The Centers for Medicare and Medicaid Services: SUPPORT Act Section 1003 Grant

Hepatitis C Webinar

SEPTEMBER 8, 2020

Department of Medical Assistance Services
Welcome and Meeting Information

• All Webex participants are muted for this event.

• If you have any questions, please use the Q&A feature.

• If you are having technical issues, please type questions or comments in the chat box.

• The webinar recording and a copy of today’s slides will be posted on the DMAS ARTS webpage
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter(s)</th>
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</thead>
<tbody>
<tr>
<td>3:30 – 3:35</td>
<td>Webinar Welcome</td>
<td>Christine Bethune, MSW, SUPPORT Act Grant Coordinator, Department of Medical Assistance Services</td>
</tr>
<tr>
<td>3:35 – 3:45</td>
<td>Virginia Medicaid Policy Updates, Prior Authorization, and Current Treatment Rates</td>
<td>Chethan Bachireddy, MD, MSc, Chief Medical Officer, Department of Medical Assistance Services</td>
</tr>
<tr>
<td>3:45-3:55</td>
<td>Virginia Hepatitis C Rates</td>
<td>Kaitlyn Hauter, MPH, Viral Hepatitis Program Coordinator and Nicole Barron, MS, Viral Hepatitis Testing Coordinator, Virginia Department of Health</td>
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<tr>
<td>3:55-4:15</td>
<td>Hepatitis C Treatment Guidelines</td>
<td>Rebecca Dillingham, MD, MPH, University of Virginia School of Medicine</td>
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<tr>
<td>4:15-4:35</td>
<td>Interrupted HCV Treatment Courses: Cases and Lessons Learned from the National Clinician Consultation Center</td>
<td>Cristina Gruta, PharmD, Senior Consultant, UCSF National Clinician Consultation Center</td>
</tr>
<tr>
<td>4:35-4:45</td>
<td>Clinician resources: the National Clinician Consultation Center and more!</td>
<td>Carolyn Chu, MD, MSc, Clinical Director, UCSF National Clinician Consultation Center</td>
</tr>
<tr>
<td>4:45-4:50</td>
<td>Hepatitis C Project ECHO Information</td>
<td>Terry Knick BSN-BC, MPH, University of Virginia School of Medicine</td>
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<tr>
<td>4:50-5:00</td>
<td>Q&amp;A</td>
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MEDICAID, HEPATITIS C, AND OPIOID USE DISORDER: A CALL TO ACTION

Chethan Bachireddy, MD, MSc
Chief Medical Officer
Virginia Department of Medical Assistance Services
Medicaid Expansion is Here!

• The rules have changed. Up to 400,000 more low-income Virginia adults are eligible for low- and no-cost health coverage

• People working in retail, construction, childcare, landscaping, food service or other jobs that do not offer health insurance may be eligible

456,969

Applications for new adult coverage are now being accepted!
Who Qualifies After Medicaid Expansion?

- **Children 0-18** (family of 3)
  - 205% FPL ($42,599)

- **Pregnant Women** (family of 3)
  - 205% FPL ($42,599)

- **Person With Disability**
  - 80% FPL ($9,712) 138% FPL ($16,750)

- **Parents** (Family of 3)
  - 33% FPL ($6,924) 138% FPL ($28,700)

- **Childless Adults**
  - 138% FPL ($16,750)

*Percent income may vary by locality*
New Adult Coverage Uses Current Health Plans

Coverage will be provided for most individuals through the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) managed care programs.

Aetna Better Health of Virginia

Optima Health

Anthem Healthkeepers Plus Offered by Healthkeepers, Inc.

United Healthcare Community Plan

Magellan Complete Care

Virginia Premier

Medicaid’s six current health plans will serve the new adult members.
How to Apply for Medicaid Coverage

Call the Cover Virginia Call Center at 1-855-242-8282 (TDD: 1-888-221-1590)

Complete an online application at Common Help:
www.commonhelp.virginia.gov

Complete an online application at The Health Insurance Marketplace:
www.healthcare.gov

Mail or drop off a paper application to your local Department of Social Services (mailing may take longer than other methods of applying.)
Find your nearest local Department of Social Services by visiting:
http://www.dss.virginia.gov/localagency/index.cgi

Call the Virginia Department of Social Services Enterprise Call Center at 1-855-635-4370 (if you also want to apply for other benefits)

Applications for new adult coverage are now being accepted!
The Syndemic

- OUD
- HCV
- HIV
- Incarceration
Virginia’s Hepatitis C Epidemic

Acute and Chronic Hepatitis C Cases 2013-2017 (VEDSS)
Virginia’s Opioid Epidemic

Total Number of Fatal Drug Overdoses 2013-2020*
Inpatient Detox
Residential Treatment
Partial Hospitalization
Intensive Outpatient Programs
Opioid Treatment Program
Office-Based Opioid Treatment
Residential Treatment
ARTS
Effective April 1, 2017
ARTS creates a fully integrated physical and behavioral health continuum of care
## Number of SUD-Related ED Visits per 100 Medicaid Members with SUD\(^1\)

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS Apr 2016 - Mar 2017</th>
<th>ARTS Year 1 Apr 2017 - Mar 2018</th>
<th>ARTS Year 2 Apr 2018 - Mar 2019</th>
<th>Percentage change since before ARTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>All SUD-related ED visits per 100 members with SUD</td>
<td>56</td>
<td>54</td>
<td>52</td>
<td>-7.1%</td>
</tr>
<tr>
<td>OUD related ED visits per 100 members with OUD</td>
<td>31</td>
<td>24</td>
<td>21</td>
<td>-32.3%</td>
</tr>
<tr>
<td>AUD related ED visits per 100 members with AUD</td>
<td>75</td>
<td>70</td>
<td>73</td>
<td>-2.7%</td>
</tr>
</tbody>
</table>

\(^1\)Members enrolled through Medicaid expansion are excluded to maintain comparability with prior years.
Hepatitis C Medicaid Policy

Recent updates in the past 2 years

• No sobriety restrictions
• No liver damage restrictions
• Generalists and specialists can prescribe
• Mavyret (glecaprevir/pibrentasvir) and Epclusa (sofosbuvir/velpatasvir) available with abridged prior authorization form
• Encourage (but not required) screening and referral for substance use disorder
• Preferred OBOTs now asked to implement universal screening and referral for HCV
Policy Flexibilities for SUD Delivery during COVID-19

• **Telehealth (including telephonic) delivery** of all substance use disorder services.
  - “Home” as an originating site
  - Payment parity
  - Buprenorphine induction

• **14 day grace period** for submission of Service Authorizations

• **Flexibility around hourly requirements** for ASAM Levels 2.1 and 2.5

• Medicaid **eligibility and enrollment** flexibilities
State of Emergency ARTS Policy Changes

Policy Flexibilities for SUD Delivery during COVID-19

• **Allowance for Opioid Treatment Programs to be reimbursed** for delivery of medications to member’s location as well as take-home dosage administration.

