Hepatitis Free Northern New England

Discovery Committees

Discovery Committees are HFNNE subcommittees designed to engage key stakeholders in problem-solving roundtables around complex and high-priority issues relating to viral hepatitis elimination in Northern New England.

Overview: Discovery Committees

Origin: Based on a model developed by the NH Viral Hepatitis Program, rooted in the pretrial process of "Discovery."

Need: To explore assumptions, facts, and evidence around differing views across on high priority issues relating to viral hepatitis.

Responding to this question: Do we risk focusing too narrowly on some "solutions" without considering others – and fracturing relationships before they are even built, if we are overly prescriptive about what *we assume* needs to be done and how *we think* it should be approached?

Focus: Building relationships across all impacted stakeholders.

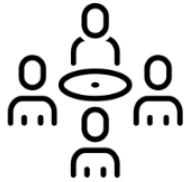
Discovery Committees

PURPOSE

Hep Free NNE Discovery Committees (DCs) are established to explore complex, politically fraught, or sensitive issues that have the potential for maximum impact for freeing Northern New England from viral hepatitis.

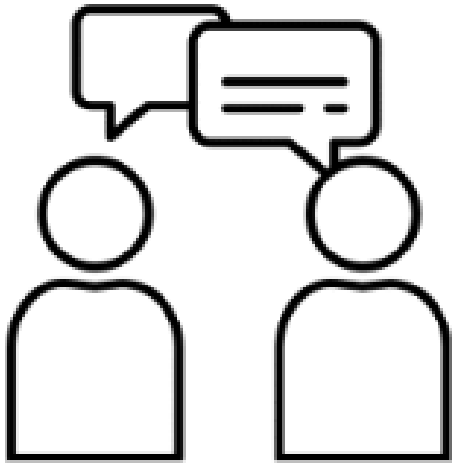
GOALS

- To approach a complex hepatitis-related topic ***curiously***, intending to discover new information, investigate assumptions, and expose complexities.
- To strengthen relationships with stakeholders around the issue area.
- To document, organize, and present the findings to broader decision-making bodies.



CURRENT COMMITTEES

(1) Medicaid Partnerships; (2) Perinatal HCV Care and; (3) HCV Care in Correctional Settings and Reentry



So far, approximately **34** stakeholders have been engaged in **24** Discovery Committee Listening Sessions and counting.

Medicaid Partnerships

Purpose Statement

The Medicaid Partnerships in VH elimination Discovery Committee will bring together stakeholders from Medicaid programs, Managed Care Organizations and key Medicaid partners such as Pharmacy Benefit Administrators, enrolled providers and someone with lived experience, or an advocacy group to:

- Identify Medicaid specific challenges to VH elimination efforts
- Explore feasibility for some popular Medicaid based solutions (subscription models, removal of PAs)
- Establish relationships and ways for stakeholders to become engaged in future Hep Free NNE planning and workgroups.

Hepatitis C Care in Correctional Settings

Purpose Statement

The HCV Care in Correctional Settings Discovery Committee will bring together stakeholders from the field of correctional healthcare to discuss the strategies, strengths, and challenges in addressing hepatitis C prevention and treatment in correctional settings and while transitioning out.

Specifically, we will outline the current state of prevention and treatment services in the tristate area. Using this information, we will identify actionable, future state goals for strengthening and standardizing systems of care and for implementing treatment and prevention activities that will ultimately lead to the elimination of HCV in incarcerated populations in Maine, New Hampshire and Vermont.

Perinatal Hepatitis C

Purpose Statement

The Perinatal Hepatitis C Discovery Committee will seek identify the gaps and barriers to:

- Hepatitis C screening of all pregnant persons being done per the American College of Obstetrics and Gynecology (ACOG) guidelines, including improving provider education;
- Age-appropriate screening for exposed or potentially exposed infants and identify best practices for increasing screening in this population;
- Identifying infants born to HCV+ mothers and;
- Linking perinatally exposed infants who test positive HCV RNA positive at 18-36 months to hepatitis C care and treatment.

THANK YOU!

