
Bree Collaborative | Hepatitis C Workgroup

May 5, 2022 | 8:00 – 9:30 a.m.

Virtual

MEMBERS PRESENT

Abha Puri, MPH, Community Health Plan of Washington

Angelica Bedrosian, MSW, Hepatitis Education Project

Emalie Huriaux, MPH, Washington State Department of Health

Gib Morrow, Kitsap County Public Health

John Scott, MD, MSc, University of Washington

Jon Stockton, MHA, Washington State Department of Health

Judith Tsui, MD, MPH, University of Washington Project

Kelsey Stedman, Kitsap County Public Health
Michael Ninburg, MPA, Hepatitis Education Project

Omar Daoud, PharmD, Community Health Plan of Washington

Patrick Judkins, Thurston County Health Department

Ryan Pistoresi, PharmD, MS, Washington State Health Care Authority

Wendy Wong, BSc, Providence Health and Services

Yumi Ando, MD, Kaiser Permanente

STAFF AND MEMBERS OF THE PUBLIC

Nick Locke, MPH, Bree Collaborative

Laura Pennington, Washington State Health Care Authority

Chelsie Porter, WA Department of Health

Penelope Sapp, Kitsap County Jail

WELCOME

Nick Locke, Bree Collaborative, welcomed everyone to the Bree Collaborative's Hepatitis C virus (HCV) workgroup. Those present introduced themselves.

Mr. Locke introduced the April minutes for approval.

Decision: April minutes were approved unanimously

REVIEW: HCV METRICS AND THE COMMON MEASURES SET

Mr. Locke briefly summarized the workgroup's previous conversations on HCV metrics then invited Laura Pennington, WA Health Care Authority, to present on the state's Performance Measures Coordinating Committee (PMCC) which determines new metrics to adopt for the state-wide common measures set. Ms. Pennington described:

- The history of the WA Common Measures Set (SCMS) since 2014
- The application of the SCMS – mostly voluntary, although the HCA uses the common measures to facilitate value-based purchasing.
- The PMCC is a group of stakeholders that sets the direction for the SCMS and ensures the process is transparent.
- If new metrics are proposed, the PMCC convenes ad hoc workgroups to determine if the measures can be incorporated.
- The main criteria for incorporation include alignment with national and existing measures, strength of evidence, and potential to improve quality.
- In 2020 the PMCC convened an ad hoc HCV workgroup and decided not to adopt any metrics because existing metrics were outdated and there was not strong nationally approved metrics.

- In the future, the PMCC is considering behavioral health measures that fit the state’s need beyond existing national measures. There may be the potential for HCV metrics to be built within the state following the same process.

Those present continued the discussion on metrics after Ms. Pennington left the call:

- Workgroup members expressed interest in continuing the conversation on metrics, even if this requires developing a “homegrown” metric for HCV. Currently no national organizations appear to be working on an HCV standard metric, including the CDC.
- The greatest gap for HCV care is starting on treatment after screening positive. Workgroup members discussed several ways to ensure a metric addresses the gaps in referral to treatment
 - A proposed metric could refer to the percentage of those with HCV who start on treatment or who complete treatment
 - One proposal was to include a metric on closed-loop referrals to treatment, although this would likely be difficult to standardize state-wide
 - Some workgroup members discussed the potential for an HCV screening questionnaire, similar to the PHQ-9.
- Workgroup members reached a consensus on a potential metric for starting HCV treatment that would draw on medication ordering. Workgroup members mentioned the current measures for anti-depressant medication management as a template. Data could be drawn from pharmacy orders to determine what % of HCV positive patients were started on drug therapy.

To Do: Mr. Locke will follow-up with Ms. Pennington about the potential to develop a homegrown metric and share resources with the workgroup before the June meeting.

HCV CARE COORDINATION

Mr. Locke presented on existing care coordination programs and strategies to address Hep C. Care coordination program examples in Washington state include the set of medical case management guidelines developed by the Hepatitis Education Project and a peer-support program from SWACH and SeaMar. Care coordination for HCV tends to follow either a healthcare professional navigation model or a peer-support model. Workgroup members discussed other examples of HCV care coordination as well as current barriers to implementation.

- Other potential examples of HCV coordination include the VA’s pharmacist-driven care management, the Chaz clinic in Spokane’s clinical coordinator model, and the Check Hep C program out of New York.
- While all workgroup members agree that these programs provide benefits to connect HCV patients to care, many barriers prevent successful implementation:
 - Financial/reimbursement issues remains the largest barrier to implementation. Workgroup members would like to see how HCV care coordination could be reimbursed in a manner similar to HIV care coordination through Medicaid.
 - Info-sharing/communication remains difficult, both between organizations (such as between a hospital and a county jail with HCV-positive incarcerated individuals) or within an organization (between the physician and the care coordinator).
 - Resources provided from navigation or peer-supports must be local. Workgroup members recommend face-to-face interactions over telehealth, and co-located HCV services wherever possible.

- Some lingering liability concerns may prevent public health or clinical organizations from providing wrap-around services such as transportation to treatment facilities.
- Technical barriers including electronic health records or IT concerns may prevent adoption.

To Do: Mr. Locke will review potential sustainable funding sources for care coordination programs, including Medicaid Title 19 or Medicaid 1115 transformation waivers for the group to discuss at the next meeting.

PUBLIC COMMENT AND GOOD OF THE ORDER

Mr. Locke reviewed the workgroups next steps: 1) the workgroup will continue to explore “homegrown” HCV metrics for the PMCC to consider, similar to current behavioral health metrics and 2) the workgroup will examine pathways to reimburse care coordination programs. Mr. Locke invited public comment, then thanked all for attending and adjourned the meeting. The workgroup’s next meeting will be on Thursday, June 2nd, 2022.

DRAFT