• Allowance for up to **90 day prescription for routine medications, including buprenorphine products**.

• **Flexibilities of urine drug tests and counseling requirements** for individuals to receive pharmacotherapy for SUD treatment.
How Can We Be Part of the Solution?

1) Identify: Screen and refer for HCV, HIV, and SUD

2) Get the X: Go through the online or in-person 8 hour training to prescribe Buprenorphine

3) Treat: Pilot MAT and HCV treatment in your facility and sign up to be a Preferred OBOT for enhanced rates
THANK YOU!

Chethan Bachireddy
chethan.bachireddy@dmas.virginia.gov
Virginia Hepatitis C Rates

September 8, 2020

Kaitlyn Hauter, MPH
# The Hepatitis Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Email</th>
<th>Phone</th>
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</thead>
<tbody>
<tr>
<td><strong>Nicole Barron, MS</strong></td>
<td><a href="mailto:Nicole.Barron@vdh.Virginia.gov">Nicole.Barron@vdh.Virginia.gov</a></td>
<td>(804) 864-7350</td>
</tr>
<tr>
<td>Viral Hepatitis Testing Coordinator</td>
<td></td>
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<tr>
<td><strong>Rachel Stallings, MPH</strong></td>
<td><a href="mailto:Rachel.Stallings@vdh.Virginia.gov">Rachel.Stallings@vdh.Virginia.gov</a></td>
<td>(804) 864-7992</td>
</tr>
<tr>
<td>Viral Hepatitis Epidemiologist</td>
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<tr>
<td><strong>Kaity Hauter, MPH</strong></td>
<td><a href="mailto:Kaitlyn.Hauter@vdh.Virginia.gov">Kaitlyn.Hauter@vdh.Virginia.gov</a></td>
<td>(804) 864-7593</td>
</tr>
<tr>
<td>Viral Hepatitis Program Coordinator</td>
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</tbody>
</table>
Time Progression of HCV Rates by County per 100,000 persons (including incarcerated individuals)
Acute and Chronic Hepatitis C Reports by Year

VEDSS data as of 8/25/20

Chronic HCV

Acute HCV

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment
Hepatitis C Reports by Age and Sex

VEDSS data as of 3/5/20
Declining incidence of acute hepatitis B in Virginia mirrors national trends
Increasing acute hepatitis C trends since 2009
A case definition change may account for some of the increase in hepatitis C from 2015 to 2016, but a true increase is also a likely contributing factor.
Conventional (clinic-based) Hepatitis C Testing

**NUMBER OF HCV TESTS (2018)**
- HCV Ab +: 618 (9%)
- RNA Confirmed: 435 (70%)
- Total: 6770

**NUMBER OF HCV TESTS (2019)**
- HCV Ab +: 671 (7%)
- RNA Confirmed: 447 (67%)
- Total: 9089

Source: DDP Hepatitis Testing Database, as of 8/24/20
Patient Demographics for Conventional HCV Testing, 2019

Source: DDP Hepatitis Testing Database, as of 8/24/20
Common Reported Risk for Persons with Positive Conventional Test, 2019

- All three (IDU, Incarceration, Birth Cohort)
- IDU Only
- IDU and Birth Cohort
- Birth Cohort Only
- Birth Cohort and Incarceration
- Incarceration Only
- IDU and Incarceration
- Other or No Reported Risk

Source: DDP Hepatitis Testing Database, as of 8/24/20
Rapid (non-clinical) Hepatitis C Testing

Source: DDP Hepatitis Testing Database, as of 8/24/20

Number of HCV Rapid Tests (2018)
- Total Rapid Ab Tests: 3442
- HCV Ab +: 442 (13%)

Number of HCV Rapid Tests (2019)
- Total Rapid Ab Tests: 4683
- HCV Ab +: 358 (8%)

Source: DDP Hepatitis Testing Database, as of 8/24/20
Patient Demographics for Rapid HCV Testing, 2019

Source: DDP, Hepatitis Testing Database, 8/24/2020
Common Reported Risk for Persons with Positive Rapid Test, 2019

- All three (IDU, Incarceration, Birth Cohort)
- IDU Only
- IDU and Birth Cohort
- Birth Cohort Only
- Birth Cohort and Incarceration
- Incarceration Only
- IDU and Incarceration
- Other or No Reported Risk

Source: DDP, Hepatitis Testing Database, 8/24/2020
Walgreens HCV Testing, 2019

Reported Risk Factors
- All three (IDU, Incarceration, Birth Cohort)
- IDU Only
- IDU and Birth Cohort
- Birth Cohort Only
- Birth Cohort and Incarceration
- Incarceration Only
- IDU and Incarceration
- Other or No Reported Risk

Gender
- Female: 47%
- Male: 53%

Birth Cohort
- Born 1945-1965 (Baby Boomer): 44%
- Not Born 1945-1965 (Not Baby Boomer): 56%

Source: DDP, Hepatitis Testing Database, 8/24/2020
Hepatitis C Treatment Pilot Care Cascade

- **Referrals**: 275
- **Fibroscans**: 262
- **Appointments Attended**: 245
- **Patients with Rx Completed**: 230
- **Completed Medication**: 108

- **100%**
- **95%**
- **89%**
- **84%**
- **73%**
Hepatitis C Treatment Guidelines: The why and how of integrating them into your practice.