Andrew Seaman
Anne-Marie Toderico
Benjamin Carbone
Brian Castonguay
Bronwyn Barnett
Bryan Slaney
Chloe Manchester
Courtney Pladsen
Jay Gupta
Kristen Chopas
Laurie Williams
Melissa Caminiti
Ryan Landry
Roxann Stubbs
Stefan Beck

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Medicaid Discovery Committee for the HepFree NNE Initiative

September 14, 2023

Kristen Chopas
Jay Gupta, RPh, C-IAYT
Andrew Seaman, MD
Roxann Stubbs, NP
Anne-Marie Toderico, PharmD

MEDICAID & THE MEDICAID DISCOVERY COMMITTEE

- As a safety net agency, Medicaid is a complicated space:
  - Care needs for a broad patient population
  - Federal compliance requirements
  - State specific policies
  - Fiscal constraints

*The **Medicaid Discovery Committee** will bring together stakeholders from Medicaid programs, Managed Care Organizations and key Medicaid partners such as Pharmacy Benefit Administrators, enrolled providers and people with lived experience, or an advocacy group to:*

1. Identify **Medicaid-specific challenges** to VH elimination efforts
2. Explore feasibility for some **popular Medicaid-based solutions** (subscription models, removal of prior authorizations [PAs])
3. Establish relationships and ways for stakeholders to become engaged in future **Hep Free NNE** planning and workgroups.

METHODOLOGY

From all three states over the course of three weeks…

- **14 Listening Sessions**
- **24 Participants**

➢ **PARTICIPANTS:**

- Providers
- Pharmacists
- Medicaid Fee For Service and Managed Care agencies
- Patient advocates

PATIENT EXPERIENCES

➢ People at Risk:

- HCV Testing/Treatment Prioritization
- Cost of Treatment
- Provider Stigma
- Prior Authorization Lab Criteria
- Patient Follow Up
- Specialty Pharmacy Requirement

PROVIDER EXPERIENCES

Provider HCV experience varies widely

- Not enough providers
  Especially able, willing, available for *complicated cases*
- Medicaid PA requirements overwhelming
- Provider resistance/refusal to treat
- Overcoming provider training barriers: ECHO programs, telehealth, flexible care models
- Managing medications within clinic
- Mobile testing and treatment for rural areas utilizing grant funding
- Pharmacist-led treatment workflows
- Provider organizations successful at navigating Medicaid processes have care workflows built around Medicaid PA requirements

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MEDICAID AGENCY EXPERIENCES

Feedback: Medicaid agencies easy to work with due to ability to get a person on the phone, speedy approvals, and ease of accommodation for unusual situations.

- **Prior Authorization**
  - **Required** in Maine, VT and NH MCOs
  - **Not required** at *Fee For Service NH* for treatment naïve patients prescribed preferred product
- **Medicaid Agencies**
  - Perception: PA changes simplified processes
  - Practice: PAs still complex, lengthy
- **Smart PAs**
- **Transportation scheduling difficulties**
- **Barriers to care**:
  - Serum Pregnancy testing (ME, NH MCOs, VT)
  - HBV antigen time requirements (ME, NH MCOs, VT)
  - Medication limitations (ME)
  - Required genotype testing (ME, NH MCOs, VT)
  - Specialty pharmacy requirement (NH MCOs)

Five Primary Access Barriers Identified in Tri-State Region

COST TO CURE

PRIOR AUTHORIZATION COMPLEXITIES

TESTING & LINKAGE TO CARE (TLC)

PROVIDER HESITANCY &

HEALTH SYSTEM CAPACITY

PHARMACY LIMITATIONS SPECIALITY VS LOCAL

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Primary Access Barriers: Successes & Ideas

COST OF CARE	PRIOR AUTHORIZATIONS	TESTING & LINKAGE TO CARE	PROVIDER HESITANCY HEALTH SYSTEM CAPACITY	PHARMACY LIMITATIONS
As always… Cost is Complicated. Agencies work with manuf. and federal gov't to receive rebates from drug manuf. that help to enhance access to cost effective curative therapies.	***Look to success in other states.*** MA, NY, CA, OR • No PA for new starts	***Pre-appointment labs*** decrease follow-up appointment times, accelerates process, makes visits more productive.	***Expanded education & outreach*** for providers is needed to decrease hesitancy and increase capacity. How to execute?	"When we make it too complex, we lose people. ***Meet them where they are at on that day,*** they will take treatment."

