Hepatitis Free Northern New England (Hep Free NNE)
Minutes – March 30, 2023
2023 Steering Committee Meeting #6

March 30th Meeting Roles
Bronwyn – facilitator & proj. mgr.
Chloe – monitor chat
Kelly – taskmaster & hands-raised

Minutes recorded by: Bronwyn Barnett

Official start time: 11:01am

Housekeeping

- Reviewed meeting roles
- No objections or revisions to the March 16th minutes
- Notification that Colleen Flanigan (Hep Free NYC) will be our guest speaker for May 11
- **Priority activity:** Stakeholder membership spreadsheet – keep adding to it!
    - As you're thinking about the planning group – also think about people who we might want to do Key Informant Interviews with and people from community groups who might represent people with lived experience who cannot make the Planning Group meetings.
- Thank you for completing the evaluation of last week's meeting
- Review of Ground Rules: focus on "Always Assuming Positive Intent"

Updates

a. **Associations/Conference (Geoff)**: Focus in building our own slide decks based on local data from the situational analysis that JSI is completing right now. JSI has surveillance data from Maine and NH – working on Vermont's data to draft an epi profile. Will need to go through a vetting & quality control process for each of the three states. Need a clear set of goals about what we want people to take away from the presentations – even if we tweak each slide deck for the different audiences.

   Possible goals for each presentation could include: 1) Background VH data from each state (JSI situational analysis/epi profile); 2) Introduction to HepFreeNNE process and goals; and 3) Call to action/how to get involved depending on the audience and where in the timeline we are when presenting. Keep the presentations to 15 minutes. Andy has lots of slides that could be added – depending on the audience. Possibly also looking to Medical Affairs at Abbvie/Gilead – more national & disease state versus the state statistics.
    i. Action item: Geoff will set up a meeting w/ Laurie, Roxann, and Andy to review slide decks.

b. **Logo update (Jonathan):** Two options were presented. The group voted for option 2 – with "Get Tested - Get Treated - Get Cured" around the top of the logo and "free from hepatitis" around the bottom. Color scheme – three colors may cost too much w/ printing. Will have a black and white version and a two-color version. Stick to darker colors for the text for accessibility.

c. **Discovery Committees (Bronwyn):** Thanks for all the thoughtful responses to the DC survey. Medicaid was ranked highest based on need & potential impact; Engaging Disproportionately Affected People as Planning Co-Authors and HCV Care in Correctional Settings tied for second; Perinatal HCV identification

and care coordination was ranked last. Micro-elimination efforts around finding patients and linking them to care – working on finding areas of greatest community need (addiction & sexual health clinic) was an additional topic identified.

i. **Next steps:** Initiate DCs for Medicaid, Engaging Affected Populations, and Corrections
    1. *Continue discussing the additional topics – what progress can be made outside a DC?*
    2. **Identify a SC lead for each committee**. This is someone who has the interest and bandwidth to engage external stakeholders around this topic. Probably would require additional check-in meetings as needed with SC co-chairs. Email me if you think you can take this on. [Action Item]**Note that we can have multiple SC members on each committee—but I want to know the point-person.*
    3. Once we have DC leads identified, we'll get together as a small group to talk next steps

Discussion: Health Care System Assessment (~30 minutes)
Given the opportunity to interview a representative of a large health care system provider of Hepatitis C testing, what question(s) would you ask? JSI is developing an interview protocol.

