	6	1.3%	*
Unknown	0	0.0%	*
Missing	0	0.0%	*

*Rates based on <5 events on an annual basis are not presented since such rates are subject to instability.

Source: Maryland Department of Health Vital Statistics Administration, 2019

TABLE 68. AVERAGE AGE AMONG VIRAL HEPATITIS B AND C RELATED DEATHS VERSUS ALL DEATHS IN MARYLAND, 2014-2018

	ALL DEATHS	HCV-RELATED DEATHS	HBV-RELATED DEATHS
YEAR			
2014	72.7	53.9	60.3
2015	72.6	56.3	59.1
2016	72.0	59.7	60.5
2017	72.2	63.8	60.6
2018	72.5	58.9	61.7

Source: Maryland Department of Health Vital Statistics Administration, 2019

TABLE 69. AGE-ADJUSTED MORTALITY RATES OF HEPATITIS C COMPARING ALL AGES AND BABY BOOMERS IN MARYLAND, 2009-2018

	AGE-ADJUSTED * HCV MORTALITY RATE PER 100,000	
	ALL AGES	BABY BOOMERS (BORN 1945 TO 1965)
YEAR		
2009	1.74	3.75
2010	1.56	4.75
2011	1.62	4.15
2012	1.46	4.80
2013	1.33	4.42
2014	1.49	5.23
2015	1.44	5.68
2016	1.27	4.31
2017	1.11	3.20
2018	0.96	2.71

* Age-adjusted to the 2000 U.S. standard population.

Source: Maryland Department of Health Vital Statistics Administration, 2019

TABLE 70. HEPATITIS B-RELATED DEATHS IN MARYLAND BY COUNTY, 2014-2018

	NUMBER OF DEATHS	CRUDE HBV MORTALITY RATE PER 100,000
MARYLAND		
Overall	30	0.10
COUNTY		
Allegany	0	*
Anne Arundel	2	*
Baltimore City	6	*
Baltimore	3	*
Calvert	0	*
Caroline	0	*
Carroll	0	*
Cecil	0	*
Charles	1	*
Dorchester	0	*
Frederick	1	*
Garrett	0	*
Harford	2	*
Howard	0	*
Kent	0	*
Montgomery	5	*
Prince George's	8	*
Queen Anne's	0	*
Somerset	0	*
St. Mary's	0	*
Talbot	0	*
Washington	1	*
Wicomico	1	*
Worcester	0	*

*Rates based on <5 events on an annual basis are not presented since such rates are subject to instability.

Source: Maryland Department of Health Vital Statistics Administration, 2019

TABLE 71. HEPATITIS C-RELATED DEATHS IN MARYLAND BY INVESTIGATION COUNTY, 2014-2018

	NUMBER OF DEATHS	CRUDE HCV MORTALITY RATE PER 100,000	AGE-ADJUSTED* HCV MORTALITY RATE PER 100,000
MARYLAND			
Overall	477	1.59	1.25
COUNTY			
Allegany	7	**	***
Anne Arundel	33	1.16	***
Baltimore City	128	4.16	3.63
Baltimore	59	1.42	***
Calvert	3	**	***
Caroline	6	**	***
Carroll	7	**	***
Cecil	5	**	***
Charles	13	**	***
Dorchester	3	**	***
Frederick	6	**	***
Garrett	4	**	***
Harford	12	**	***
Howard	12	**	***
Kent	3	**	***
Montgomery	36	0.69	***
Prince George's	87	1.92	***
Queen Anne's	5	**	***
Somerset	1	**	***
St. Mary's	5	**	***
Talbot	1	**	***
Washington	29	3.86	***
Wicomico	7	**	***
Worcester	5	**	***

* Age-adjusted to the 2000 U.S. standard population.