Thank you to the Medicaid Discovery Committee's Listening Session Participants

- Kathryn Nurnberger
- Michael Ouellette
- Cheryle Pacapelli
- Rachel Picone
- Michael Rapaport
- Taylor Robichaud
- Megan Rusby
- Andy Seaman
- Carlysle Schenk
- Ashley Smith
- Arlene Wiseman
- Marcy Wood
- Laureen Biczak
- Sean Buckley
- Peg Clifford
- Sue Durkin
- Betsy Eccles
- Lise Farrand
- Staci Hermann
- Rebecca Hill
- Lisa Hurteau
- Jacqueline Hyde
- Megan Jensen
- New Hampshire Recovery Coaches

TAKE AWAYS:

- Listen to the voices that were graciously shared.
- Take their experiences and feedback and set the navigation towards HCV Elimination in the Tri-States.

HepFree NNE – Correctional Healthcare Discovery Committee

October 5, 2023

Bronwyn Barnett
Stefan Beck
Melissa Caminiti
Benjamin Carbone
Brian Castonguay
Ryan Landry
Bryan Slaney

Discovery Committee: HCV Care in Correctional Settings

Goal

- Outline the ***current state*** of prevention and treatment services
- Identify actionable, ***future state*** goals for strengthening and standardizing systems of care

Stakeholders

- Nursing leadership, medical providers, pharmacists, administrative leadership, and community partners from ME, NH, and VT

Timeframe

- Virtual group meetings and individual interviews occurred between June and September 2023

Current State

Hep C Screening

- State prison systems:
  - Universal screening at intake
  - Annual screening is based on clinical presentation and known or reported risk factors
- Maine Jail:
  - Screening based on clinical presentation and known or reported risk factors

Ideal State

Hep C Screening

- **Universal screening** at **intake** in **all** correctional settings
- **Universal screening at annual/biannual physicals**
- **Real time assessment and screening** after suspected or known engagement in high-risk activities (e.g., new tattoo, infection or abscess related to injection, etc.)
- **Follow-up screening** in the community

❖Topic to research further:

- Universal and/or selective testing prior to release into the community

Current State

Hep C Treatment

- ME and NH state prison systems provide treatment for all medically appropriate individuals
- ME Jail and VT DOC (unified system) provide treatment to those who meet specified treatment thresholds
- Challenges for jails/unified systems:
  - Short and unknown sentence lengths
  - Need for more robust community partnerships to assist with treatment
- Challenge for All
  - Financial resources
  - Community partnerships for ongoing treatment and/or treatment initiation at release

Ideal State

Hep C Treatment

- **All** medically appropriate individuals with Hep C **receive treatment while incarcerated**
- **Pathways** exist to accommodate individuals who release during the **mid-course of treatment**
- **Solid community referral networks exist**
- **Health navigators embedded** and able to follow individuals after release to assist with accessing community treatment
- Immediate and long-term **payment mechanisms established** for individuals releasing prior to treatment completion
- Community based **MOUD treatment and Hep C treatment bundled**

Current State

Discharge Planning

Discharge planning occurs in all settings, but there are numerous barriers, including:

- Discharge planners may not be medically trained and may not understand the needs of those with Hep C
- Discharge planners typically don't follow individuals after they release and therefore can't assist with navigating community care
- Difficulty obtaining community appointments due to long waitlists and providers being hesitant to work with formerly incarcerated individuals
- In jail settings short and/or unknown sentence length makes discharge planning even more complicated
- Current processes heavily reliant on providing comprehensive discharge education and on independent follow-through of the releasing individual
- Medical coverage may be unknown, non-existent, or have a long waiting period

Ideal State

Discharge Planning

- All individuals with Hep C will have access to a **dedicated discharge planner** who provides care navigation post-release
- Workflows developed to provide ample **lead time to plan** for Hep C care needs
- Referral pathways to community-based resources developed to ensure **timely access to follow-up care**
- **Reduce stigma** and foster increased willingness to work with formerly incarcerated individuals
- Bidirectional communication pathways developed to ensure **comprehensive and timely information exchange**
- **Release of information** (ROIS's) signed for **all** potential providers

