

NWX-BPHC

Moderator: Mark Yanick
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1:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. Today's call will feature question and answer periods. At that time if you'd like to ask a question, you may do so by pressing star then 1 on your phone. Today's call is being recorded. If you have any objections, you may disconnect at this time.

I'd now like to turn today's call over to Mr. Mark Yanick. You may begin.

Mark Yanick: Thank you very much. Thank you, everyone and thank you for your patience for waiting - (the) call. We're very excited. And thank you, operator. Welcome to the BPHC Technical Assistance Enrichment Call that's entitled Stopping a Silent Epidemic, Policy and Practice Innovations to Treat and Prevent Viral Hepatitis.

We want to give you a few instructions before we get started. I know we started a little bit late. And one of the things is that if you are viewing this and watching this and listening to this via the phone and also Adobe Connect, we ask you to mute one or the other. Listen to it either through your computer or through the phone. You might get some feedback if you don't.

Currently all, as the operator said, all the phone lines are muted, so we will give instructions as to what to dial in if you have questions via the phone. For many of you, we know this is - you're using Adobe Connect for the first time.

It's the first time we're actually using it on a grantee TA Enrichment Call, so we're very excited.

And we want to do a little bit of just brief familiarizing you with the system and how that works and some of the features if you're logged onto the Adobe Connect screen. You'll see in the middle of the screen the presenta- today's slide presentation. And on the left-hand side of the screen at the top - on the left-hand side, you will see three boxes.

On the top, you will see the camera pod and you should see Jim in about one second and he will be waving. And that will happen. When you don't see a live person - there he is. And can you please mute your phone so we don't get the feedback. Thank you. And underneath Jim - well, when Jim is talking and other live speakers, you'll see them there. And when we have our other presenters who will be phoning in, you'll see their photographs.

Underneath that the second pod is what we call the - well, there's the information on how you can access the call in number if you need the audio (on assistant code). And also if you're having any difficulty on your end for Adobe Connect, there is the phone number where you can call and get some help with that.

On - underneath that you will see the Q&A where we call the chat pod. And when it's time for any Q - questions and you are viewing us through Adobe Connect, we ask that you enter your questions there.

And let's see. Let's do a quick - it's a very, very quick polling question to see how many of you have used Adobe before. You'll see that question come up. If this is your first time, we want to just test it really, really quick. And you will see is this the first time, can you just click on your answer and you're

seeing the numbers tally up. So that's what we'll be doing throughout the presentation to get some polling questions and some feedback from you before the presenters speak. You see that we have a lot of folks so far saying this is their first time, so we're excited and welcome.

Okay. Now I want to move directly into - and now that we've given the instructions, I want to introduce now Jim Macrae who is the Associate Administrator of the Bureau of Primary Health Care. And Jim, take it away.

Jim Macrae: Great.

Mark Yanick: Thank you.

Jim Macrae: Thank you. And thanks, everybody, for participating on today's call. We are ver- I should say Adobe Connect call. We're very excited about using the technology. This is actually the second time that I've ever done it in terms of a presentation. We actually did it with our own staff about a week ago and actually it worked extremely well, so we're actually very excited to now be sharing it with our grantees out there.

And we really do want your feedback in terms of how this particular medium works in terms of getting information to you all, the use of the poll questions, as well as just the ability to actually ask questions. We think that's really important and one of the great features of using this type of technology. So from that standpoint, we're very excited about today's session.

But in particular we're excited because of the topic that we're focused on today. In particular, you know, we are very interested in hearing from a group of experts on what they are doing to stop what really is a silent epidemic of viral hepatitis in this country.

This is a condition that is impacting on many of our populations that are served at health centers and has really been an epidemic that has not always gotten a lot of attention nationally. But with the release of the HHS Action Plan for Viral - to Prevent and Stop Viral Hepatitis, there's definitely more attention at a national level. And we think personally that health centers are in a great position to be able to address this particular condition, prevent it in some cases, but really provide treatment for our patients in a number of venues.

In addition, we're very excited about today's session because in previous sessions we've gotten a lot of feedback that people have really appreciate the opportunity to hear from peers and colleagues on different items that of interest to health centers, but in particular we've heard a real interest from our clinical staff in our health centers to do more clinical quality focused activities and to really focus some of our trainings for front line clinicians as well as the staff that provide care. And so today's session really is focused in that area.

In particular, what we're going to do today is provide you a clinical review of viral hepatitis, we're going to provide you a fairly quick overview of the HHS viral hepatitis action plan, we're going to spend some time hearing and - hearing from some experts as well as a description of several state and local health department hepatitis treatment partnerships that they have with health centers, and most importantly - or I shouldn't say most importantly, but I think really most impactfully, hear presentations from three of our current BPHC health center grantees who will talk about what they're actually doing to address hepatitis B and C.

We'll conclude today's session with a presentation on Project ECHO, which we think is a very innovative program that actually utilizes telehealth in the

treatment of viral hepatitis. It's been actually used by several of our grantees to deal with not only hepatitis, but also with HIV/AIDS, and we think this is really a technology that could be a springboard for us in the future.

Lastly, we'll be sharing some, what we consider, valuable resources that you can access and utilize. And again, as I said, we really do want this session to be interactive, so we're going to try to create opportunities for you to ask different poll questions, ask any kind of questions of the presenters, and basically encourage you to tell us, you know, how effective this works because we want your feedback.

With that I will turn it over to Dr. Seiji Hayashi who is the Chief Medical Officer for the Bureau of Primary Health Care who will be our lead facilitator today for our session. So thank you, Seiji.

Dr. Seiji Hayashi: Great. Thank you very much, Jim. And once again, welcome to all the participants on this call, especially the presenters. You know, every time I do a panel or a session live, I like to sort of see a show of hands of who is in the audience. We'd like to do a poll and see who is on the call today and if you can go on the Adobe Connect and click on who you are or what profession type you represent that would be great. I see people are log- clicking in and...

Jim Macrae: I'm going to try to get the camera off of me and onto Seiji. So we'll see what we can do in terms of that.

Dr. Seiji Hayashi: Thanks, Jim.

Man: Seiji, can you maybe...

Woman: Oh (unintelligible).

Dr. Seiji Hayashi: Oh. You know what, Jim, I'll go back.

Woman: He already moved it.

Man: (Unintelligible).

Dr. Seiji Hayashi: All right. Well, a number of you polled in and it looks like there are many non-direct care providers there. We have administrators, physicians, CEOs even, three of them, thank you very much, I know you guys are busy, and especially the clinicians who are on.

So with that now I would like to introduce Dr. John Ward who is the Director of the Division of Viral Hepatitis at CDC. And John is responsible for planning and directing national and international research, surveillance, and public health programs related to viral hepatitis prevention and control. In addition to the - his work in viral hepatitis, John Ward experience - has experience which includes 14 years in the field of HIV/AIDS conducting early studies of HIV/AIDS transmission, natural history and diagnosis, evaluation of prevention measures and to protect the blood supply and directing national HIV/AIDS surveillance. So with that I'll...