Rebecca Dillingham, MD/MPH
Associate Professor of Medicine
University of Virginia Division of Infectious Disease and International Health
Dr. Dillingham has received an investigator-initiated grant from Gilead. She also serves as a consultant to Warm Health Technologies, Inc, an mHealth company.
25 Years Since Discovery—A Timeline of Major Milestones

- **1989**: Discovery of hepatitis C virus
- **1991**: First hepatitis C treatment approved
- **1992**: US blood supply safe from hepatitis C virus
- **1996**: Hepatitis C infections continue to dramatically decline
- **1998**: CDC first recommends hepatitis C testing
- **2007**: Deaths from hepatitis C surpass HIV in US
- **2010**: Institute of Medicine report issued
- **2012**: First National Testing Day; CDC recommends testing all people born 1945-1965 for hepatitis C
- **2013**: USPSTF recommends hepatitis C testing for persons at high risk for infection and 1-time screening for everyone born 1945-1965
- **2014**: Realizing the potential of an all-oral cure
- **2011**: Increase in acute hepatitis C cases

**Elimination of Hepatitis C**
Hepatitis C Treatment 2010-2020

Interferon-Based Regimens

- 50% CURE

Direct Acting Antivirals

- 95% CURE
Welcome to HCVGuidelines.org
The AASLD and IDSA in partnership with the panel have created an updated web experience to facilitate easier and faster access to this important resource. Please select a patient profile from the menu above, click on a guidance section below, or use the search box to begin.
## Recommendations for One-Time Hepatitis C Testing

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-time, routine, opt out HCV testing is recommended for all individuals aged 18 years or older.</td>
<td>I, B</td>
</tr>
<tr>
<td>One-time HCV testing should be performed for all persons less than 18 years old with activities, exposures, or conditions or circumstances associated with an increased risk of HCV infection (see below).</td>
<td>I, B</td>
</tr>
<tr>
<td>Prenatal HCV testing as part of routine prenatal care is recommended with each pregnancy.</td>
<td>I, B</td>
</tr>
<tr>
<td>Periodic repeat HCV testing should be offered to all persons with activities, exposures, or conditions or circumstances associated with an increased risk of HCV exposure (see below).</td>
<td>IIa, C</td>
</tr>
<tr>
<td>Annual HCV testing is recommended for all persons who inject drugs, for HIV-infected men who have unprotected sex with men, and men who have sex with men taking pre-exposure prophylaxis (PrEP).</td>
<td>IIa, C</td>
</tr>
<tr>
<td>RECOMMENDED</td>
<td>RATING</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Persons with current HCV infection should receive education and interventions aimed at reducing liver disease progression and preventing HCV transmission.</td>
<td>IIa, B</td>
</tr>
<tr>
<td>Abstinence from alcohol and, when appropriate, interventions to facilitate cessation of alcohol consumption should be advised for all persons with HCV infection.</td>
<td>IIa, B</td>
</tr>
<tr>
<td>Evaluation for other conditions that may accelerate liver fibrosis, including hepatitis B and HIV infections, is recommended for all persons with active HCV infection.</td>
<td>IIb, B</td>
</tr>
<tr>
<td>Evaluation for advanced fibrosis using noninvasive tests (serum panels, elastography) or liver biopsy, if required, is recommended for all persons with HCV infection to facilitate an appropriate decision regarding HCV treatment strategy, and to determine the need for initiating additional measures for cirrhosis management (eg, hepatocellular carcinoma screening) (see Monitoring section).</td>
<td>I, A</td>
</tr>
<tr>
<td>Vaccination against hepatitis A and hepatitis B is recommended for all susceptible persons with HCV infection.</td>
<td>IIa, C</td>
</tr>
<tr>
<td>Vaccination against pneumococcal infection is recommended for all patients with cirrhosis.</td>
<td>IIa, C</td>
</tr>
<tr>
<td>All persons with HCV infection should be provided education about how to prevent HCV transmission to others.</td>
<td>I, C</td>
</tr>
</tbody>
</table>
Cascade of Care

SVR = Sustained Virologic Response = “Cure”

Yehia 2014, PLoS One
FIGURE 1 | Hepatitis C cascade of care. VL, viral load; SVR, sustained virologic response.
<table>
<thead>
<tr>
<th>Reason</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple no-shows despite scheduled appointments</td>
<td>53</td>
<td>26.5%</td>
</tr>
<tr>
<td>Unable to contact to schedule an appointment</td>
<td>41</td>
<td>20.5%</td>
</tr>
<tr>
<td>No reason documented</td>
<td>24</td>
<td>12.0%</td>
</tr>
<tr>
<td>Incarcerated</td>
<td>20</td>
<td>10.0%</td>
</tr>
<tr>
<td>Patient Preference</td>
<td>19</td>
<td>9.5%</td>
</tr>
<tr>
<td>Referred/Treated Elsewhere</td>
<td>16</td>
<td>8.0%</td>
</tr>
<tr>
<td>Moved Out of Area</td>
<td>10</td>
<td>5.0%</td>
</tr>
<tr>
<td>Deceased</td>
<td>5</td>
<td>2.5%</td>
</tr>
<tr>
<td>Pregnant</td>
<td>4</td>
<td>2.0%</td>
</tr>
<tr>
<td>Spontaneous Viral Clearance</td>
<td>4</td>
<td>2.0%</td>
</tr>
<tr>
<td>Othera</td>
<td>4</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Data obtained from clinic database maintained by nurse coordinator.

a “Other” includes lack of transportation (1), work conflict with clinic schedule (1), initial visit scheduled and upcoming (1), deferred due to upcoming surgery (1).
<table>
<thead>
<tr>
<th>Major Themes</th>
<th>Proposed Interventions to Improve Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural Barriers: Financial, Scheduling, Transportation, Health-system level</td>
<td><strong>Expand Medicaid</strong>; Utilize pharmaceutical company drug assistance programs; Educate patients on available resources and supportive care; Aim for clinic responsiveness, ease of scheduling, and confidentiality</td>
</tr>
<tr>
<td>Stigma</td>
<td>Provide education on harm reduction strategies; <strong>Co-locate treatment for substance use disorder and HCV</strong>; Educate clinic staff on creating a welcoming atmosphere</td>
</tr>
<tr>
<td>Ambivalence</td>
<td>Acknowledge and address the uncertainty related to having HCV; Focus patient education campaigns on ambivalence and the potential for treatment to relieve patients of the burden of uncertainty</td>
</tr>
<tr>
<td>Prior Experiences of HCV Disease and Treatment</td>
<td>Explore patients’ or others’ prior experiences with HCV treatment; Address favorable changes in treatment since earlier therapies</td>
</tr>
<tr>
<td>Patient-Provider Relationship</td>
<td><strong>Encourage expansion of HCV treatment to where patients are already receiving care and have established relationships</strong></td>
</tr>
</tbody>
</table>