**Rates based on <5 events in the numerator are not presented since such rates are subject to instability.

***Rates based on <20 events in the numerator are not presented since such rates are subject to instability.

Source: Maryland Department of Health Vital Statistics Administration, 2019

TABLE 72. LEADING UNDERLYING CAUSE OF DEATH AMONG REPORTED DEATHS WITH HEPATITIS B LISTED AS AN ADDITIONAL CAUSES OF DEATH IN MARYLAND, 2014-2018

	N	PERCENT
UNDERLYING CAUSE OF DEATH (ICD-10)		
Liver cell carcinoma	27	22.0%
Chronic viral hepatitis B without delta agent	0	0.0%
Acute hepatitis B	0	0.0%
Acute hepatitis B without delta agent and with hepatic coma	0	0.0%
Acute hepatitis B without delta agent and without hepatic coma	0	0.0%
Alcohol dependence	0	0.0%
Alcoholic cirrhosis of the liver	5	4.1%
Alcoholic liver disease (unspecified)	0	0.0%
Malignant neoplasm of liver (unspecified as primary or secondary)	12	9.8%
Accidental poisoning by and exposure to narcotics and psychodysleptics	1	0.8%
Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances	0	0.0%
Chronic obstructive pulmonary disease (unspecified)	0	0.0%
Chronic viral hepatitis C	5	4.1%
Other underlying cause of death not specified	73	59.3%
Total	123	100.0%

ICD-10 or International Classification of Diseases, Tenth Revision codes were used for the respective underlying cause of death category.

Source: Maryland Department of Health Vital Statistics Administration, 2019

TABLE 73. LEADING UNDERLYING CAUSE OF DEATH AMONG REPORTED DEATHS WITH HEPATITIS C LISTED AS AN ADDITIONAL CAUSES OF DEATH IN MARYLAND, 2014-2018

	N	PERCENT
UNDERLYING CAUSE OF DEATH (ICD10)		
Liver cell carcinoma	251	19.4%
Acute hepatitis C	0	0.0%
Chronic viral hepatitis C	0	0.0%
Alcohol dependence	0	0.0%
Alcoholic cirrhosis of the liver	57	4.4%
Alcoholic liver disease (unspecified)	6	0.5%
Alcoholic hepatic failure	2	0.2%
Malignant neoplasm of liver (not specified as primary or secondary)	66	5.1%
Accidental poisoning by and exposure to narcotics and psychodysleptics	9	0.7%
Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances	3	0.2%
Chronic obstructive pulmonary disease (unspecified)	23	1.8%
Chronic viral hepatitis B without delta agent	0	0.0%
Other and unspecified cirrhosis of the liver	49	3.8%
Other underlying cause of death not specified	825	63.9%
Total	1,291	100.0%

ICD-10 or International Classification of Diseases, Tenth Revision codes were used for the respective underlying cause of death category.

Source: Maryland Department of Health Vital Statistics Administration, 2019

TABLE 74. CASES OF HEPATOCELLULAR CARCINOMA BY YEAR OF DIAGNOSIS IN MARYLAND, 2007-2017

	N	RATE PER 100,000 *
YEAR		
2007	318	5.3
2008	351	5.7
2009	363	5.8
2010	392	6.0
2011	424	6.3
2012	462	6.7
2013	499	7.1
2014	515	7.1
2015	513	6.8
2016	594	7.8
2017	529	6.9

*Rates are per 100,000 and age-adjusted to the 2000 US Standard Population.

Source: Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry, 2019

TABLE 75. CASES OF INTRAHEPATIC BILE DUCT BY YEAR OF DIAGNOSIS IN MARYLAND, 2007-2017

	N	RATE PER 100,000 *
YEAR		
2007	24	0.4
2008	43	0.7
2009	27	0.4
2010	47	0.8
2011	45	0.7
2012	57	0.9
2013	92	1.4
2014	85	1.2
2015	78	1.2
2016	99	1.4
2017	113	1.5

*Rates are per 100,000 and age-adjusted to the 2000 US Standard Population.