Current State

Education and Prevention

- Irregular healthcare staff education often without a standard curriculum
- Education for incarcerated individuals occurs at intake, during annual physicals, at release, and as needed typically in association with an event (e.g., injection related infection or new prison tattoo)
- Education materials are not always checked for health or cultural literacy, unknown or inconsistent schedules for updating the materials
- Teach back method for education not consistently used
- Many prison- and jail-based efforts are aimed at mitigating existing infections vs. preventing new infections

Ideal State

Education and Prevention

- Develop **standardized annual education** for healthcare staff
- Update curriculum at least biannually and **incorporate teach back** as part of the education process
- Create **standardized patient education materials** using the concepts of **health literacy and cultural competency** and update at least biannually
- Ensure that patient education materials include **detailed timelines for follow-up care**
- Supplement one-on-one education with periodic **classes** and develop a **peer support** system to assist with ongoing education
- Ensure **education is setting relevant** (e.g., risks of using shared needles/ink for prison tattoos)
- **Bundle** MOUD and Hep C care to reduce reinfection

Additional time needs to be dedicated toward discussion and development of prevention methods to employ in correctional settings

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Special Thank You

Subject Matter Experts

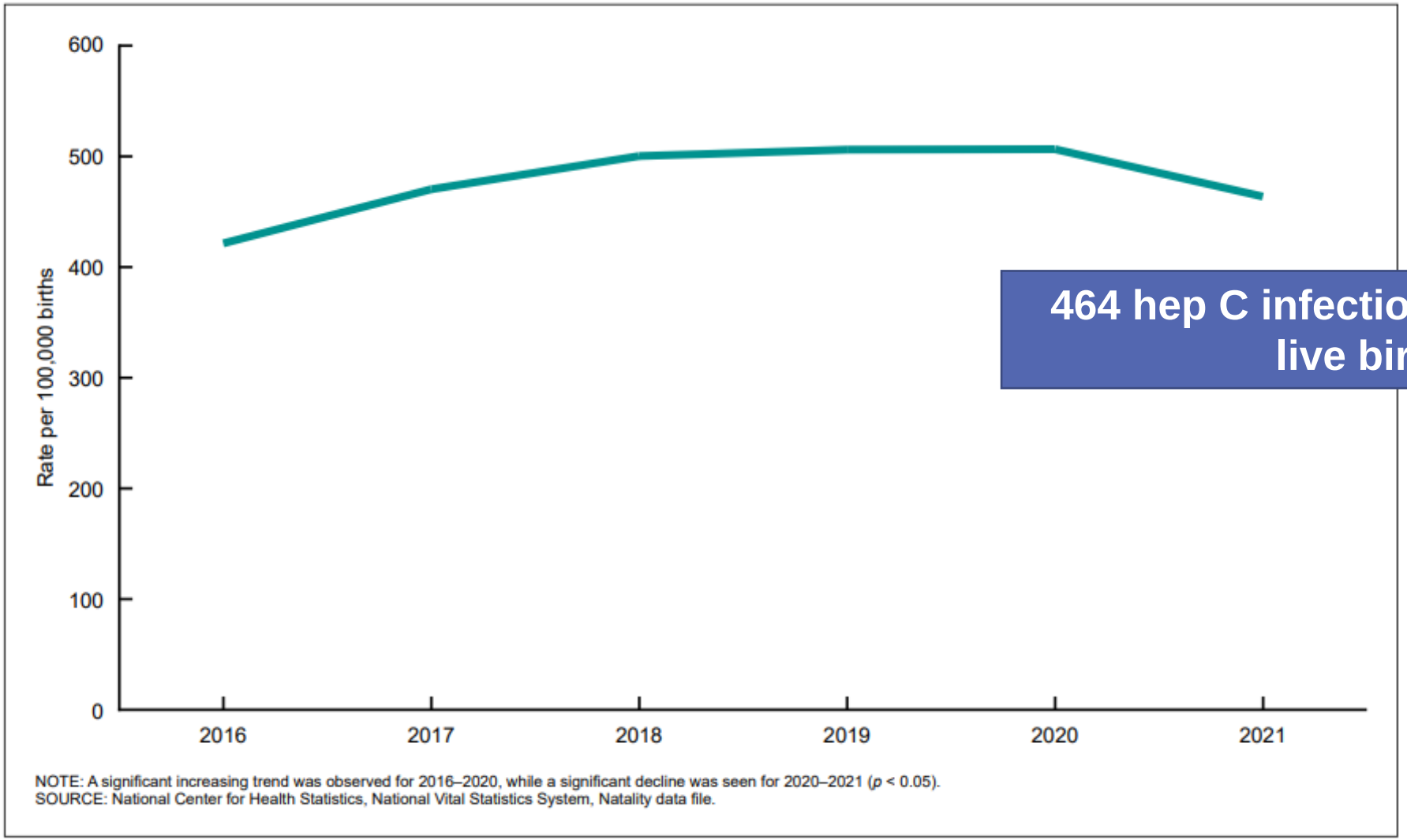
- **Bronwyn Barnett** – NH Department of Health and Human Services
- **Stefan Beck** – Gilead Sciences, PA
- **William Boylan** – Wellpath
- **Melissa Caminiti** – Groups Recover Together
- **Benjamin Carbone** – NH DOC
- **Brian Castonguay** – Wellpath/ME DOC
- **Amy Cummings** – Maine Family Planning – Reproductive Justice Program
- **Isaac Dayno** – VT DOC
- **Celia Englander** – NH DOC
- **Ryan Landry** – NH DOC
- **Jacqueline Rose** – VT DOC
- **Brenda Shattuck** – VT DOC
- **Jessica Sherman** – VT DOC
- **Bryan Slaney** – Kennebec County Jail (ME)
- **Max Titus** – VT DOC