Woman: (Unintelligible).

Dr. Seiji Hayashi: ...hand it over to John Ward.

Dr. John Ward: Thank you, Seiji. And good day, everyone. It's a great opportunity to participate in this enrichment series and I really have enjoyed getting to know Seiji and others in the Bureau of Primary Health Care over the last several

years as we have tried to improve the preventive services for people at risk or living with viral hepatitis.

What I'd like to do in my short period of time here is to give you a brief overview about some of the clinical and particularly epidemiologic aspects of hepatitis, particularly hepatitis B and C, what are some of the unmet needs that are driving us to more strategic thinking about what should be done about viral hepatitis, and outlining some of the high points regarding the HHS Action Plan.

Hepatitis B and C shares some modes of transmission, but there are some differences. Hepatitis B is spread by blood and sexual contact, particularly among adolescents and adults and among perinatal transmission from mother to child during the birth process and there's household transmission through other indirect blood exposures. Hepatitis C is spread much more directly or more heavily focused on blood exposures and to a lesser extent through mother to child transmission and sexual contact.

Both of these viruses have been transmitted at much higher frequency in earlier years reflecting preventive interventions. In the case of B we have a vaccine, in the case of C we do not, but with - we do have blood bank testing and other measures such as preventive measures targeting injection drug users which have reduced incidence rates. That said, we still have tens of thousands of persons becoming infected with both of these infections every year.

In the case of hepatitis B, we're still concerned that we have newborns that are infected at the time of birth. They have about a 20% chance of dying prematurely from hepatitis B related liver disease and liver cancer. However, that said, adults tend to be the ones who get hepatitis B acutely most frequently in the US representing low vaccination coverage.

Hepatitis C, after long periods of declining Hepatitis C incidence that has now plateaued and we're seeing increases in reports of hepatitis C among young adults and even adolescents in states such as Massachusetts and states reporting similar phenomenon in the Midwest and in some Southern states. And that is the major risk group for hepatitis C now is injection drug use, although for both B and C we see expo- transmission in health care settings.

The major - one of the major areas of concern though is the number of persons living with hepatitis B and hepatitis C. It's quite a large population living with this chronic infection, which puts them at risk for hepatitis related liver disease and liver cancer in future years. And to sort of compound that problem, multiple studies have shown that the maj- many if not most of that large population are unaware of their infection and therefore not receiving the care they need that could protect the health of their liver and stop their progression of disease either through managing cofactors that accelerate liver disease or therapeutic - or making available therapeutic options.

And we see this morbidity increasing now. Liver cancer rates are going up. At least half of that's related to hepatitis C. And when we project the morbidity and mortality from hepatitis C, as is shown in this slide, we - based on the projections over the last - the trends over the last several years, those projections of increasing morbidity and mortality are expected to continue unless we do something different for the next several decades.

And when you compare the - sort of the statistics in contrast to another chronic viral disease, HIV, it sort puts in stark relief some of the limited capacity that's currently being applied to viral hepatitis if you look at the larger problems that people living with B and C relative to HIV, the number of undiagnosed infections across those three infections, the number of deaths,

which were also represented on that previous slide, in contrast to HIV, and the relative - and the large disparity in capacity for prevention, care, and research for B and C rela- in comparison to HIV.

(That really - that's) a lot of policy soul searching, frankly, over the last several years, starting within an IOM, Institute of Medicine, report in 2010 which called attention to this large disparity.

And in response, HHS developed an action plan which set out six critical areas that needed more attention and capacity building relating to education of communities and providers, ways of improving testing and linkages to care and treatment, strengthening surveillance so that we could guide therapeutic and preventive efforts more effectively, eliminating transmission of vaccine preventable hepatitis, we have a very powerful prevention tool, we need to be applying it better, it called attention to a critical risk population of injection drug use, and recognizing that transmission is continuing in the health care setting and that's unacceptable and needs to change.

The plan also set out clear goals of increasing proportion of persons living with hepatitis C and B that know their status, reducing the incidence of hepatitis B, and to - and particularly eliminate mother to child transmission.

To give you just some aspects of the objectives and the activities under some of these larger categories, within each of this point - within this plan. And I would really, you know, encourage you to read it because it really tasks HRSA, CDC, and our partners, as well as others, NIH, FDA, et cetera, to do specific activities.

And I'm mentioning some of these where HRSA and CDC have some collaborative opportunities. One of those is building a better educated

workforce related to viral hepatitis prevention care and treatment. Multiple sources have shown - in studies have shown large gaps in knowledge about how - who to vaccinate, who to screen, and what to do when someone is found positive.

We also need to be recognizing communities need more information, particularly those experiencing health disparities such as Asian-Pacific Islanders, and Dr. Wang will be presenting those in a few moments, where we have large prevalence of hepatitis B. But those are other - there are other populations experiencing disparities as well.

We also have created some opportunities to help people understand hepatitis B, become more aware of it. We launched the first World Hepatitis Day on July 28 of last year and we're going to have an h- National Hepatitis Testing Day this year slated for May 19. And hopefully you'll be hearing more about those in the future.

The plan goes into quite a bit of detail about how we can be improving testing and linkage to care, beginning with our policy statements. CDC currently recommends that all populations with a greater than 2% hepatitis B prevalence should be routinely screened. So those are persons born for the most - in - for example in Asia and in Africa, but also men who have sex with men and injection drug users. We recommend that anyone with a history of IDU should also be tested for hepatitis C. And we're recommending - or considering a recommendation because of the large prevalence, it's 3% among persons born between 1945 and 1965, that this population be considered for routine one-time testing as well.

I also wanted to - we - there - the plan goes into some detail about opportunities to integrate testing as a routine service in federally funded

prevention and care programs, including Ryan White as well as community health centers, implement performance measures so that people can get feedback as to how well they or their institution is doing in implementing these, and implementing care models, and we'll be hearing more about Project ECHO in a moment, and that public health capacity also needs to be expanded for testing and linkage to care.

Surveillance, quickly, which is more of a public health role where we have standard systems, but the plan really goes and really encourages better collaborations across agencies so that we in public health can pull data from community health center networks, for example, that could help us in disease monitoring and trend detection.

As I mentioned, we go into some detail about those IDU as a risk population. I know many community health centers have drug users as a - as part of their patient populations. And again, how can we work together to improve education, outreach, access to drug treatment, and helping those persons get onto treatment and decrease their infection for their own health, but also to decrease transmission risk to their contacts in the future.

Looking forward, I think one of the advantages of this plan is that HHS has developed a framework for ongoing collaboration to implement the plan. I think it's sparked a lot of discussions about how, for example, Bureau of Primary Health Care and our group at CDC can work together. We have some examples of how hepatitis services have been integrated within health - community health centers. I've given you a couple of - one example that was done just over the last several years that was refereed in the Institute of Medicine report and we're going to be hearing more about Project ECHO in a moment.