- What surveillance is in place for QA?
- Can a provider completely bypass the EMR prompts to do the testing? Is the EMR updated to screen & link?
- Level of system buy-in to the vision of eliminating hepatitis. How much buy-in do we need? It's more of a community effort and less of a large health system issue. It's not a priority to health systems right now bc they are struggling with other things.
- Chief Medical Officers, Population Health – have other focuses.
- **Focus on nontraditional health care settings** – gas stations, etc. Correctional system. Probation and parole, transitional housing, sober houses. Spectrum of the justice system.
    - **From the Medicaid perspective** – nontraditional settings are difficult to pay. Are traditional health systems interested in partnering with nontraditional settings – use the reimbursement system for the larger systems to feed the nontraditional ones.
    - If we do explore the testing and care, what would it take for the organizations to use insurance payments including Medicaid? Is it using a partnering with a health care organizations, co-locating services = creative solutions to extend services into the community but rely on traditional billing infrastructure and payer contracts with more traditional settings. So not reinventing it on the payer side or CBO side.
- How can we leverage pharmacies? Can pharmacies test? Having every option available to every type of person. If I'm getting my prescription there anyway, having a DBS kit there. Just another place. In terms of focusing it on the health system, it would be good to understand what the pharmacist are doing in those health systems to provide care related to hepatitis. BC there are two different tracts of pharmacy – retail (vax), and clinical pharmacists working in health system and ambulatory clinics – in ME FQHC, it's a pharmacists-driven protocol: they run the process of HCV treatment to management. Each state has its own protocol.
- What about the large national pharmacies – CVS Minute Clinic, Walgreens? Seems like it would be easy for them to offer testing and treatment onsite. Retail/commercial pharmacies bc they are everywhere –the incentive for them is being able to dispense medication if able to diagnose and work up a patient. Lots of the Minute Clinics are staffed by Nurse Practitioners so it might be even easier in terms of having someone who is already licensed to diagnose and prescribe. No Minute Clinics in VT. NNE has more urgent care centers (Convenient MD – which has been a partner w/ NH DPHS on COVID + MPOX). National carriers require lots of contract work.
- Labs: How do you help people get to the lab? If we can do away with PA, then medically we can make treatment decisions based on DBS so we don't need people to go to the lab. But Medicaid in all three states still require data that can only obtained by a venous blood draw.
- Abbvie/Gilead – home kits that can be shipped off for results. But don't get the things you need for a fibrous panel which you need for current PAs (might also want them if they are older). DBS cannot get the things you need for a fibrous assessment bc of the platelets. Not worth the effort to figure that out – *better to get rid of the fibrous assessment requirement.* There are other ways to decide who needs fibrous assessment and who

doesn't. No matter what there will be a number of people who need to get to the lab even if we get rid of the PA.

- Have not yet identified with any specificity on who we are talking to for key informant interviews – need to ID these people, who it would be helpful to interview.
- Who are the nontraditional providers we should be talking to? Snowball approach, with the same version on an interview protocol.
- In terms of the timeline, would like interviews completed in the next couple months.

Wrap up

Reviewed action items

- **Geoff** will reach out to Laurie, Roxann, and Andy to review industry slide deck templates.
- **Everyone** – email Bronwyn if you are interested in leading a discovery committee, or if you are interested in participating in one.
- **Everyone** – please take a look at the stakeholder worksheet that Jonathan developed. Cast a wide net, paying extra attention to key sectors that are not yet represented.

Any Other Business (Parking Lot)

Next meeting: April 13, 2023 @ 11am via ZOOM.

Slides prepared by Bronwyn Barnett, NH VHPC

Please add your name/pronoun/affiliation to the chat. Thank you!

Hep Free NNE

2023 Steering Committee Meeting #6

March 30, 2023

Start time: 11:01am

Mission: To guide and oversee a viral hepatitis elimination strategic planning process that engages a diverse group of partners across Northern New England (Maine, New Hampshire, and Vermont), with a focus on prioritizing and amplifying the voices of individuals disproportionately affected by viral hepatitis and the organizations that serve them.

Vision: A clear framework for how Northern New England will be a place where new hepatitis B and C infections are prevented, every person knows their status, and every person with viral hepatitis has high-quality health care and treatment free from stigma and discrimination. (Adapted from the National Strategic Plan.)

Core Values:

- **Partnerships.** We recognize that no singular entity can eliminate viral hepatitis on its own and that the success of the plan will depend on our ability to engage traditional and non-traditional partners focused on addressing an array of factors driving health outcomes.
- **Harm reduction.** We believe in the key principles of harm reduction (National Harm Reduction Coalition) and are committed to developing strategies that celebrate the rights of people who use drugs.
- **Intersectionality.** We understand that any plan to eliminate viral hepatitis must address the many ways that power collides and intersects to create systems of discrimination, disadvantage, and barriers to health.
- **Many voices.** We know that the efficacy of any viral hepatitis elimination plan is contingent on the diversity of voices contributing to its development, and we celebrate our role as stewards for engaging and amplifying those voices.
- **Syndemic approach.** We acknowledge the overlapping epidemics of HIV, STIs, VH, and injection drug use and promote a harmonized, integrated, whole-person response to transform siloed strategies into systems of care.