Source: Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry, 2019

TABLE 76A. DEMOGRAPHICS AMONG HEPATOCELLULAR CARCINOMA CASES IN MARYLAND, 2013-2017

	YEAR	
	2013 TO 2017	
	COUNT	PERCENT *
OVERALL		
Total	2,737	100%
SEX AT BIRTH		
Male	2,045	75%
Female	692	25%
Unknown	0	0%
Missing	0	0%
AGE GROUP (YEARS)		
0 to 19	17	1%
20 to 29	9	0%
30 to 39	29	1%
40 to 49	91	3%
50 to 59	722	26%
60 to 69	1,072	39%
70+	797	29%
Unknown	0	0%
Missing	0	0%

TABLE 76B. DEMOGRAPHICS AMONG HEPATOCELLULAR CARCINOMA CASES IN MARYLAND, 2013-2017 (CONTINUED)

	YEAR	
	2013 TO 2017	
	COUNT	PERCENT *
BIRTH COHORT		
1900 to 1944	760	28%
1945 to 1965	1,841	67%
1966 to 1988	115	4%
1989 to 2019	21	1%
Unknown	0	0%
Missing	0	0%
RACE		
American Indian or Alaskan Native	7	0%
Asian	164	6%
Black/African American	1,065	39%
Native Hawaiian or Other Pacific Islander	<6	**
White	1,471	54%
Other	24	1%
Unknown	<6	**
Missing	0	0%
ETHNICITY		
Non Hispanic or Latino	2,642	97%
Hispanic or Latino	s	**
Unknown	0	0%
Missing	<6	**
VITAL STATUS		
Alive	677	25%
Deceased	2,060	75%
Unknown	0	0%
Missing	0	0%

* Percent values may not add up to 100 due to rounding error and/or data suppression.

<6 = Case counts of 1-5 are suppressed per Maryland Department of Health/Maryland Cancer Registry Data Use Policy.

s = Case counts are suppressed to prevent disclosure of data in other cell(s).

** Percentages for suppressed cell counts are suppressed.

Source: Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry, 2019

TABLE 77A. DEMOGRAPHICS AMONG INTRAHEPATIC BILE DUCT CANCER CASES IN MARYLAND, 2013-2017

	YEAR	
	2013 TO 2017	
	COUNT	PERCENT *
OVERALL		
Total	483	100%
SEX AT BIRTH		
Male	245	51%
Female	238	49%
Unknown	0	0%
Missing	0	0%
AGE GROUP (YEARS)		
0 to 19	0	0%
20 to 29	<6	**
30 to 39	s	**
40 to 49	17	4%
50 to 59	98	20%
60 to 69	146	30%
70+	206	43%
Unknown	0	0%
Missing	0	0%
BIRTH COHORT		
1900 to 1944	199	41%
1945 to 1965	253	52%
1966 to 1988	s	**
1989 to 2019	<6	**
Unknown	0	0%
Missing	0	0%
RACE		
American Indian or Alaskan Native	<6	**
Asian	31	6%
Black/African American	116	24%
Native Hawaiian or Other Pacific Islander	0	0%
White	332	69%
Other	<6	**
Unknown	<6	**
Missing	0	0%

TABLE 77B. DEMOGRAPHICS AMONG INTRAHEPATIC BILE DUCT CANCER CASES IN MARYLAND, 2013-2017 (CONTINUED)

	YEAR	
	2013 TO 2017	
	COUNT	PERCENT *
ETHNICITY		
Non Hispanic or Latino	465	96%
Hispanic or Latino	18	4%
Unknown	0	0%
Missing	0	0%
VITAL STATUS		
Alive	78	16%
Deceased	405	84%
Unknown	0	0%
Missing	0	0%

* Percent values may not add up to 100 due to rounding error and/or data suppression

<6 = Case counts of 1-5 are suppressed per Maryland Department of Health/Maryland Cancer Registry Data Use Policy.