We are - we - it does appear that there will be some resources available in FY12 to stimulate more testing and linkage to care and I see that community health centers in collaborations with their local health departments would be a prime opportunity to use these resources when they become available to spur more testing and linkage to care. And hopefully we can disseminate that information more broadly once the funding opportunity has become finalized.

So in summary, we've made some real progress in viral hepatitis prevention, particularly in preventing transmission, although there's still a lot of work to do. We have a huge task now with a large population of persons living with hepatitis and how can we decrease these expected increases in morbidity and mortality in the future. And I think to be effective in that regard, we really need to build partnerships between public health and clinical care providers and so I look forward to seeing how we can do that with community health centers. Thank you very much for the opportunity to participate today.

Dr. Seiji Hayashi: Dr. Ward, thank you so much. That was really a nice way to start off the session. And thanks for explaining why hepatitis is such an important issue for us.

Before we get going again to the next section, I'd like to do a poll. So now that you guys have heard, you know, about that hepatitis action plan, prior to hearing from Dr. Ward how much did you know about, you know, the HHS Viral Hepatitis Action Plan? If you can click into the poll. People are clicking in. Uh-oh, who's winning? (Mildly now the board) looks like - well, it's great that the majority of you have actually heard about it. This is actually great news. And thank you so much for that.

So as we move into our next section about state partnerships, I'm going to introduce Chris Taylor who is the Associate Director for Viral Hepatitis for

the National Alliance of State and Territorial AIDS Directors or NASTAD. In his role he provides support and technical assistance to state health departments which have the viral hepatitis programs and advocates on their behalf with the Administration, Congress, and Federal agencies.

So I have another question. As a health center, what is your current level of partnership between you and your state health department regarding viral hepatitis? If you can answer that. Great. People - it looks like there's some activity with the health department which is great. I see one person with complete involvement. That is fantastic. Great. Thank you very much for the answers.

And now we're going to move over to Chris Taylor. It's all you.

Chris Taylor: Great. Thank you, Seiji. Hello, everyone, thank you for joining today's Webinar. I think this is a really important topic and we're thrilled that HRSA's Bureau of Primary Health Care has provided this venue to talk with you about viral hepatitis both from a prevention standpoint, but also a care and treatment standpoint as well.

I'd also like to acknowledge CDC's Division of Viral Hepatitis and John - Dr. John Ward who you heard - just heard from for his leadership on viral hepatitis prevention, linkage to care, and really the instrumental role that CDC and Dr. Ward in particular had in calling for the cross HHS Action Plan on Viral Hepatitis.

So as Dr. Hayashi said, I do work for the National Alliance of State and Territorial AIDS Directors or NASTAD and many times, you know, folks think, oh, you're an HIV/AIDS organization that represents state health

department HIV programs so how does hepatitis fit in all of this? And so I'll give you a little bit of a snapshot of that.

But it was around the end of the 1990s that our members, HIV programs in state health departments, came to us and they were getting a lot of questions, particularly around hepatitis C, which had been identified in the late 90s, and a lot of the questions were coming into health departments in the HIV or STD immunization programs. And so it was at that time that we did start our hepatitis program in the year 2000.

Around the same time, CDC started funding adult - or started funding hepatitis C coordinators in nearly every state. And we're going to talk a little bit about the role of hepatitis C coordinators or adult viral hepatitis prevention coordinators in a moment.

But really, the CDC, state, and local health departments really are trying to build some infrastructure around core public health services, but of course we can't do this without, you know, practitioners at the community level, such as yourself. And so really we're looking for opportunities from a public health standpoint from the state health departments really to partner not only with local public health and community-based organizations, but with federally qualified health centers. Because you're seeing so many of the people that are at risk for not only viral hepatitis, but maybe HIV and a whole host of other health issues.

And so I do - on behalf of NASTAD, as well as our members, I do want to thank you for the important work that you're doing across the board not only related to HIV and viral hepatitis, but really serving populations who have, you know, a whole host of health conditions.

So you can see there a little bit about NASTAD's viral hepatitis program. As I mentioned, we do represent state HIV/AIDS programs and directors and their staff, but also adult viral hepatitis prevention programs. And just like many other disease specific areas, there has been a lot of discussion over the past couple of years of how do you work with community health centers and federally qualified health centers.

And so many of you on the line probably feel like you're the most popular kid on the block, this is something I talk about with some of our colleagues here at the Bureau of Primary Health Care, partially because of the great work that you're doing, but also there's been an increased emphasis over the last probably ten years from a federal perspective on the important role that you do play.

And again, as, (well), as you all know and we've mentioned earlier, you're interacting on a daily basis with the individuals who are at increased risk for viral hepatitis. So we want to make sure that we're able to partner with you, that you know of some of the opportunities to partner with state public health agencies so that we can achieve our common goal of reaching populations at increased risk, identifying new cases of hepatitis B and hepatitis C, and making sure that they're being medically evaluated.

So here are some folks that are located organizationally within state health departments, as well as some larger city and county health departments that are really important for you know - for you to know about. These are wonderful resources. Sometimes they have funding, sometimes they don't. That is an important thing to put out there.

But it is important that you know who these individuals are in your state or your city. It was great to see that many of you are already working with your

pub- local or state health departments, but I want to walk through some of these individual positions and talk about the important role they play and how they might be able to assist you and how might you be able to partner with them.

So the first, I have already mentioned, is the adult viral hepatitis prevention coordinator. And actually if you want to go back a slide that would be great. Thank you. Is the adult viral hepatitis prevention coordinator. And Dr. Ward at CDC, his program funds these positions in 55 jurisdictions.

And really their role is to build an infrastructure, make sure that there's testing going on in states, in localities, and so they're really working with local public health, community-based organizations, as well as community health centers, so many of these coordinators will have a state taskforce that's looking at the prevention and care needs of communities impacted by viral hepatitis.

So I certainly encourage you, whether you're a clinician, an administrator, a nurse, social worker, if you don't know who the adult viral hepatitis prevention coordinator is, or any of those individuals listed, to please search their Web site, you can search CDC's Web site, for their contact information. And I'll have my contact information at the end of the presentation and you can always contact me if you want to get their phone number or email address.

The second person that's really important for you to know about is the perinatal hepatitis B coordinator. And we have made incredible strides in the US - in the United States for reducing the number of infants that are born with chronic hepatitis B. Is our work done? No. We still have a lot of work to do to eliminate perinatal transmission of hepatitis B. But there is a resource in the health department, again the state health department, but many large city health departments as well.

So if you're - if you've got a pregnant mom who is chronically infected with hepatitis B, most likely you're going to be getting a call or be getting contacted by the perinatal hepatitis B coordinator to make sure that, you know, mom is managed correctly and that baby is handled correctly so that we can make sure that transmission doesn't occur.

A couple other pla- people in the health departments that I'll just touch on briefly. Many of you might be working with the adult vaccination coordinator or the Vaccines for Children coordinator in your state or city's immunization programs. These are wonderful resources as well. We know that community health centers are the medical home for a lot of individuals and families who are receiving Vaccines for Children's vaccines.