TELEMEDICINE CONNECTION PROGRAM

UVA ID Specialist  
Will see your patients in your clinic via telehealth  
Specialty Pharmacy will assist in obtaining patient meds

HEPC TRAINING PROGRAM

Each quarter HEPC holds a training day where LIPs learn to treat HCV independently  
Prior to the training day HEPC will assist in getting your clinic ready to implement a hepatitis C treatment program  
After training, your clinic will have access to UVA ID consultation and staff to assist with the process and to obtain medication
• Moving to on-line separated into several sessions
• CE credits available
• No cost to participants
• Follow-up ECHO program monthly
• *Brings the guidelines to life and provides practical steps for integrating them into your practice*
Me being in this program (HCV) and getting into treatment gave me my confidence back. I went from being depressed to feeling like I was getting my life back. I’m very grateful for the program and don’t know where I would be without it. Thank you.
Interrupted HCV Treatment Courses: Cases and Lessons From the National Clinician Consultation Center (NCCC) HEPlines

Cristina Gruta, PharmD
Senior Consultant/Clinical Pharmacist
National Clinician Consultation Center
Objectives

• Explain the role the HCV Warmline (HEPline) can play in providing clinical support to HCV providers
• Discuss the different types of HCV treatment lapse scenarios
• Describe factors that lead to interruptions in HCV treatment
• Discuss pre-emptive or real-time interventions that HCV treaters can make to avoid or minimize treatment interruptions
What does the NCCC do?

Call Volume (by service-line), 1992-2018
“Anatomy” of a HEPline Consultation

Pharmacy review: potential drug interactions between HCV medications, prescribed, and non-prescribed therapies

Which DAA regimen should I select for a previously-treated 63yo with GT1a? He also has diabetes and acid reflux.

Explore whether there is a “question behind the question”: does this patient have cirrhosis? How can I make that assessment?

Help determine whether additional input from hepatologist or other specialist could be beneficial

Share updated treatment guidelines and other clinical/educational resources
Wide range of case topics

My patient’s HCV antibody test just came back positive and she is 5 months pregnant. What should I do?

I’m not sure if my patient has cirrhosis: what regimen should I select and how many weeks of treatment do I give?

My patient has HBV serologies of someone with recovered infection (HBsAb+, HBcAb+). How should I follow them once we start DAA treatment?

Can the HCV Warmline team serve as the “consulting specialist” since my state’s insurance program requires review by a specialist?
HEPline: Case “A”

- Caller is NP in Northern California FQHC→ not the pt’s PCP but is the HCV “treater” in the clinic
- Pt is 28 yo male with GT 1a infection, tx-naïve; VL 94,230; FIB-4→ 0.92
- Pt still actively using IV drugs
- Decision was to tx pt with GLE/PIB x 8 weeks starting Feb 2019
- Caller saw pt in urgent care in mid-March 2019 (for non-HCV related reasons) and at that visit reported missed doses of G/P
- Pt reportedly went to rehab sometime in late March/early April– missed G/P doses x 1 week
Case “A” – Treatment interruption timeline

14 day supply rec’d
Feb 22

Resumed tx
Feb 22

14 day supply rec’d
FEB 22-MAR 7

Missed doses
20 days late
MAR 22 – APR 11

Missed doses
1 week late
Feb 15-22

14 day supply rec’d
MAR 8 - 22

Now what?

FEB 1

10 WEEKS

APR 11

QUESTION  What is best approach?
What our consultation data showed

- Reviewed HEPl ine calls 11/1/18 through 4/30/20
- Identified calls that pertained to interrupted or lapsed HCV treatment
- Excluded calls if not patient-specific, i.e. posing general question
- Excluded calls involving pregnant patients
- Collected both caller and patient demographics
- Identified situational themes for the context of interruptions
Number of cases reviewed

Cases by state N = 395

Cases with lapsed treatment N=47
Caller demographics

### Caller Profession

- Physician Assistant: [Bar Graph]
- Pharmacist: [Bar Graph]
- Nurse Practitioner: [Bar Graph]
- MD - other: [Bar Graph]
- MD - Internal Medicine: [Bar Graph]
- MD - Infectious Diseases: [Bar Graph]
- MD-Fam Medicine: [Bar Graph]

### Years HCV Experience

- **Range:** <1 to 25
- **Average:** 3.25
- **Median:** 1.50

### Patient Load/Month

- 48%
- 26%
- 13%
- 8%
- 5%

### Caller Facility Type

- Community Clinic/IHS: 68%
- Hospital-based practice: 11%
- Dept of Public Health: 2%
- Pharmacy (Retail): 2%
- Private Practice: 15%

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<table>
<thead>
<tr>
<th>Years HCV Experience</th>
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<tbody>
<tr>
<td>range</td>
<td>&lt;1 to 25</td>
</tr>
<tr>
<td>average</td>
<td>3.25</td>
</tr>
<tr>
<td>median</td>
<td>1.50</td>
</tr>
</tbody>
</table>
Patient demographics

<table>
<thead>
<tr>
<th>Patient Gender</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>15</td>
</tr>
<tr>
<td>Male</td>
<td>31</td>
</tr>
<tr>
<td>DNA/NA</td>
<td>1</td>
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</table>

<table>
<thead>
<tr>
<th>Patient Age</th>
<th>Years</th>
</tr>
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<tbody>
<tr>
<td>Range</td>
<td>23-70</td>
</tr>
<tr>
<td>Average</td>
<td>47.068</td>
</tr>
<tr>
<td>Median</td>
<td>48</td>
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</tbody>
</table>