** Percentages for suppressed cell counts are suppressed.

Source: Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry, 2019

TABLE 78A. DEMOGRAPHICS AMONG ALL CANCER CASES EXCLUDING HEPATOCELLULAR CARCINOMA AND INTRAHEPATIC BILE DUCT CANCER CASES IN MARYLAND, 2013-2017

	YEAR	
	2013 TO 2017	
	COUNT	PERCENT *
OVERALL		
Total	153,068	100%
SEX AT BIRTH		
Male	74,678	49%
Female	78,379	51%
Unknown	11	0.01%
Missing	0	0%
AGE GROUP (YEARS)		
0 to 19	1,316	1%
20 to 29	1,985	1%
30 to 39	4,675	3%
40 to 49	11,895	8%
50 to 59	30,607	20%
60 to 69	44,176	29%
70+	58,400	38%
Unknown	14	0%
Missing	0	0%
BIRTH COHORT		
1900 to 1944	56,186	37%
1945 to 1965	77,929	51%
1966 to 1988	16,571	11%
1989 to 2019	2,368	2%
Unknown	0	0%
Missing	14	0%
RACE		
American Indian or Alaskan Native	280	0%
Asian	5,137	3%
Black/African American	40,730	27%
Native Hawaiian or Other Pacific Islander	188	0%
White	105,122	69%
Other	1,151	1%
Unknown	460	0%
Missing	0	0%

TABLE 78B. DEMOGRAPHICS AMONG ALL CANCER CASES EXCLUDING HEPATOCELLULAR CARCINOMA AND INTRAHEPATIC BILE DUCT CANCER CASES IN MARYLAND, 2013-2017 (CONTINUED)

	YEAR	
	2013 TO 2017	
	COUNT	PERCENT *
ETHNICITY		
Non Hispanic or Latino	149,428	98%
Hispanic or Latino	3,457	2%
Unknown	0	0%
Missing	183	0%
VITAL STATUS		
Alive	96,407	63%
Deceased	56,661	37%
Unknown	0	0%
Missing	0	0%

* Percent values may not add up to 100 due to rounding error and/or data suppression.

Source: Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry, 2019

TABLE 79. AVERAGE AGE AMONG CASES OF HEPATOCELLULAR CARCINOMA BY YEAR OF DIAGNOSIS IN MARYLAND, 2013-2017

	AVERAGE AGE (YEARS)
YEAR	
2013	64
2014	64
2015	64
2016	65
2017	65

Source: Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry, 2019

TABLE 80. AVERAGE AGE AMONG CASES OF INTRAHEPATIC BILE DUCT CANCER BY YEAR OF DIAGNOSIS IN MARYLAND, 2013-2017

	AVERAGE AGE (YEARS)
YEAR	
2013	69
2014	66
2015	66
2016	67
2017	67

Source: Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry, 2019

TABLE 81. CASES OF HEPATOCELLULAR CARCINOMA BORN BETWEEN 1945 TO 1965 IN MARYLAND BY YEAR OF DIAGNOSIS, 2013-2017

	ALL CASES	CASES BORN BETWEEN 1945 TO 1965	PROPORTION OF ALL CASES BORN BETWEEN 1945 TO 1965
	N	N	PERCENT
YEAR			
2013	534	332	62%
2014	538	352	65%
2015	529	361	68%
2016	607	420	69%
2017	529	376	71%

Source: Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry, 2019

TABLE 82. CASES OF HEPATOCELLULAR CARCINOMA BORN BETWEEN 1945 TO 1965 IN MARYLAND BY YEAR OF DIAGNOSIS, 2013-2017

	ALL CASES	CASES BORN BETWEEN 1945 TO 1965	PROPORTION OF ALL CASES BORN BETWEEN 1945 TO 1965
	N	N	PERCENT
YEAR			
2013	98	42	43%
2014	88	50	57%
2015	81	39	48%
2016	103	56	54%
2017	113	66	58%

Source: Maryland Department of Health Center for Cancer Prevention and Control Maryland Cancer Registry, 2019

TABLE 83. MARYLAND'S HEPATITIS C RAPID TESTING PROGRAM HCV CARE CASCADE, 2017-2019

	ANTI-HCV -		ANTI-HCV +		HCV RNA TESTED*		HCV RNA +		REFERRED TO/ ALREADY IN CARE †	
	N	PERCENT *	N	PERCENT *	N	PERCENT *	N	PERCENT *	N	PERCENT *
OVERALL										
Total	10,273	100%	574	100%	381	100%	277	100%	151	100%
YEAR										
2017	2,589	25%	111	19%	76	20%	60	22%	31	21%
2018	3,585	35%	163	28%	112	29%	81	29%	58	38%
2019	4,099	40%	300	52%	193	51%	136	49%	62	41%

Percent values may not add up to 100 due to rounding error.
- means negative.
+ means positive.