We also want you to be aware and many of you may be working or be grantees of HIV/AIDS programs either through your state health - state or city health department or directly from HRSA's HIV/AIDS Bureau. So again, these are all folks within a state or city health department that you should feel comfortable reaching out to asking for assistance.

Next slide, please. So I know you're already doing wonderful things related to hepatitis. There's always a place that we can take a next step though. So I have a series of slides, there's three slides, that really talk about some short-term strategies, some medium-term strategies, and some longer term strategies.

So the things you're seeing on the screen right now are things that everyone can do with pretty limited financial resources. It might take more time or some staff time or devoting time for an in-service, but this is if you're not already doing something or you would like to do more, these are some great starting places.

Really, talk about a staff in-service. You know, there's been a lot of movement and a lot of exciting things happening in the world of hepatitis B lately as far as a diagnostic standpoint, as far as treatment as well. So bringing folks in, whether it be from your health department or one of your own staff persons or clinicians to talk about some of these things.

You know, they're as simple as having brochures or posters in your waiting room. Developing a referral guide for support groups and, you know, maybe it's not at a local level, but in the national level where your patients or your clients can get more information.

So those are some free things that you can do. And I know that the Bureau of Primary Health Care is going to share some resources at the end of the presentation on where you can get some more information.

So some things that you can do that might take a little bit of resources. And again, you know, as a federally qualified health center, most of you should be able to bill and can bill for some of these services, whether it's through private insurance or through Medicaid or Medicare. So really, we would like to see, you know, across the board, but particularly in community health centers the offering of hepatitis B and hepatitis C testing, hepatitis A and hepatitis B vaccinations.

Some health centers have actually implemented support groups not only around hepatitis, but, as I mentioned before, other health issues. That you know your population, they feel comfortable coming to your center, this might be an opportunity for you to develop a support group or an educational program for people living with hepatitis or partner with a community-based provider to do that.

The next slide, please. Finally, kind of the long term. And this is something that I think that all of us would like to see a medical home or wherever someone is accessing medical services, both preventative and treatment oriented, that it's one-stop shopping. That the clients that you're seeing, you know, they can come there, they can get testing and vaccination if they need it. They can get that medical monitoring and case management and some of the wrap around services that you all are so great at providing.

We'd also like to see, you know, doing more research and linking with some of your federal as well as state and local researchers to be able to capitalize on some of the great work that you're doing. And ultimately we'd like to see, you know, a successful treatment and a sustained virologic response or, as some of us will say, a cure.

So next slide, please. Certainly Dr. Ward talked about the HHS Viral Hepatitis Action Plan. I encourage you to look at that. Identify opportunities that you can do at the state or the local level. But there is a lot of other great resources out there and NASTAD was really please last year to do a consultation among - between health departments as well as some community health centers from around the country and really talked about the relationships.

Oftentimes, you know, always we have the same goals in mind. We want to make sure that communities are healthy, that we're identifying folks and getting them into care and treatment programs or presenting, you know, the onset of illness or the acquisition of disease. But many times, you know, we think, oh, they speak a completely different language than I do in the health department or I do in the community health center.

And so we have put together a report that is available on NASTAD's Web site, and the Web address is listed there, that reports out some of the best strategies and the model programs, things that really seem to work between successful collaborations between state HIV/AIDS, viral hepatitis programs, as well as community health centers. So we look forward to opportunities to continue working with our members, as well as individual community health centers, state primary care author- associations, et cetera.

So my time is up. I thank you once again for all the work that you're doing. You really are making a difference and we appreciate your work. Thank you.

Dr. Seiji Hayashi: Great. Thank you so much, Chris. It is really great to hear all the things that are going on at the state level and we wholeheartedly encourage all health centers and our stakeholders to partner with their state health departments and everything at the state level.

At this point, I want to just take, you know, maybe one or two questions from the audience. And we actually have one question already into our queue in the Q&A section and the question is - I think that this is for John - for you, John. The question is, "How do you estimate the prevalence and incidence of viral hepatitis for those people who don't know about their status?" John.

Dr. John Ward: The main way we - at this point, we use national surveys. The one in particular, the NHANES, the national health survey that includes a interview in the home and then a standard physical and history and blood taking. And then we - that's how we derive our estimates of national prevalence, which is about 1.3% and about 3.3% for those persons born between 1945 and 1965. Then we interviewed those persons who were found positive in that survey and asked them did you know you were positive before you were tested. And

about - it's at right about 49% of persons said they were aware before and the others were not.

And what troubles us as part of that is that - and when you ask them, well, why were you tested, less than 10% were tested because someone asked them about a risk for hepatitis C. Most of them were picked up secondarily because they were being tested like through a routine physical and they found an elevated ALT on their lab work and then that prompted testing.

So that's - other surveys have used other methodology that's in the literature, but that's how - that's our main way of doing it at CDC.

Dr. Seiji Hayashi: Great. Thank you very much, John, for that answer. I have one question for Chris. You know, often the state coordinators and the people at the state level are the ones who really sort of try to figure out what are all the other federal activities going on. You know, here on the call we have HRSA and CDC, but what other agencies may be involved in viral hepatitis?

Chris Taylor: That's a great question. And I was glad that Dr. Ward brought up, you know, the importance of kind of cross agency collaboration at the federal level because really we need to see more of that at the state and local level as well.

And I think, you know, historically we've seen, you know, HIV, you know, just because we've got a 30 year history of communities responding to HIV. And so I think we can learn from, we can utilize some of those networks that already exist. But also, you know, some of the racial and ethnic health organizations that are out there, we want to bring them into the fold. Certainly jails and prisons we want to bring in, correctional health. And chemical dependency. Those are all folks that we want to bring to the table so that we can make sure that education is getting out there. But making sure that, you

know, if one agency, you know, is doing some work we can make sure that, you know, everyone in the jurisdiction kind of that's the go-to place, that's the area of expertise.

Now just like in the federal government, sometimes state governments are big bureaucracies and they - different programs speak different languages. So sometimes it takes outside partners, such as community health centers or bureaus of primary care - or primary care associations, sorry, to be the conveners of some meetings and ask for the health department programs that you're working with across your portfolio to get all the people in the same room and talk about not only issues that maybe the health department is driving, but what's really important for you as providers of services at the front line level.

So I hope that helps answer your question.

Dr. Seiji Hayashi: Great. Thank you very much. John and Chris, thank you so much for the great overview. And I'd like to go onto our next segment of our presentation and Webinar. Now we'll look at a perspective from the field from two health center grantees.

Our next presenter is Dr. Su Wang who is the Assistant Director - Medical Director at the Charles B. Wang Community Health Center in New York City, which is a federally qualified health center and a Bureau of Primary Health Care grantee which serves the Asian population in the greater New York City area. And I am actually - I was told that not only in the New York City metro area, but actually regionally in the Eastern half of the United States. Dr. Wang directs the center's hepatitis B activities, which include the hepatitis B care program for infected patients and a hep B mom's program and community outreach and screening.