Patient Race

- Alaskan Native/American Indian: 2%
- Asian: 10%
- Black/African American: 12%
- White: 50%
- Bi-racial: 19%
- Other: 2%
- Unknown: 2%
Patient HCV characteristics

<table>
<thead>
<tr>
<th>Tx Naïve or Experienced</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced</td>
<td>3</td>
</tr>
<tr>
<td>Naïve</td>
<td>42</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
</tr>
</tbody>
</table>

For “indet/NA” category, genotyping not covered by HCV treatment funds
HCV treatment course selection

For >28 days lapsed, range >4 weeks to 2 years

*For >28 days lapsed, range >4 weeks to 2 years
WHAT LEVEL OF ADHERENCE TO DAA TREATMENT IS NEEDED TO ACHIEVE SVR12?
ANCHOR: pilot study of HCV treatment at drop-in harm reduction organization in Washington, DC

• Single-center study
  – 76% men, 93% black, 33% cirrhotic, 58% injected drugs at least daily, 33% receiving medication-assisted therapy for drug use

Patients with chronic HCV infection, opioid use disorder, and opioid injection in last 3 mos; no decompensated cirrhosis or contraindicated DDIs (N = 100)

• Primary endpoint: SVR12

ANCHOR: HCV treatment at harm reduction organization

- 93 patients in ITT analysis
  - Lost to follow-up: n = 8
  - Deceased: n = 3
  - Virologic failure: n = 9
  - SVR12: n = 73 (78%)
- Per protocol SVR12: 89% (73/82)
- Virologic success unaffected by baseline demographics such as drug use frequency, housing stability, medication-assisted therapy

<table>
<thead>
<tr>
<th>Adherence Measure in ITT Population</th>
<th>SVR12, %</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wk 4 HCV RNA &lt; 200 IU/mL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 80)</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>No (n = 8)</td>
<td>25</td>
<td>.0005</td>
</tr>
<tr>
<td>No treatment interruptions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 76)</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>No (n = 12)</td>
<td>67</td>
<td>.22</td>
</tr>
<tr>
<td>Completed 2 or 3 of 3 SOF/VEL bottles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 87)</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>No (n = 6)</td>
<td>0</td>
<td>.0001</td>
</tr>
<tr>
<td>Finished SOF/VEL on time (vs late)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 20)</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>No (n = 43)</td>
<td>88</td>
<td>.65</td>
</tr>
</tbody>
</table>
ANCHOR study—additional observations

• 59 pts completed 12 weeks of treatment but not all on time

<table>
<thead>
<tr>
<th>Number (%) of pts completing 12 week course</th>
<th># days completed beyond expected completion date</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 (48%)</td>
<td>1-7</td>
</tr>
<tr>
<td>9 (16%)</td>
<td>8-14</td>
</tr>
<tr>
<td>9 (16%)</td>
<td>&gt;14</td>
</tr>
</tbody>
</table>

• Of 58 pts who reached week 24 follow-up, 52 (90%) attained SVR
What are the limits of imperfect adherence?

• Studies are small
• Show encouraging success if SOF/VEL regimen completed 1-2 weeks beyond intended end-of-treatment
• Do other DAA options offer similar forgiveness?
• But what about those who miss more than 1-2 weeks of treatment?
HCV treatment lapse - multiple types of scenarios

My patient didn’t know to call the pharmacy to refill his SOF/VEL and it’s been 10 days. Is it okay to continue?

A new patient to us says they took a month of SOF/LDV a year ago but stopped. Now they are ready to be treated. Should we start over or give rescue therapy?

Our patient received her first month of HCV treatment, started using meth again and was LTFU. Now she is back after a 3 week lapse. Do we stop?
WHAT CIRCUMSTANCES LEAD TO TREATMENT GAPS?
Reported reasons for lapses (HEPline cases)

<table>
<thead>
<tr>
<th>OVERALL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>10</td>
</tr>
<tr>
<td>Lost to follow-Up</td>
<td>2</td>
</tr>
<tr>
<td>Substance involvement/relapse</td>
<td>9</td>
</tr>
<tr>
<td>Unstable housing/homelessness</td>
<td>2</td>
</tr>
<tr>
<td>Pharmacy Issues (delivery)</td>
<td>5</td>
</tr>
<tr>
<td>Patient confusion- med access</td>
<td>5</td>
</tr>
<tr>
<td>Incarceration</td>
<td>3</td>
</tr>
<tr>
<td>Insurance lapse/issues</td>
<td>2</td>
</tr>
<tr>
<td>Patient could not get to clinic</td>
<td>3</td>
</tr>
<tr>
<td>Patient acutely sick/hospitalized</td>
<td>6</td>
</tr>
<tr>
<td>Adverse effect (suspected)</td>
<td>3</td>
</tr>
<tr>
<td>Clinic miscommunication</td>
<td>1</td>
</tr>
<tr>
<td>Immigration from other country</td>
<td>1</td>
</tr>
<tr>
<td>Patient adherence issues/forgets</td>
<td>2</td>
</tr>
</tbody>
</table>

Most common identified reasons:

1) Substance involvement/relapse
2) Medication access issues
   • Pick-up confusion
   • Lost deliveries
   • Insurance lapses/issues
3) Acute illness or exacerbated chronic illness
TREATING HCV IN PRIMARY CARE SETTING: MODELS OF CARE
HCV in primary care settings

FQHC in Philadelphia with high burden of underserved population with high rates of mental illness and/or substance involvement

HCV treatment team lead by physician assistants and NPs (supervised by 2 PCPs) but no onsite GI/hepatologist

Rest of team included
- Behavioral health consultants (BHCs)
- HCV treatment coordinator
- 340B pharmacy which processes prior authorizations, assess for drug interactions, provides medication refills

CONCLUSION:
“With the proper support and integrated BHCs, treating HCV in a primary care setting with high rates of substance abuse and mental health illness is possible and effective.”
Pharmacist role in HCV treatment

- IHS facilities treated pts with HCV using pharmacists as point of contact
- Utilized collaborative practice agreement and HCV telehealth to external specialists
- Pharmacists provide comprehensive HCV care under MD supervision
- Analysis of collaborative practice looked at charts for proportion of pts with HCV Ab status, confirmatory testing, liver staging, treatment and SVR rate.
- Biggest gap was step between staging and initiation of treatment
- Concluded feasibility of treating HCV in rural settings