Perinatal Hepatitis C Discovery Committee Findings

October 5th, 2023

Perinatal hepatitis C infections have increased and remain high

Figure 1. Rate of maternal hepatitis C virus infection: United States, 2016–2021



NOTE: A significant increasing trend was observed for 2016–2020, while a significant decline was seen for 2020–2021 ($p < 0.05$).
SOURCE: National Center for Health Statistics, National Vital Statistics System, Natality data file.

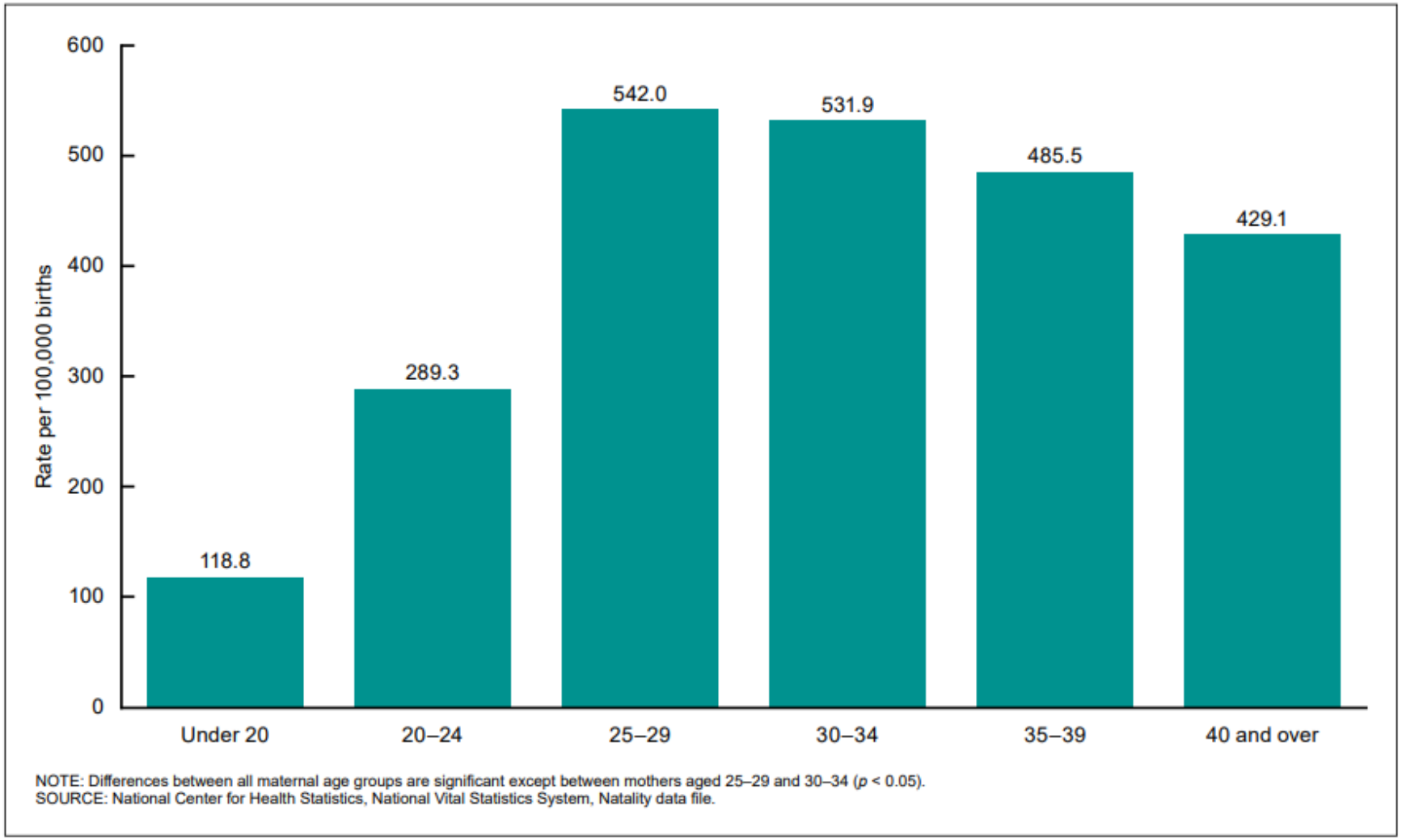
464 hep C infections per 100,000 live births