So with that I hand it over to you, Su.

Dr. Su Wang: Thank you, Dr. Hayashi. I want to thank HRSA for having this really important call, thanks to Dr. Hayashi for inviting me to speak, and also to everyone in HHS who's actually played a role in this action plan, which I think has great potential in actually ultimately helping the patients that we serve.

I'm also very excited to hear John's announcement that there might be an RFP for potential funding and we will definitely be looking out for that. And thanks, Chris, I thought your strategies were really important and really good ideas for some concreted ideas of what health centers can do.

So I want to start off with just some background on the hepatitis B virus and infection. Hepatitis B is a virus transmitted through blood. It can be transmitted perinatally, through sex with an infected partner, or also infected needles. It is not transmitted by saliva, food, or casual contact, though there is - this is a common misbelief that we find a lot in our patients and I think this actually contributes to stigma about the disease.

It's also unique because it can be a acute or a chronic infection. Acute infections usually do resolve and require no intervention. Ninety-percent of adults who acquire hepatitis B acutely and have a good immune system will require no intervention and actually develop immunity. Those who develop chronic infections usually have it for life.

So 90% of those who acquire hep B during childhood, for example from their mothers, will develop lifelong infections. And though there are excellent medications available now to control the disease and the viral load, they rarely

can actually cure it. So that makes it a little bit different from hep C where a cure is likely - is possible.

So hep B is one of our nation's greatest health disparities. One out of ten Asians has chronic hepatitis B and screening programs around the US have shown a 5 to 15% prevalence rate in Asians while the general population prevalence is only 0.3%. And what's remarkable is that two-thirds of those infected are unaware and that they have not been diagnosed yet. So it's also striking that more than half of those with hepatitis B in the US are Asians, but not to only think of Asians as those who are at risk, it does also affect those from Latin America, Africa, or Europe.

So the good news about hepatitis B, unlike hepatitis C and HIV, there is an effective vaccine that prevents transmission. This is a three-shot series that has been part of the universal childhood vaccination since 1991. What is striking is that hepatitis B infection affects more people globally than HIV, but as Dr. Ward mentioned, it gets far less attention and funding.

So most individuals with chronic hepatitis B are asymptomatic and this is often a problem because people don't go see the doctor if they feel fine, but it turns out one out of four may eventually develop cirrhosis or liver cancer. It has been shown that early intervention can prevent complications and is cost effective. However, as an MMWR report showed last year, liver cancer rates are actually on the rise in the US and this is largely due to chronic hep B and hepatitis C infections.

So this is just some information about Charles B. Wang Community Health Center where I work. We served almost 39,000 patients in 2010. The vast majority were served in a language other than English and earned less than 200% of the poverty level. Twenty-two-percent are uninsured, 72% received

either Medicaid or Medicare insurance, and 6% had commercial insurance. So using EMR, we are able to estimate that our hep B infection rate in our population is about 13%. So this equal to about 5000 patients in our hepatitis B registry and about 2800 of these are considered active patients.

So this is a table that summarizes some of our community wide screening efforts throughout the past ten years. We've worked with a number of partners, as you can see here, that range from the Chinese-American Medical Society, New York City Department of Health and Mental Hygiene, pharmaceutical companies, and NYU just to mention a few.

Our prevalence rates, as you can see on the very right here, basically show that our prevalence rates range from 11 to 25%. So from these community screening programs, it was very obvious that our community had a very large burden of disease.

So how did we develop our hepatitis B program? Well, one of the first components of our program was to incorporate screening and vaccination into primary care. So besides training our care providers, we also built in EMR-based reminders. We developed case managing strategies to improve our vaccine completion rate and our follow up rates.

One of our ongoing programs is a unique collaboration with the New York City Department of Health where we are the testing site for household contacts of pregnant hepatitis B women. This is the perinatal program which Chris alluded to.

Next, because we found this disease was actually so prevalent in our community and many of our patients did not have access to specialist care, we actually developed a hep B care model. So one of the largest components of

this was training the physicians. So there are obviously different levels of hep B care a provider could provide and your population may not merit full provision of hepatitis B care, but at base all primary care physicians should at least know who to screen and vaccinate and how to interpret the test results.

The next step would be to know how to evaluate hepatitis B disease, such as ordering the viral load, liver function test, the e-Antigen status, and then following that be able to monitor a patient for disease progression and screen for liver cancer through an ultrasound or AFP test.

Finally, learning to treat with antivirals probably took the most training, so all our internists at this point do it now. It is not uncommon for primary care physicians in the New York City area to treat hepatitis B if they see a lot of Asian patients.

We also did a lot of training with our support staff. Our nursing staff had to learn how to provide hepatitis B education and also help our uninsured patients apply for patient assistance plans so that they could receive free medication from the pharmaceutical companies.

So our next step was to kind of go up a level and implement the collaborative care model, which is a more extensive set of changes to improve our healthcare delivery of hepatitis B. So many of you have seen this and are familiar with the collaborative care model. This has been well described for depression and diabetes and we decided to tailor it for hepatitis B.

So what we did is we looked at the areas that could be improved on within the health care system ultimately in order to in- to lead to more productive interactions between the hepatitis B patient and the practice team, like the providers and the nursing staff.

So these just show the main areas of change within a health (care) organization. The first thing I'm going to talk about, delivery system design. So first we formed a hepatitis B collaborative workgroup. So this group meets monthly, it has broad representation and includes physicians, a head nurse, our front desk manager, our care manager, and also a representative from the clinical informatics team.

We also have a chair - the chair manager who specifically tracks the patient visits in our hep B care program and she calls them if they have missed several visits.

We find this extremely important for patient retention. She also follows the women and babies in our hepatitis C moms program and helps coordinate care between internal medicine, women's health, the delivering hospital, and pediatric providers.

So it's quite a c complicated set of places that a mom and a baby go to.

So next is decision support. And this is a really important area especially as we talking about training primary care providers to treat a complicated fairly specialized disease.

So as mentioned we have regular provider trainings and this includes tox and case reviews by specialists.

And we also post the summary of (AA LG) hepatitis B guidelines in every exam room.

And we hold a yearly peer review of hepatitis B.

So what happens here is doctors actually review each other's charts the patients records to see if each patient has received the basic hepatitis B care standards.

So this is just of the hepatitis B infected patients. So this sense of being a very good refresher for everyone and our physicians actually receive a bonus if they do well which is another good incentive.

So next is EMR. We've had EMR since 2006. And we find our electronic medical records have been a crucial support tool for decision support.

So what we've done is make specific hepatitis B tailored flow sheets and forms. And we've done things like group all the hepatitis B tests near each other on the order screen.

And by doing this we're helping the doctors process the patient's information more quickly and also make it less likely for them to miss ordering a test.