“These data indicate that rural clinics using collaborative practice agreements with pharmacists can be instrumental in HCV services at the primary care level and have strong outcomes in HCV treatment/SVR12.”
Check Hep C → NYC DOHMH patient navigation program

Program based in either FQHCs (where care was “onsite”) or harm reduction/needle exchanges (pts linked to “offsite providers”)

Patient navigators provided risk assessment, health education, treatment readiness and medication adherence counseling, and medication coordination

CONCLUSION- Check Hep C successfully supported high-need participants through HCV care and treatment, and SVR rates demonstrate the real-world ability of achieving high cure rates using patient navigation care models.
LESSONS LEARNED - HOW DO WE PREVENT HCV TREATMENT GAPS?
Preventing HCV treatment lapses/gaps-
Patient factors

• Motivation/readiness
  – Educate about health benefits and prevention of forward transmission
  – No need to be abstinent to be treated

• If ready, do they have ready access to
  – Insurance coverage and if not special programs
  – Medical visits, including specialist access if HCV treatment not done in primary care
  – Labs/pharmacy

• Are there co-occurring issues/social determinants that may potentially affect adherence?
  – Housing/place to store meds safely
  – Transportation
  – Substance involvement – where are they with this?

• Patient understanding of medication regimen before and during treatment
  – Dosing/administration/side effects/consequences of suboptimal adherence
  – When/how to pick up meds or setting up delivery at appropriate timeframe
  – How to communicate with clinic staff
Preventing HCV treatment lapses/gaps - Medical system factors

• Structure of HCV treatment team (other than the provider)
  – Who coordinates care? Is there HCV panel management?
  – Does community have HCV patient navigation program?
  – What is the system for reminding patients of visits, labs, pharmacy pickups?
  – Who takes care of prior authorizations or insurance issues?

• Addressing patient’s substance involvement and mental health needs
  – Are social services and mental/behavioral health support available?
  – Is MAT co-located in clinic or coordinated with another clinic?
  – Is HIV PrEP offered for those with ongoing risk?

• Optimize communications with the patient, the pharmacy, within the clinic
  – What is follow-up protocol (phone calls, in-person visit, labs)?
  – What is best mode of communication with pt– text, phone, email, EMR portal
Preventing HCV treatment lapses/gaps-
Pharmacy factors

• How comfortable is patient/clinic with chosen pharmacy?
• Does the pharmacy have reliable patient reminder systems?
• Does pharmacy contact prescriber for missed prescription pick-ups?
• What is role of specialty pharmacies if available?
  – May be able to do prior authorizations
  – Should have specialized pharmacists/staff with HCV training
  – 340B pricing?
• Dispensing of 14-day vs 28-day supplies of HCV regimen
  – Is it better?
  – Payor/PBM determines this
• If mail order is mandated by health plan
  – How will plan coordinate delivery with patient?
  – If pt homeless, is there option to mail to clinic or local pharmacy
SUMMARY

- Treatment lapses/gaps appear to be common (>1/10 cases) among HEPline calls received.
- Best approaches to HCV treatment interruptions are not addressed in current HCV treatment guidance.
- ANCHOR and other studies suggest perfect adherence not needed to achieve SVR12, but need to identify outer bounds of missed doses.
- Reasons for treatment lapses varied but most commonly involved substance involvement/relapse and medication access/supply issues.
- Gaps in care coordination evident among patient, provider(s), pharmacy, case management, etc.
- To minimize treatment gaps, consider optimizing:
  - Treatment of substance involvement, e.g. co-location of SUD treatment or use telemedicine for co-management.
  - Care coordination (panel management, treatment navigators, case management) in primary care settings.
  - Linkage to dispensing pharmacy for prescription coordination.
Case A – Treatment interruption timeline

14 day supply rec’d
FEB 1 - 14

14 day supply rec’d
Feb 22

Missed doses
Feb 15 - 22
1 week late

Resumed tx
FEB 22

14 day supply rec’d
FEB 22 - MAR 7

Missed doses
MAR 8 - 22
20 days late

Now what?
MAR 22 – APR 11

10 WEEKS
FEB 1 – APR 11

QUESTION ➔ What is best approach?
HEPline Case “A”- Advice

• Discussed with our team’s hepatologist, ID physician, a senior PharmD (very experienced in HCV care)

• Acknowledged to caller than there is no clear evidenced-based answer for “next steps” → recall pt took about 6 weeks worth of GLE/PIB over a 10-11 week timespan

• Advised to check VL now, consider doing resistance testing and gave option to 1) complete last 2 weeks of GLE/PIB or 2) wait to see if pt cleared and if not can offer rescue therapy with SOF/VEL/VOX

OUTCOME → pt achieved SVR12!
Thank you!
To learn more, please visit www.nccc.ucsf.edu

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1OHA30039-03-01 (AIDS Education and Training Centers National Clinician Consultation Center) in partnership with the HRSA Bureau of Primary Health Care (BPHC) awarded to the University of California, San Francisco.
Clinician resources: the National Clinician Consultation Center… …and more!

September 8, 2020

Carolyn Chu, MD, MSc, FAAFP | Clinical Director

University of California – San Francisco
Provider support/capacity-building is a cornerstone for improving treatment access and health outcomes.
GOAL 1  PREVENT NEW VIRAL HEPATITIS INFECTIONS

GOAL 2  REDUCE DEATHS AND IMPROVE THE HEALTH OF PEOPLE LIVING WITH VIRAL HEPATITIS

GOAL 3  REDUCE VIRAL HEPATITIS HEALTH DISPARITIES

GOAL 4  COORDINATE, MONITOR, AND REPORT ON IMPLEMENTATION OF VIRAL HEPATITIS ACTIVITIES

Challenges in Addressing Viral Hepatitis

The Action Plan also seeks to address a number of challenges that must be confronted as we work to improve our national response including:

- Limited data
- Low provider awareness and low public awareness and perceived risk
- Limited public health and health system response

- The perceived high costs of treatment and the large numbers of people chronically infected
- Stigma and discrimination
- Opioid epidemic
Our guiding principle: “low-threshold” support

Same-day treatment entry

Harm-reduction approach

Flexibility

Wide availability

Same-day support, individualized discussions (often case-based)

Practical strategies, respect for caller

“Options, not answers” (agility to assist providers with differing resources and experiences, and from diverse practice contexts)

Readily-accessible, multi-professional subject matter expertise

“So thankful for this resource! Timely, helpful, and clear guidance from experienced experts – so easy to access and great response time!”

