
Bree Collaborative | Hepatitis C Workgroup

July 7th, 2022 | 8:00 – 9:30 a.m.

Virtual

MEMBERS PRESENT

Angelica Bedrosian, Hepatitis Education Project

Aura Payne, Hepatitis Education Project

Emalie Hurliaux, MPH, Washington State
Department of Health

Jon Stockton, MHA, Washington State
Department of Health

Judith Tsui, MD, MPH, University of Washington

Omar Daoud, PharmD, Community Health Plan
of Washington

Patrick Judkins, Thurston County Health
Department

Ryan Pistorosi, 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

Chelsie Porter, WA Department of Health

Kimberly Tabor, Hepatitis Education Project

Reina Davis, Hepatitis Education Project

WELCOME

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

Mr. Locke introduced the June minutes for approval.

Decision: Minor edits were made to examples of pharmacist-led HCV programs (examples include Evergreen Treatment Services and Providence). Minutes were approved with edits.

REVIEW: CARE COORDINATION

Mr. Locke reviewed the workgroup's previous discussion on defining types of care coordination services. Between June and this month's meeting, Mr. Locke met with workgroup members who conduct care coordination programs to develop more recommendations.

Those present continued the discussion on care coordination and examined key barriers and recommendations:

- Additional barriers to care coordination suggested by workgroup members include: resources to provide phlebotomy, tech access/telehealth services, and providing targeted in-person care coordination (as opposed to phone services)
- Workgroup members suggested that MCOs provide care coordination services in-person as opposed to just telephone services. HCV patients are often complex cases requiring more in-person support. In addition to being a practical, cost-saving intervention, care coordination services can be seen as an equitable intervention to reduce disparities in HCV care.
- In addition to care coordination, workgroup members suggested peer navigator models to reach rural and underserved patients. Oregon has a model for peer navigators called Prime Plus that may inform our recommendations.
- Workgroup members stressed the importance of having care coordinators/peer navigators conduct outreach to HCV positive patients.

- Additional services that care coordinators can provide include testing/screening for HCV, navigating insurance, and providing patients technology and training for telehealth (if acceptable to the patient)
- The workgroup discussed how to encourage more in-person care coordination through plans. Perhaps the HCA can work to expand care coordination requirements in contracts with MCOs.
 - The HCA requested more information about care coordination – including targets and metrics – before incorporating into contracts.
 - The DOH referenced targets from the Hepatitis Education Project and the Ryan White Standards for HIV care coordination.
 - It would be useful for more care coordinators to rotate at OUD/syringe-service sites’

In addition to care coordination recommendations, workgroup members discussed how to address additional infectious disease that may be suitable for care coordination.

- Members proposed a high-level recommendation to “consider including other infectious disease (ex. Hep B, syphilis, TB) screening and treatment with Hepatitis C programs.

To Do: Mr. Locke will review resources recommended during the meeting, including the OR Prime Plus program and Ryan White Standards.

REVIEW: PHARACIST RECOMMENDATIONS

Mr. Locke reviewed the workgroup’s previous discussion on integrating pharmacists into the care team. Between June and this month’s meeting, Mr. Locke met with workgroup members who have developed collaborative drug treatment agreements to treat HCV. The workgroup discussed new recommendations for pharmacists treating HCV.

- In addition to CDTA and Medicaid 340B reimbursement, pharmacists may need to be reimbursed for their cognitive work with patients. Existing reimbursement models focus on reimbursing the medication only
 - One option is to reimburse pharmacists similar to Medication Therapy Management (or Complete Medication Review) – which is an existing model to reimburse pharmacist’s time for a 45-minute consult with patients.
- Workgroup members also discussed administering tests at retail pharmacies. Reimbursement for HCV tests at a pharmacy is possible but may not be enough to cover the pharmacist’s time to administer the tests.
 - The FDA recently approved retail pharmacies to provide COVID-19 antivirals – we may be able to learn from this process to develop reimbursement rates for HCV screening and medication via retail pharmacies.
- Overall workgroup members agreed it was important to connect pharmacists to HCV treatment, as pharmacies are often more accessible in the community and easier for patients to travel to.

To Do: Mr. Locke will review the recommendations and add reimbursement recommendations related to CMR or examples from COVID-19 pharmacy reimbursements.

DISCUSSION: RAISING AWARENESS AMONG PROVIDERS

Mr. Locke introduced a new conversation on raising awareness and increasing provider engagement with HCV work. Case managers and providers/pharmacists currently working with HCV often describe the difficulty of connecting patients to a low-barrier, non-stigmatizing provider, and many providers

refuse to take HCV patients who are currently using drugs. Emalie Huriaux, MPH, described the DOH's ongoing work with the HepC Free WA. Community engagement/education programs are currently on hold because there are not enough providers to treat HCV yet. Provider outreach must come first

- One idea from the DOH was to develop a provider outreach campaign between the HCA DOH, MCOs, and LPHJs which would include educational events to describe the epidemiology of HCV and current treatment guidance, as well as the state's interest in eliminating HCV. This campaign would include local provider champions demonstrating efficacy in their practice.
- Workgroup members discussed other barriers that prevent provider engagement:
 - Many providers are worried about failure – having patients with HCV who are using drugs not complete treatment. It is important to acknowledge this fear and assure providers that it is possible to re-treat patients who do not complete their medication schedule the first time, or to try alternative medications.
 - Other providers mention that they are not comfortable with the HCV medication or treatment process. It may be useful to have peer-support for providers who can act as informal consults. This peer-provider model has been successful for buprenorphine and in the SeaMar CHC. (This may exist nationally, but we could work to increase awareness in Washington)
 - More providers (and healthcare leadership) need to understand that this is an emergency, and we have the opportunity to eliminate this viral disease. Perhaps better public health messaging or educational programs can increase urgency.

To Do: Mr. Locke will review the examples from existing programs brought up in the discussion and draft some potential next steps for the workgroup to review at the next meeting.

PUBLIC COMMENT AND GOOD OF THE ORDER

Mr. Locke invited public comments and adjourned the meeting. The workgroup's next meeting will look the current recommendations in a consolidated recommendations and examine potential next steps that the workgroup can take to have the largest impact in the state. The next meeting will be held on Thursday, August 4th from 8:00 – 9:30 AM.