National Vital Statistics Reports, Vol. 72, No. 3, April 11, 2023

https://www.cdc.gov/nchs/data/nvsr/nvsr72/nvsr72-03.pdf

The highest rates of parental hepatitis C are among pregnant persons 25-29 years old

Figure 2. Rate of maternal hepatitis C virus infection, by age of mother: United States, 2021

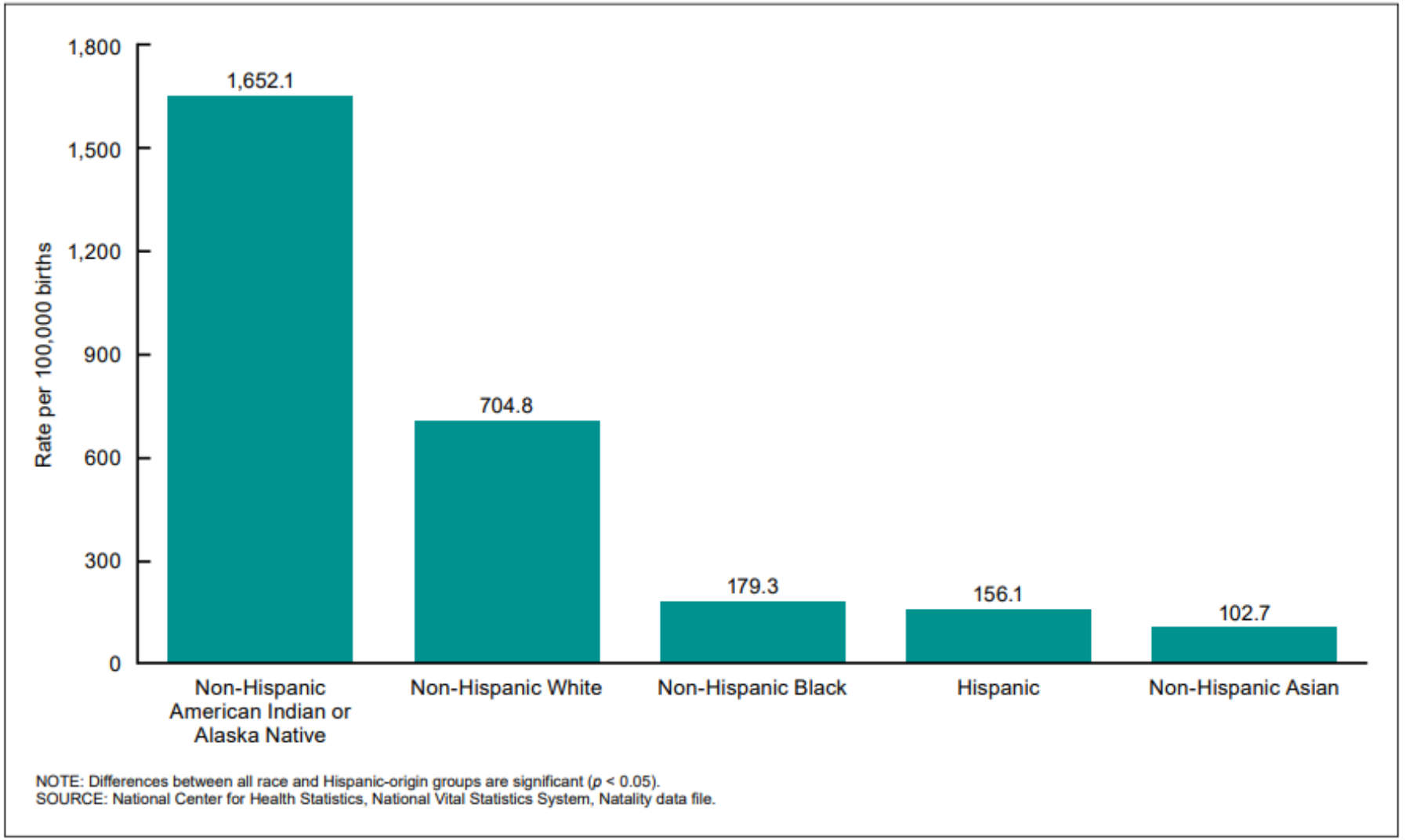


NOTE: Differences between all maternal age groups are significant except between mothers aged 25–29 and 30–34 ($p < 0.05$).
SOURCE: National Center for Health Statistics, National Vital Statistics System, Natality data file.

National Vital Statistics Reports, Vol. 72, No. 3, April 11, 2023

American Indian and Native Alaskan Natives are disproportionately impacted

Figure 3. Rate of maternal hepatitis C virus infection, by race and Hispanic origin of mother: United States, 2021