“This service is amazing and so very helpful. I have used it several times and always come away feeling informed and ready to provide the best care to my patients.”

“I view this group as a lifeline when I have questions – it’s a fabulous resource for busy providers!”

“The person I spoke to was so nice, supportive, and well-informed. I was nervous that my question was kind of a dumb one or something I should have known, but she didn’t make me feel like that at all. It was a great experience.”

“The consultant I spoke with saved my day. The care and concern I received was astounding, the consultant went above and beyond to help me and my patient.”
So— who operates the national HCV, Substance Use, and HIV Warmlines?
Founded in 1990s at San Francisco General Hospital; Department of Family & Community Medicine, University of California San Francisco

- One of the first **free, nationally accessible** provider-facing resources to address HIV-specific questions at the point of care
- **Any clinician is welcome to call** (all experience levels/backgrounds/-settings)
Founded in 1990s at San Francisco General Hospital; Department of Family & Community Medicine, University of California San Francisco

- One of the first **free, nationally accessible** provider-facing resources to address HIV-specific questions at the point of care
- **Any clinician is welcome to call** (all experience levels/backgrounds/settings)

**Clinical depth** across multiple domains: 500+ years of collective experience

- HIV
- Viral hepatitis
- Substance use
- Primary care
- Behavioral health

**Experience with** safety net health centers, Ryan White-funded programs, local health departments, correctional settings, tribal communities/providers
Multi-disciplinary, multi-professional consultants

Principal consultants include highly experienced primary care & specialty-boarded physicians, specialty clinical pharmacists, advanced practice nurses
How can providers access our HCV tele-consultation services?

Dial (844) HEP-INFO

Hours of operation: 9am-8pm EST | Mon-Fri

We ask callers for basic demographic and practice information for internal record-keeping purposes (all calls are confidential; no PHI obtained)

-- OR --

Submit cases/inquiries online: nccc.ucsf.edu
### Callers don’t need to:

- Sign-up in advance
- Clear their clinic schedules
- Memorize a patient’s medical chart/history
- Limit inquiries to complex scenarios or patient-specific questions *(general questions are welcome!)*
- Download any apps or utilize special technology/IT equipment

### What to expect:

- Professional, compassionate consultants
- Evidence-informed, practical guidance
- Individualized support to help develop tailored treatment plans
- We are happy to receive f/u calls
- If helpful, consultants may send f/u information by email: resources, articles
Things we cannot do

- **Provide direct assistance with patient referrals** (except perinatal HIV) → *happy to share provider locator resources*

- **Offer medico-legal counsel** → *may be able to share information on best practices, other references*

- **Speak with/advise patients** → NCCC does not offer direct “consultant to patient” services (our consultants do not evaluate, diagnose, or treat callers’ patients // no access to patient records)

- **Limited availability for formal individual/group trainings** → *happy to share information on local educational opportunities/resources*
Common consultation topics: HCV

- **Initial treatment, retreatment, reinfection** (therapy options, timing/duration)
- **Liver disease staging** (non-invasive approaches, discordant testing results)
- **Medication interaction** assessment, management
- **Missed doses** (how to avoid, how to manage) and **laboratory monitoring** before/during/after HCV treatment
- **HBV, HIV coinfection, perinatal HCV** (delivery considerations, breastfeeding)
- **Navigating treatment approval** process
NCCC data: quick snapshots

69yo with longstanding HIV, DM2, obesity now s/p gastric bypass
Should I change ART due to malabsorption issues?

55yo with severe CVD, no cirrhosis, prior peg-RBV
Is this patient ok to re-treat in a primary care setting?
Interactions between DAAAs and cardiac meds?

45yo with OUD previously on ER naltrexone, relapsed and incarcerated again:
Now what?

62yo with HBV-HCV co-infection:
What do I treat first?
How do I monitor?

Can your HCV Warmline consultants assist as specialists for our treatment requests?

32yo PWID w/ newly diagnosed acute HIV and 26 weeks pregnant: How can I start ART?
Calls* from Virginia and surrounding states

*FY17-20 | Includes non-occupational (sexual exposure, IDU) PEPline calls; excludes occupational PEP calls
Calls (excluding all PEP) from Virginia and surrounding states, by consultation line

**Late 2014:** PrEPline

**Winter 2015:** Substance Use Warmline

**Fall 2017:** Hepatitis C Warmline
Additional clinical resources
This lesson will focus on the fundamentals of treating HCV infection. Understanding the treatment of HCV mono-infection is critical to mastering care of HIV/HCV co-infection.

Core Competency 4: HCV Treatment

Lesson 1: Fundamentals of Hepatitis C Virus Treatment

July 2017
Updated: December 2018, January 2020
HEP Drug Interactions (Univ of Liverpool)

HEP Drug Interactions

About Us  Interaction Checkers  Prescribing Resources  Videos  Site News  Contact Us  Support Us


Having trouble viewing the interactions? Click here for the Interaction Checker Lite.