* HCV RNA test are ordered for all patients who test HCV antibody positive, however not all patients are RNA tested for various reasons including patients not keeping appointments, unable to contact patient, patients leaving before test sample is collected, patient refusing, and additional reasons.
† After patients are identified as HCV RNA positive Maryland Hepatitis C Rapid Testing Program partners attempt to notify all patients of their test results and refer them to HCV medical care. From 2017 to 2019 among the 277 patients who tested HCV RNA positive, 151 were referred/already linked to HCV care, 55 were lost to follow-up, 7 refused, 2 pending appointment confirmation, and 62 were not referred to care for one of the following reasons: unable to locate, being out of jurisdiction, moving out of state, incarceration, or being reported as deceased.

Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services Bureau
Center for Viral Hepatitis Maryland HCV Rapid Testing Program, 2019

TABLE 84. MARYLAND HEPATITIS C RAPID TESTING PROGRAM LINKAGE TO CARE OUTCOMES, 2017-2019

	YEAR	
	2017 TO 2019	
	COUNT	PERCENT
OVERALL		
Total	151	100%
REFERRED TO/ALREADY IN CARE		
Attended appointment	92	61%
Did not attend appointment	43	28%
Already in care	16	11%
NOT REFERRED TO CARE		
Out of jurisdiction	25	17%
Unable to locate	12	8%
Incarcerated	11	7%
Deceased	10	7%
Moved	4	3%
OTHER OUTCOMES		
Lost to follow-up	55	36%
Pending	2	1%
Refused care	7	5%

Percent values may not add up to 100 due to rounding error.

Note linkage to care outcomes are defined as:

1. Already in Care: patient stated they are already receiving HCV medical care.
2. Attended Appointment: patient attended first scheduled HCV care appointment, appointment was verified by a medical provider, and client was successfully linked to care.
3. Did Not Attend Appointment: patient was referred to care (i.e.. initially accepts assistance and appointment is scheduled) but does not attend appointment.
4. Deceased: patient is found to be deceased and not referred to care.
5. Lost to Follow up: patient is initially located but is lost to follow-up before to scheduling an HCV care appointment.
6. Moved: patient has moved out of Maryland and is not referred to care.
7. Pending: Patient was referred to care and additional follow-up is needed to confirm whether or not they attended HCV care appointment / additional contact needs to be made with patient to refer them to HCV care
8. Refused: patient refused hepatitis C linkage to care assistance (i.e.. does not want an HCV care appointment scheduled or connection to a provider related to HCV care)
9. Unable to Locate: patient is unable to locate via phone call, text, email, and/or in person. Unable to contact/communicate with patient.
10. Out of jurisdiction: patient has moved out of jurisdiction of Hepatitis C Rapid Testing program and is not referred to care.
11. Incarcerated: Patient was incarcerated or detained up before scheduling an HCV care appointment.

Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services Bureau
Center for Viral Hepatitis Maryland HCV Rapid Testing Program, 2019

TABLE 85. MARYLAND COMMUNITY-BASED PROGRAMS TO TEST AND CURE HEPATITIS C CLINICAL PARTNER HCV TESTING CASCADE, 2017-2019

	YEAR	
	2015* TO 2019	
	COUNT	PERCENT
ANTIBODY TESTING		
Anti-HCV +	2,967	100%
RNA TESTING AMONG THOSE ANTI-HCV+		
HCV RNA tested	2,750	93%
HCV RNA +	2,213	75%

+ means positive.