As another layer we also programmed in reminders that we'll see that the patient is overdue for their hepatitis blood test or an ultrasound.

In terms of clinical information systems out of EMR we're able to create a hepatitis B registry and this identifies all individuals with hepatitis C infection.

If an individual's in the registry basically the word hep B shows up on their EMR banner and this allows the physician to automatically see that the patient has hep B without even looking at the problem list.

So we also have EMR reports of all the hep B screening and vaccination that is done at our health center.

And then we created a hep B registry from the hep B registry we pull clinical data of all the infected patients.

So at a quick glance we're able to see everybody's lab tests their last ultrasound date and whether they're on medication and when their last refill date was.

And we hope all this will to ultimately improve the care of the entire population.

So lastly self-management support is a big the key part of how we engage our patients in their own care. So many of you know this is also big objective with patient-center medical home and implementing this for hep B actually helped us achieve level three patient-centered medical home status.

So briefly we standardized the hep B education by the nursing staff within the EMR (briefly) accessible resource patient resources on hep B. And one of them is that patient the portable patient tracker which I will show you later.

So this is a summary sheet we made up of the 2009 (AA) cell (D) hepatitis B guidelines. The original document is almost 40 pages to get through it so this is kind of a cheat sheet that we posted in all the exam rooms for the doctors.

And I believe this is available as a download for this call.

So next this is the registry form, which basically prepopulates all the patient's lab tests have it related hepatitis B lab test. As you can see here it allows the

physician to really quickly track and trend the patient's bio-load and also the liver function test.

And we also included ASP, which is a tumor marker and the ultrasound so that you can see right away when the last ultrasound was done.

So this has probably been one of the most useful tools for our physicians.

So next these are the reminders that I mentioned that we program in using protocols and EMR.

So this is an assessment and plan page where the physician puts all the orders in at the end of the visit.

And at the bottom right under preventative care basically if the patient is overdue for their bio-load or their liver function test or AFP or ultrasound it would pop up here so that it would remind them to order these tests.

So and lastly this is the education form which we created that's used by our nursing staff. So as you can see we have them for many conditions.

And for the hepatitis B we made it easy by creating a check off list for the nurses to make sure they cover all the important topics.

And lastly this is the hepatitis B patient tracker which we created it's bilingual. This actually folds up to the pocket sized and we ask the patients to bring this to their visits this is a way of engaging them in their own care.

So as they're here we fill in the test results. There's a space for bio-load the liver functions test. And this allows them to see what's happening with their

disease whether their bio-loads going up or down because we feel like it's important for them to know the status of their disease as well.

And importantly what medicines are on we find many patients and you all probably have experience with this come to their doctor's office and they actually don't know the medicines they're on and this is quite important for hepatitis C because of the chance of resistance.

And physician needs to know what past medications a patient been on for hep B in order to decide what they should be what they should go on.

So my take home message is are that as HQACs refer many populations who are at risk for hepatitis C infection. Many of you see foreign born patients like us who come from endemic countries.

And besides Asia don't forget that individuals from Latin America, Africa and parts of Europe are also at risk.

You may see HIV infected or MSM or (IBGA) populations and these are all at risk in each of these screens.

So we are at the front lines of serving these vulnerable populations and we need to increase screening.

And screening is simple. By ordering these three tests the surface antigens the hepatitis C surface antibodies and the hepatitis C core antibody you're able to identify who -- which patient is immune, infected with (hep) b, or needs vaccine.

And as a side note CDC has some actually great charts that you can post out that help with interpretation of the test results.

So again early in diagnosis in care of clinic hepatitis B does make a difference and prevents complications of cirrhosis and liver cancer.

Finally the collaborative care model provided us a thorough approach to improving delivery of hep B care. It can also help your center with patient-center medical home measures as well if you're in the middle of pursuing that.

I'm happy to answer any questions as you go through the chat or also through email. And I think we'll be doing that after Danielle's talk.

Thank you very much for having me.

Dr. Seiji Hayashi: Great thank you so much Su. And for those on the -- and they'll be connect and on the phone. Leave the queue there for the volume being a little bit low.

Hopefully we were able to resolve that. So I'd like to move on to discussing hepatitis care for the homeless. And caring for viral hepatitis in primary care is difficult as it is.

But then when you add in the vulnerabilities apparent in those that experience homelessness I think the challenge becomes even greater.

And this is why it's a pleasure for me to introduce Dr. Danielle Robertshaw from the Health Care for the Homeless in Baltimore, Maryland.

She is a board certified family physician and she's a medical officer at Health Care for the Homeless.

And her job duties include overseeing clinical services provided by Health Care for the Homeless to the homeless adults, children, and families.

So with that I present to you Dr. Danielle Robertshaw.

Dr. Danielle Robertshaw: Wonderful. Thank you so much Dr. Hayashi and thank you all for the HRSA for hosting and inviting me to participate.

As mentioned my name is Danielle Robertshaw and my focus is working with homeless individuals and families.

The first part of my discussion today will focus on why hepatitis C is particularly important in this population and the second part of the discussion will focus on the ways that we've attempted to improve hepatitis C care at Health Care for the Homeless in Baltimore.

We know that hepatitis C is the most common blood borne infection in the United States. And as Dr. Ward had mentioned earlier we know that around 20,000 new infections occur annually with an unfortunately high percentage that become chronically infected in more than half who are likely unaware of their infection.

We have evidence that certain groups such as homeless individuals and those who have been incarcerated are at particular high risk for hep C infection.

Long-term hepatitis C can have a variety of affects on an individuals' health. Patients may suffer from non-specific symptoms such as fatigue, nausea, anorexia, chronic pain, and depression.

Obviously these symptoms can have a direct impact on a person's quality of life. And also as earlier mentioned hepatitis C can lead to chronic liver disease include cirrhosis and liver failure as well as cancer.

In the United States hepatitis C is the most common cause of liver transplant and is the principal cause of death from liver disease.

A study published in 2011 noted that all cause mortality meaning death from any cause not necessarily linked directly to liver disease was more than two times higher for those infected with hepatitis C than those who are not.

In Baltimore at Health Care for the Homeless our recent statistics show that 21% of our adult patients have been diagnosed with chronic hepatitis C.

And this is actually slightly less than the estimates for the estimated national average which suggest that between 22% and 52% of homeless adults may be infected.

And as a reminder the prevalence as mentioned by Dr. Ward for the general US population is between one point three and one point nine percent.

The demographics for Baltimore Health Care for the Homeless 77% of our patients are African American, 18% Caucasian, and 3% Hispanic.

We see more men than women and the majority of our patient are between 25 and 64 years of age.

Seventy five percent are actually uninsured while 19% have Medicaid and 6% Medicare.

Nationally the data collected on the complex comorbidity of chronically homeless adults estimates an average of eight chronic active medical problems per patient.

We believe the three point four percent of our homeless population is infected with HIV. Approximately one out of three have mental health diagnoses while an estimated two out of three meet criteria for substance abuse.