Housekeeping

Please add your name/pronoun/affiliation to the chat.

- Meeting roles
- Any objections or revisions to the March 16th minutes?
- Colleen Flanigan (Hep Free NYC) - Guest speaker for May 11
- Priority Activity: Stakeholder membership spreadsheet – keep adding to it! We'll circle back to this in April.
- Thank you for completing the evaluation of last week's meeting
- Steering Committee Membership – still expanding & onboarding new members based on a predetermined matrix
- Ground rules reminder

Sector	Represented?
Academia	Yes, but not enough
Public health and internal state programs	Yes
Corrections	Yes
Criminal justice, law enforcement	No
Medicaid	Yes
Injury Prevention Services	No
Substance use and mental health services	Yes, but not enough
HIV care providers	Yes, but not enough
Hospitals	Yes, but not enough
Laboratories	No
Industry and research	Yes
Community-based organizations	No
Harm reduction organizations and members	Yes, but not enough
People with Lived Experience (with drug use and/or viral hepatitis)	No
People Who are Unhoused or Experiencing Homelessness	No
People Who are Incarcerated or Recently Incarcerated	No
Federally Qualified Health Centers	No
Cancer Care	No, working on it
Health equity	

Ground Rules

1. Always assume positive intent.
2. Ground yourself in the mission and core values of this committee before every meeting.
3. “Speak up and step back.”
4. Close decisions and identify action items.
5. Try to avoid getting stuck in the weeds. Focus on the strategic part of the discussion.
6. Off topic comments will be added to the “Any Other Business” section of the agenda to be addressed at the end of the meeting (*time permitting*), electronically after, or added to a future meeting.
7. Review the agenda and prior meeting minutes, especially if you were absent from a previous meeting.
8. Avoid sharing protected/private health information.
9. Ask to pause the recording or for a closed meeting if you need to discuss sensitive information.
10. Do not assume that all meeting members are equally knowledgeable about a topic. Provide context.

"What do you mean by that?“

“Help me understand…”

"Can you tell me more about that?"

"I think what you mean is _____, am I on the right track?"

"I'm not following. Can you clarify what you meant by _____?"

"The landscape around _____changed. We have a better understanding of XXX. Let's try shifting perspectives and seeing where the conversation goes."

Be open to the fact that your information may be incomplete....

And that there may be a better way to get across what you're trying to communicate

Accept in yourself and in others that you're not always going to "package" what you want to say in the best way.

No perfection paralysis! Perfection kills conversation.

And what we think is the correct language/approach today, is going to evolve tomorrow as we learn more. **Be open to shifting.**

The important thing is authentic, meaningful conversations.