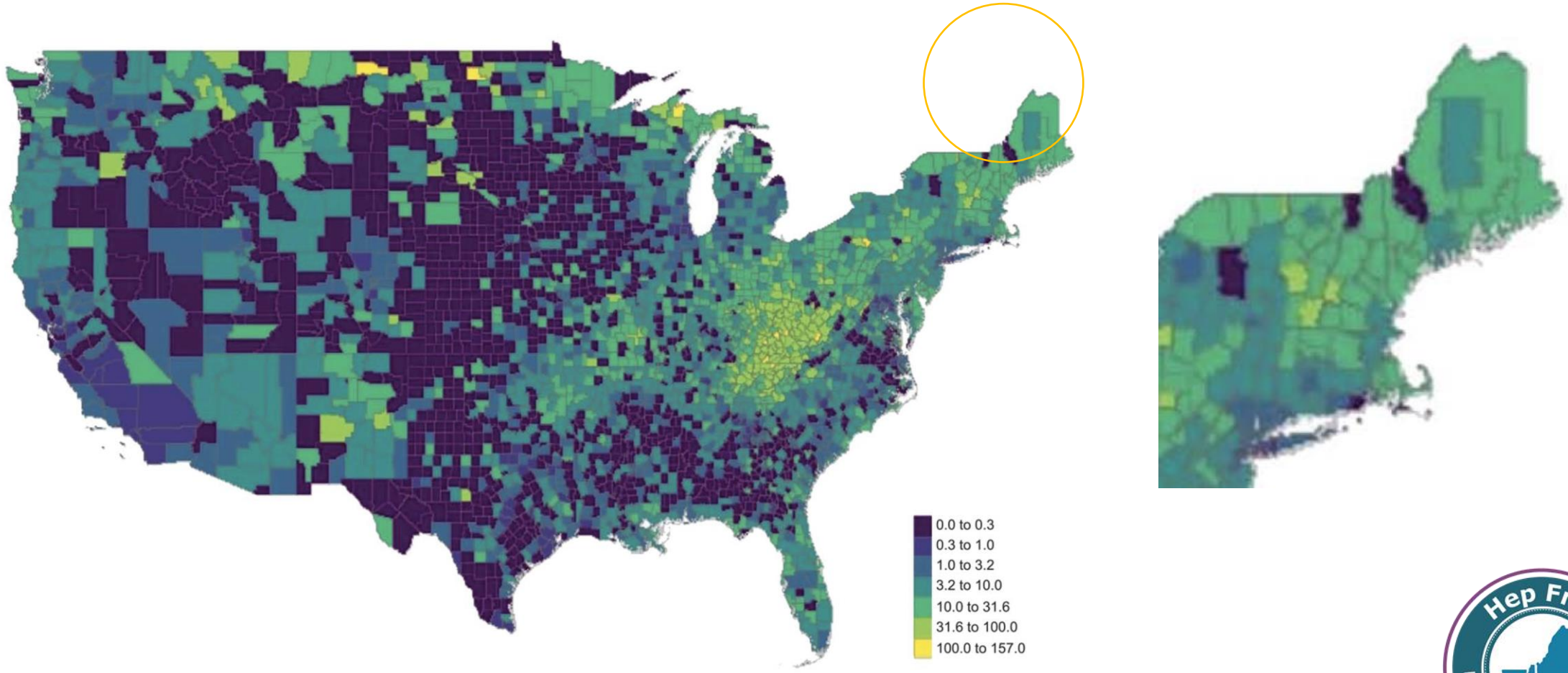


NOTE: Differences between all race and Hispanic-origin groups are significant ($p < 0.05$).
SOURCE: National Center for Health Statistics, National Vital Statistics System, Natality data file.

National Vital Statistics Reports, Vol. 72, No. 3, April 11, 2023

Perinatal hepatitis C prevalence varies widely by county

Heat Map of Perintal Hepatitis C Prevalence by County, 2017



Rossi. Obstet Gynecol. 2020;135:387.

Challenges


GET TESTED. GET TREATED. GET CURED.
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FREE FROM HEPATITIS

PRENATAL (during pregnancy)

There is a general sense of ***fragmentation*** *and* ***lack of clarity*** *about which providers are responsible for information sharing*

Lack of Knowledge:

- Lack of awareness among public and practitioners of need for HCV screening

Patient History of IVDU:

- May complicate blood draw
- May be triggering/shameful

Missed Prenatal Care.

Screening Accessibility:

- Some facilities cannot offer in-office testing

DPH Reporting:

- No current designation for pregnancy

PERINATAL (post-partum)

There is a general sense of ***fragmentation*** *and* ***lack of clarity*** *about which providers are responsible for information sharing*

Lack of Knowledge:

- Continued lack of awareness of need to screen infants and children

Lack of Information/Communication:

- Missing maternal history - HCV exposure is not well-documented /not shared among providers
- Prenatal and birth history/parent infection not transmitted to pediatric provider