There is significant overlap with 50% of those who are mentally ill also having a substance abuse disorder.

I chose these particular demographics to highlight in order to look at some of the potential issues that arise in the treatment of hepatitis C.

The American Association for the Study of Liver Disease provides in-depth guidelines for medical providers on a variety of liver diseases including hepatitis C.

When assessing a patient for possible treatment they've divided the recommendations into three categories.

Obviously what you see on the slide is only a very small portion of what's included in those recommendations. The full medical criteria are available on their Website.

The criteria listed here are those that may be particularly important when working with the homeless population.

The first category defines the characteristics of persons for whom therapy is a widely accepted. And while some of this may seem obvious it is important to consider on a case by case basis.

The criteria states that patients must be willing to be treated and adhere to treatment guidelines.

And I would imagine that most medical providers would agree that a willingness to be treated does not always imply an ability to adhere.

For the second category for those whom therapy is currently contraindicated it includes major uncontrolled depressive illness and severe concurrent medical diseases.

For those whom therapy should be individualized they include current users of illicit drugs or alcohol and those co-infected with HIV.

So given what we've reviewed so far the list of potential barriers to successfully treating hepatitis C is lengthy.

Some of the major barriers for homeless itself include at the systems level a lack of insurance. Not having insurance or not having adequate insurance produces many roadblocks.

Patients may not have access to primary care; they may not get screened or tested. Referral and specialty care is often nonexistent or very limited not only for hepatitis C itself but also for mental health and substance abuse treatment.

Medication access becomes extremely difficult. Many of our clients also lack access to or lack consistent access to items that are considered necessary basics such as food, housing, and transportation.

And it's going to have a negative affect on the ability to adhere both to appointments as well as the complicated medical regiments that may have significant side affects.

Social isolation and lack of a strong support system is common in homeless adults and that can contribute to a sense of being overwhelmed by chronic health issues.

For patients dealing with substance abuse, psychiatric or complex medical comorbidities there may be a direct barrier to meeting criteria for treatment eligibility as well as complicated adherence for those who do qualify.

Studies have shown that with an integrated approach these populations can achieve treatment outcomes similar to those of other populations.

When looking at chronic disease there are often multiple layers to providing quality care.

At Health Care for the Homeless we have when we decided to focus on hepatitis C as a quality improvement initiative we started by developing three separate areas of interest.

First with those things that we could potentially do in a primary care setting with our current resources, second were those that we could improve internally if we had more resources, and third those areas that would require external resources or assistance.

So in 2010 led by one of our dedicated nurse practitioners (Kathleen Becker) the focus was on devising internal adapted guidelines.

Once completed we implemented a number of activities to educate the providers and work the protocol into our clinic flow.

You can see here to the right this is our original protocol pre-EMR in the old-fashioned paper version.

Simultaneously while implementing that stuff we identified areas of priority such as testing and vaccinations that required resources beyond what we had available and worked on expanding local partnerships to help us meet these goals.

In 2011 we continued to work on our initial goals but also expand it to focus on the process as a huge part of meeting goals.

We worked on internally strengthening the patient care team as well as utilizing our newly implemented EMR for tracking, provider communications, and care reminders.

So our initial step and that which you have the most follow up data on was focusing on the standards of care for hepatitis C from a primary care perspective.

Compiling this list helped us to improve our move towards our first goal, which was finding a way in a resource limited setting to standardize the care and ensure the highest possible quality.

And I put up this list here and a lot of it focuses on appropriate testing not only for hepatitis C but also for HIV, hepatitis A and B, vaccinating as fully as possible, educating our clients and counseling them both those who are positive for hepatitis C but also those who maybe negative but involved with risky behaviors.

Working with our clinicians to make sure we are monitoring appropriately and co-managing disease symptoms and treatment side affects.

And we have a great system here for peer and group support, which we utilize for health education and self management goals.

We also worked with our teams to make sure we were screening, counseling, and treating for both substance abuse and depression and referring for evaluation and treatment when needed.

So what you see here is some of the original data that we captured from our 2011 Phase I.

We did see some significant improvement in a number of areas including both testing and vaccination.

Currently we're working not only on improving our provision of services but also our ability to track these services in a meaningful way.

The next five main areas of focus include education and counseling and that includes working on improved provisions standardization and documentation, enhanced utilization of our EMR system now upgraded, and incorporating decision support and anticipating information sharing between providers.

Compliance continues to be an issue and we continue to work on it both for appointments and medications. We've also worked out a further pathways for referring for specialty care and diagnostic tests and working on tracking treatment access and outcomes.

So we learned a lot of lessons. Some of the key themes that came out of this process for us are listed here. This is actually an interesting slide to put together as a number of our initiatives that had seemed small at the time actually had a bigger impact than we had anticipated.

And I think that most people would agree that integrated multi-disciplinary team approach is ideal in a number of ways and for us this (queue I) process really reinforced this importance but it also highlighted some of unique resources we had at HCH and assisted us in improving how the care team functions as a unit.

We're fortunate to have primary medical substance abuse and mental health treatment available on site but we started to realize how important our street outreach team and our medical respite program became in assisting our vulnerable clients who the evaluation and treatment process.

Social work and case managers of course are often the glue that hold the team together assisting with benefits, paperwork, food resources, housing, and applications for medications.

And I think as we become more successful at navigating patients through the process we found that medications were actually a barrier on a greater number of levels than we had thought.

Access both for the insured and uninsured is a cumbersome and time consuming paperwork process which puts stress on already limited staff resources.

For patients the side effects could often be intolerable due to their living situation and we became aware of potential pitfalls and hopefully preempted them.

For example diarrhea obviously becomes an issue for someone who sleeps outside or is staying in a crowded shelter.

Several of the newer medications especially the recent updated treatments instruct the patient to take the medication three times a day with food which is obviously a huge struggle for patients that may only have consistent access to a single meal a day.

We were fortunate during this process to find a willingness among local hepatitis C providers to become partners. We were able to work with the health department for better access to vaccines.

We found several specialists in a local hospital who saw there was an broadening access to evaluation and treatment services and now have access to donated lab services, imaging and liver biopsies, as well as GI consults appointments for uninsured patients.

We're able to use harm reduction in a number of ways and made sure we educated all providers on such things as safe injecting and access to sterile injection equipment including needle and syringes.

And I think that improving the provider knowledge actually had a very direct and a very positive effect on the education then provided to patients.

We held several staff trainings on motivational interviewing so that providers had a greater comfort level in working with patients who are not yet ready to seek substance abuse or mental health treatment.

We were able to get several donations from local groups to have hygiene products on hand such as toothbrushes and razors and we found this had a small impact on appointment compliance, a big impact on patient satisfaction, and a hypothetical and hopeful impact on decreasing transmission.

I think one of our biggest challenges during the timeframe was the MR implementation and then subsequent upgrades.

And after seeing Dr. (Wong)'s presentation I'm really hopeful that we're headed in a similar direction.