*Data beginning May 15, 2015 when the Maryland Community-based Programs to Test and Cure Hepatitis C began.

Source: Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services
Bureau Center for Viral Hepatitis Maryland Community-based Programs to Test and Cure HCV, 2019

TABLE 86. MARYLAND COMMUNITY-BASED PROGRAMS TO TEST AND CURE HEPATITIS C CLINICAL PARTNER HCV CARE CASCADE, 2017-2019

	YEAR	
	2015* TO 2019	
	COUNT	PERCENT
HCV CARE CASCADE		
Patients HCV RNA +	2,876	100%
Patients worked up for treatment, with liver staging and/or genotype results	2,055	71%
Patients with liver staging results	1,851	64%
Patients prescribed HCV treatment	1,124	39%
Patients who started HCV treatment	848	29%
Patients who completed HCV treatment	710	25%
Patients who achieved documented sustained virologic response (SVR) ¥	535	19%

Percent values may not add up to 100 due to rounding error.

+ means positive.

Note:

1. Liver staging is defined as patient received a METAVIR fibrosis staging score on the scale of F0 to F4.
2. Prescribed HCV treatment is defined as the treating HCV provider wrote a prescription for direct-acting antiviral (DAA) HCV medication for the patient.
3. Started HCV treatment is defined as having documented the patient has began oral DAA HCV treatment regimen.
4. Completed HCV treatment is defined as having documented the patient successfully completed their 8, 12, or 12week or more DAA HCV treatment regimen.
5. Achieved documented sustained virologic response or SVR is defined as having documented 12 weeks post treatment completion the patients had a non-detect HCV RNA lab test.

* Data beginning May 15, 2015 when the Maryland Community-based Programs to Test and Cure Hepatitis C began.

Source: Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services
Bureau Center for Viral Hepatitis Maryland Community-based Programs to Test and Cure HCV, 2019

TABLE 87. MARYLAND COMMUNITY-BASED PROGRAMS TO TEST AND CURE HEPATITIS C HIGHLIGHTED PATIENT CHARACTERISTICS, 2015-2019

	YEAR	
	2015* TO 2019	
	COUNT	PERCENT
OVERALL		
Patients	3,366	100%
CHARACTERISTICS		
Born between 1945-1965	1,124	33%
Male	2,483	74%
Black/African American	2,742	81%
Medicaid enrollee	2,342	70%
HIV co-infected	149	4%

Percent values may not add up to 100 due to rounding error.
+ means positive.

* Data beginning May 15, 2015 when the Maryland Community-based Programs to Test and Cure Hepatitis C began

Source: Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services
Bureau Center for Viral Hepatitis Maryland Community-based Programs to Test and Cure HCV, 2019

TABLE 88. MARYLAND COMMUNITY-BASED PROGRAMS TO TEST AND CURE HEPATITIS C CLINICAL COALITION PARTNERS, 2015-2019

	YEAR	
	2015* TO 2019	
	COUNT	PERCENT
OVERALL		
Patients	3,366	100%
CLINICAL SITES		
Health Care For the Homeless	934	28%
Baltimore City STI Health Clinics	1160	34%
Jai Medical Center ‡	852	25%
Total Health Care	253	8%
Chase Brexton Health Care - Mt. Vernon	173	5%
John Hopkins Community Physicians †	63	2%
University of Maryland, Family Medicine ¥	46	1%
CCI Health & Wellness ¶	18	1%
Park West Health System ¶	167	5%

Percent values may not add up to 100 due to rounding error.
+ means positive.
STI = sexually transmitted infections

* Data beginning May 15, 2015 when the Maryland Community-based Programs to Test and Cure Hepatitis C began.