Missed Appointments:

- Childbearing parent not seen by specialty care following referral

Service Availability:

- Lack of providers in rural areas
- Limited lab availability

Length of Treatment:

- Completing/taking daily medication challenging for younger children

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Opportunities

PRENATAL

Treat In-Office:

- Follow-up with virology **if referred out** much less likely
- **Eager to be treated** as part of ongoing SUD treatment and/or postpartum care

Screen All Pregnant Patients:

- Ensure information is available **in birth record** and available **in child's record**

PERINATAL

Registry of infants born to HCV+ parents

- Recall at 18 months to ensure final antibody test has been completed
- Ensure child who tests positive has been referred to ID specialist for treatment

Ensure infants attend well child visits

- Ensure medical records contain HCV exposure information

Awareness in clinics serving Children in Foster Care

- Ensure awareness of need to follow up on HCV results
- Test on entry into foster care, if no testing recorded

Ensure pediatric providers awareness

- Ensure knowledge of latest screening recommendation and viral load test as early as 2 months old

Coming up next!

10:45-11:00am – Break

11:00-11:45am – Interactive Priority-Setting for the Elimination Plan

11:45am-12:00pm – Next Steps and Closing Q&A

Please do not leave the breakout room or the Zoom meeting!

- **You will be brought back to the main Zoom room automatically at 10:59am**