<table>
<thead>
<tr>
<th>HEP Drugs</th>
<th>Co-medications</th>
<th>Drug Interactions</th>
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<td>Check HEP/HEP drug interactions</td>
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<tr>
<td>A-Z</td>
<td>Indication</td>
<td>Trade</td>
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<tr>
<td>Adefovir</td>
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<tr>
<td>Daclatasvir</td>
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<td></td>
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<tr>
<td>Elbasvir/Grazoprevir</td>
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<tr>
<td>Entecavir</td>
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<td></td>
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<tr>
<td>Gilecaprevir/Pibrentasvir</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lamivudine (HBV)</td>
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## HIV-HCV treatment interactions (Toronto)

### Hepatitis C Agents

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<th>INSTIs</th>
<th>NNRTIs</th>
<th>PI</th>
<th>RTI</th>
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</thead>
<tbody>
<tr>
<td>BICTEGRAVIR (Biktarvy)</td>
<td>ELVITEGRAVIR/COBI/CISTAT (Strivil, Gerovaya)</td>
<td>EFAVIREN (Sustiva, Atripla)</td>
<td>ATAZANAVIR (Reyataz/Norvir, Everolux)</td>
</tr>
<tr>
<td>DOLUTEGRAVIR (Tivicay, Triumeq, Juluca)</td>
<td>DORAVIRINE (Pifeltro, Deltovir)</td>
<td>ETRAVIRINE (Intelence)</td>
<td>DARUNAVIR (Prezista/Norvir, Prezvi, Symtuza)</td>
</tr>
<tr>
<td>RALTEGRAVIR (Isentress)</td>
<td>RILPIVIRINE (Edurant, Complera, Odefsey, Juluca)</td>
<td>NEVIRAPINE (Viramune)</td>
<td>LOPINAVIR (Kaletra)</td>
</tr>
</tbody>
</table>

### Direct Acting Antivirals (DAAs)

- **Glecaprevir + pibrentasvir (Moviret):**
  - Potential for ↓ glecaprevir, pibrentasvir
  - Potential for ↑ glecaprevir, pibrentasvir

- **Ledipasvir + sofosbuvir (Harvoni):**
  - Potential for ↑ tenofovir

- **Velpatasvir + sofosbuvir (Epclusa):**
  - Potential for ↓ velpatasvir
  - Potential for ↑ tenofovir

- **Velpatasvir + voxilaprevir + sofosbuvir (Vosevi):**
  - Potential for ↓ velpatasvir, voxilaprevir
  - Darunavir
  - Atazanavir, lopinavir: potential for ↑ voxilaprevir
  - Potential for ↑ tenofovir

- **Elbasvir + grazoprevir (Zepatier):**
  - Potential for ↓ elbasvir, grazoprevir
  - Potential for ↓ elbasvir, grazoprevir
  - Potential for ↑ elbasvir, grazoprevir

Project ECHO at UVA

Project ECHO® (Extension for Community Healthcare Outcomes) helps democratize medical knowledge and develops specialty care capacity in underserved communities. At UVA, Project ECHO programs use Zoom® videoconferencing technology to connect our specialists to primary care providers around Virginia.

About the Trainings

Our ECHO programs recruit a cohort of participants for regular remote mentoring sessions, usually weekly or biweekly. Each session is comprised of a brief didactic presentation by the specialist expert, followed by the presentation and discussion of de-identified sample cases. The specialist experts act as mentors, training community providers to provide care in clinical areas previously outside their expertise.

Learn more: Watch the ECHO video.

CME Credits

Most sessions offer continuing medical education (CME) credits, maintenance of certification (MOC) credits, and continuing nursing education (CNE) credits.
Thank you!
For more information: nccc.ucsf.edu

Carolyn.Chu@ucsf.edu (Carolyn Chu, Clinical Director/PI)
HEPC Project ECHO

MANAGING HEPATITIS C IN PRIMARY CARE

TERRY KEMP-KNICK, BSN-BC, MPH UVA
Virginia Hepatitis C Education & Patient Connection (HEPC)

We started as a collaboration between VDH and UVA to help provide treatment access to people with hepatitis C infection in rural areas of SWVA via telemedicine.

We began training providers and support staff to continue to increase capacity to treat HCV.

We are now working with the Department of Corrections with a Referral on Release program. To help those that were unable to be treated while incarcerated to find treatment for HCV close to home upon release.

You can see all of our programs at www.virginiahepc.com
Virginia Project ECHO Extension for Community Health Outcomes
Empowering clinics to offer access to HCV treatment locally

COVID has made other plans for us: As the ability to meet in larger groups is not certain in these times, we will hold our next training session via ECHO webinar - we will meet for one hour weekly for 6 weeks.

Next training dates will be in October - TBD

There is a sheet to sign up if you are interested on our website under Programs: HEPC Training.
Clinic teams learn general information together, then separate for information to maximize their understanding of the role they have in ensuring successful implementation of HCV treatment in their clinic setting.
Monthly ECHO Call 3rd Wednesday of each month 4:00-5:00 pm

Registration for ECHO is only required once, you will then have access to all content and to future sessions

Registration Link: https://connect.VirginiaProjectECHO.org/Series/Registration/210

We ask that our independently treating providers send us any interesting cases they have encountered prior to the date of the call. We review these with the group to expand everyone’s understanding and abilities.

We also present new education during this time to increase the depth of knowledge on treating hepatitis C.

Next Training Will be via ECHO – Tentative Dates

<table>
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<th>Time</th>
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<td>Tuesday October 13</td>
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<td>Wednesday October 21</td>
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<tr>
<td>Tuesday October 27</td>
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<td>Tuesday November 3</td>
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<tr>
<td>Tuesday November 17</td>
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<tr>
<td>Wednesday November 18</td>
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</tbody>
</table>

Monthly ECHO Call
QUESTIONS??

Contact information:
Terry Kemp Knick, BSN-BC, MPH
tmk2s@hscmail.mcc.Virginia.edu
434-305-5561
www.virginiahepc.com
QUESTIONS?
Hepatitis C Provider List

DMAS has developed a survey to identify Medicaid providers interested in being included on a publicly available list for Medicaid members seeking Hepatitis C treatment. Our goal is to address the increasing Hepatitis C crisis by facilitating referrals to Hepatitis C treatment for members.

• Provider's name, email, and phone number will be included on the list.
• At the close of today's event, you will be directed to the survey. Press 'continue' in Webex when prompted so that you can be directed to the external RedCap survey.
• The survey will also be emailed if you are unable to complete it today.
• Participation and inclusion on the Hepatitis C provider list is voluntary.
• Please complete the survey by **September 15, 2020**

**Survey link:** [https://www.survey.dmas.virginia.gov/surveys/?s=PEFRN8R3Y8](https://www.survey.dmas.virginia.gov/surveys/?s=PEFRN8R3Y8)

If you have any questions or concerns about the survey, please contact Jason Lowe, SUPPORT Act Grant Manager, at [SUPPORTGrant@dmas.virginia.gov](mailto:SUPPORTGrant@dmas.virginia.gov)