† Coalition partner beginning year 1 only

‡ Coalition partner beginning year 2 after program initiation

¥ Coalition partner beginning year 3 after program initiation

¶ Coalition partner beginning year 4 after program initiation

Source: Maryland Department of Health Prevention and Health Promotion Administration Infectious Disease and Prevention Health Services
Bureau Center for Viral Hepatitis Maryland Community-based Programs to Test and Cure HCV, 2019

TABLE 89. NUMBER OF UNIQUE PATIENTS TESTED FOR HBV BY HEPATITIS B INITIATIVE OF WASHINGTON DC, 2015-2019

	PATIENTS TESTED FOR HBV				
	TOTAL TESTED	HBSAG POSITIVE		ON TREATMENT	
	N	N	PERCENT	N	PERCENT
OVERALL					
Total	4,375	155	100.0%	109	70.3%
COUNTY					
2015	565	15	9.7%	10	9.2%
2016	1,156	28	18.1%	19	17.4%
2017	1,063	50	32.3%	38	34.9%
2018	735	30	19.4%	22	20.2%
2019 *	856	32	20.6%	20	18.3%

*Data for 2019 reported through October only.
Percent values may not add up to 100 due to rounding error.

Source: Hepatitis B Initiative of Washington DC, 2019

TABLE 90. MARYLAND SITES WHERE HEPATITIS B INITIATIVE OF WASHINGTON DC CONDUCTED HBV TESTING, 2015-2019

	MARYLAND HBI-DC SITES	
	N	PERCENT
OVERALL		
Total	110	100.0%
COUNTY		
2015	12	10.9%
2016	24	21.8%
2017	23	20.9%
2018	23	20.9%
2019	29	26.4%
TYPE OF SITE - MARYLAND		
Faith-based location	70	63.6%
Health Care Setting	9	8.2%
Health Fair	31	28.2%
Local Health Department	0	0.0%

*Data for 2019 reported through October only.

Source: Hepatitis B Initiative of Washington DC, 2019

TABLE 91. DEMOGRAPHIC CHARACTERISTICS AMONG PATIENTS TESTED HBSAG POSITIVE FOR HBV BY HEPATITIS B INITIATIVE OF WASHINGTON DC, 2015-2019

	YEAR											
	2015		2016		2017		2018		2019 *		2019 *	
	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000	N	RATE PER 100,000
OVERALL												
Total	15	100%	28	100%	50	100%	30	100%	32	100%	155	100%
SEX AT BIRTH												
Male	8	53.3%	17	60.7%	25	50.0%	18	60.0%	18	56.3%	86	55.5%
Female	7	46.7%	11	39.3%	25	50.0%	12	40.0%	14	43.8%	69	44.5%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Missing	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
AGE GROUP (YEARS)												
0 to 19	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	3.1%	1	0.6%
20 to 39	2	13.3%	2	7.1%	13	26.0%	12	40.0%	3	9.4%	32	20.6%
40 to 59	6	40.0%	12	42.9%	21	42.0%	14	46.7%	17	53.1%	70	45.2%
60 to 79	6	40.0%	14	50.0%	14	28.0%	4	13.3%	10	31.3%	48	31.0%
80+	1	6.7%	0	0.0%	2	4.0%	0	0.0%	1	3.1%	4	2.6%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Missing	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
RACE												
Asian	12	80.0%	18	64.3%	29	58.0%	18	60.0%	6	18.8%	83	53.5%
African American/ Black	3	20.0%	10	35.7%	20	40.0%	12	40.0%	26	81.3%	71	45.8%
Hispanic	0	0.0%	0	0.0%	1	2.0%	0	0.0%	0	0.0%	1	0.6%
Native Hawaiian or Other Pacific Islander	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
NATIVITY												
Foreign-born	15	100.0%	28	100.0%	50	100.0%	30	100.0%	32	100.0%	155	100.0%
US-born	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Not Reported/ Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
INSURANCE STATUS												
Insured	8	53.3%	15	53.6%	14	28.0%	23	76.7%	9	28.1%	69	44.5%
Uninsured	7	46.7%	13	46.4%	36	72.0%	7	23.3%	23	71.9%	86	55.5%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Missing	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

*Data for 2019 reported through October only.
Percent values may not add up to 100 due to rounding error.

Source: Hepatitis B Initiative of Washington DC, 2019