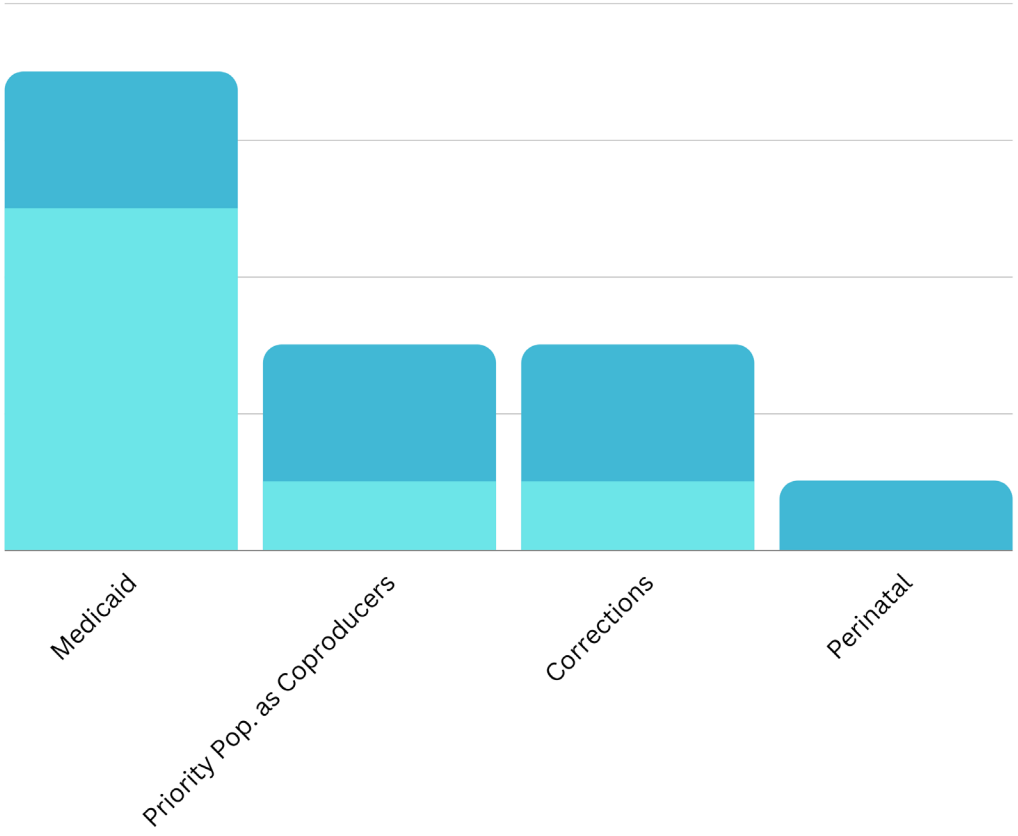
Positive intent, honest dialogue, personal and peer accountability, self-reflection

Updates

a. **Associations/Conferences**
    a. Lead: Geoff
b. **Logo update**
    a. Lead: Jonathan/JSI
c. **Discovery Committees**
    a. Lead: Bronwyn
d. **Compensating people with lived experience for their time during SC meeting*s***
    a. Lead: David/Chloe

11:35

Discovery Committee Survey Results



Medicaid was ranked highest based on need & potential impact

Engaging Disproportionately Affected People as Planning Co-Authors and HCV Care in Correctional Settings tied for second

Perinatal HCV identification and care coordination was ranked last

Additional Topics Identified

Micro-Elimination Efforts - Finding the patients and linking them to care.

Target: Addiction Health and Sexual Health Clinics, aligning access to those at greatest risk. Young men and women less than 45 years of age. As we know, the younger demographic isn't actively engaged into care; rather, they seek care when medically necessary: ex. Emergency Rooms.

Notes: *Keeping in mind the collective state infrastructure, a micro verses marco elimination approach might be helpful.* Work on finding areas of greatest community need, i.e., Addiction and Sexual Health Clinics. Are there opportunities for partnership. The goal is testing and linkage to care. In Northern New England, patients and providers have choice and access to HCV treatment. The goal is to expediate time to cure and find and treat patients where they are.

Additional Topics Identified

Tools to improve outcome (eg. point of care testing, linkage agreements, reimbursement) that will either incentives to care or program management of enhanced services for care

DC – next steps

Initiate DCs for Medicaid, Engaging Affected Populations, and Corrections

Continue discussing the additional topics – what progress can be made outside a DC?

Identify a SC lead for each committee. This is someone who has the interest and bandwidth to engage external stakeholders around this topic. Probably would require additional check-in meetings as needed with SC co-chairs. Email me if you think you can take this on. [Action Item]

**Note that we can have multiple SC members on each committee—but I want to know the point-person.*

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Health Care System Assessment

Given the opportunity to interview a representative of a large health care system provider of Hepatitis C testing, what question(s) would you ask?

11:55

Wrap up

A. Review action items (Taskmaster) 

B. Evaluation Reminder

C. *Time Permitting:* Any Other Business (Parking Lot)

12:00

Next meeting: April 13, 2023