We know EMR has added a lot to our ability to coordinate and track care and we're hopeful that we will continue to move forward with technology in a way that will enhance care provisions.

So thank you very much.

Dr. Seiji Hayashi: Danielle thank you so much for that really insightful presentation.

We're going to hold the question-and-answers till the end and I want to introduce to you to our final presenter who is Dr. Saverio Sava from the First Choice Community Health Care in Albuquerque, New Mexico who will present on Project ECHO.

Dr. Sava is board certified in family medicine as he graduated from Albany Medical College. He completed a residency in family medicine at the University of Connecticut.

Dr. Sava is an Associate Professor at the University of New Mexico Department of Family Community Medicine and Medical Director of the First Choice Community Health Care and practices at the Mountain Valley Regional Health Center located in Edgewood, New Mexico.

So with that Dr. Sava.

Dr. Saverio Sava: Thank you very much. It's nice to follow such nice presentations just getting an overview of hepatitis C and then the really nice presentations from the two community health centers who are also working on developing models that work for that.

Let me start with a little bit of who we are. First choice is a federally qualified health center founded back in 1972 we're celebrating our 40th anniversary this year.

We provide medical dental, behavioral healthcare and which services we're major safety net provider to the uninsured in Bernalillo County and the surrounding counties of New Mexico.

We also like to see ourselves as an innovator of change on community development.

We have eight locations in three counties and we're presently serving about 50,000 patients we had over 200,000 visits last year.

This is a picture of our centers in various locations some rural some a little more urban.

But I'm really going to focus here on celebrating successes because I think our relationship with the University of New Mexico Project ECHO has really transformed our ability to care for not only hepatitis C but various other chronic health problems.

Project ECHO utilizes the specialty expertise of an academic health center in partnership with primary care and public health practices in rural and underserved communities.

The picture of the Project ECHO team and this is a very important picture because this is what most of us sit at on Wednesday afternoons those of us that provide hepatitis C care.

The central picture is Dr. Sanjeev Arora and his team at the University of New Mexico.

And the peripheral pictures are providers in various community health centers, public health offices around the state of New Mexico.

This is a view from the other perspective of Dr. Arora's perspective of showing his viewing of all the candidates.

And also during each session we tend to have some didactic component also.

What Project ECHO represents is really a bold experiment that implements a new approach to providing healthcare.

Obviously as we've heard today hepatitis C is a growing concern. I think this map just captures again the prevalence of this sort of internationally.

In New Mexico we have to make that we have more than 20,000 cases of hepatitis C. Right in by 19 -- 2004 when we first looked at the data less than five percent of these had been treated.

Of course without treatment about 8000 patients will develop cirrhosis with several thousand deaths. Also we're working very closely with our prison systems. There's at least 2300 prisoners diagnosed in our present correction system probably more than 2400.

None were treated prior to this process. New Mexico has the highest rate of chronic liver disease and cirrhosis death in the nation.

So the goals of this project was to develop the capacity to safely and effectively treat hepatitis C in all areas of New Mexico and then to monitor outcomes.

We want to develop a model to treat complex diseases that would be exportable to all rural locations and also to developing countries.

The methodology is to use technology such as we're using today -- multi-point video conferencing to leverage the health care resources. We're using a disease management model for improving outcomes.

And really a major component of this is the case based learning. It's learning by doing of primary care providers, nurse practitioners, public health folks out in community sites.

Of course we are very compliant with all our central database. Rural New Mexico if you haven't been here yet is very is very unpopulated.

The largely a large Hispanic population in New Mexico a large native American population. Our poverty rate is higher than the national rate.

We have e a huge amount of uninsured cases and 32 of our 33 counties are listed as medically underserved areas.

So the steps to do this the first is to train physicians, pharmacists, and educators in hep C. The way we trained was using an (I) health again the telecompany type of modality.

And these networks become knowledge networks for people sharing information. So by initiating co-management there are learning loops for all the providers involved.

We collect data and the data's monitored centrally which assures both patient safety and provider compliance with federally established protocols.

We also have worked as best to cost effectiveness of the programs, you know. Now with the benefit to providers, well first of all providers have achieved a lot of between medical education by participating in these networks.

Plus there's an amazing amount of professional interaction with colleagues with similar interests. Providers of consistently voiced that they feel less isolated and this has really helped a lot of our small community health centers in recruitment and retention of providers.

They also obtain some HCV certification and they have access to this specialty folks down at the university.

How is it worked so far on model. Although we've had over 500 HCV telehealth clinics.

Now again those are just one of the multiple tele-health clinics that Project ECHO has originated. We've served over 5000 patients already engaging them in (text C) treatment through this project and we've issued over 6100 new continued medical education hours to the clinicians providing.

There was a wonderful trial that was used to study this. Just want to review that the purpose was of course to train primary care clinicians in rural areas and prisons to develop hep C treatment to rural population.

To show that such care was safe and is effective in fact given in the university clinic and to show that Project ECHO's improved the access of hep C to minorities.

For that study group we involved 16 community based sites. Many of which are First Choice sites. We involve five correctional institutions.

And the control study was the University of New Mexico Liver Clinic. The end point was to achieve of sustained viral response which was no detectable virus six months after completion of treatment.

And this is our study group. It was actually 407 patients that have hepatitis C and 146 of these were treated at the university clinic and 261 at the community sites.

And this is sort of the good news of that study this was actually published in June of 2001 in the New England Journal of Medicine.

Large number of minority patient participated. And our cure rates were very, very consistently across the board. The ECHO treatments actually matched the treatments in the university center.

So what we show through this model was that rural primary care clinicians can delivery hep C care under the supervision of the Project ECHO that space affective at that given at university clinic.

Also we also access care to the huge number of minorities here. And the important points here to mention is that none of these patients ever have to make a visit to the university clinic.

They get their entire care in their community health center.

This is a map of just the many Project ECHO community clinics around the state of New Mexico including hepatitis C but also rheumatology clinics, wellness clinics, pain clinics, clinics looking at other chronic diseases like diabetes.

And this really I think in terms of transforming modern healthcare has been a force multiplier. At the local sites help build primary care teams with providers, nurses, medical assistants, community health workers, and then help the sites seek diseases across the spectrum of care.

Now I just want to finish by saying what are the organizational challenges that we went through as a community health center to implement this and things that you can sort of look towards if those sites out there that want to initiate this kind of model.

And I just want to divide that into a couple of sections. What are the ideological barriers financial constraints and training and staff problems?

So first of all the ideological barriers I remember our first management meetings someone said wait a minute that's not what we do, we don't treat chronic diseases like hepatitis C that's specialty work.

So you have to go through that process of selling that to your management team including vector as a slight loss of replacing the primary care.

Financial barriers. It does have a mild affect on productivity although we found that it's not a major affect on productivity.

There is an issue of buying some provider time to free them up to provide to participate in these ECHO conferences.

And of course one of the things that's difficult for all of us and probably different a little bit from state to state is that we often deal with fixed payment systems for our patients so it doesn't let us build higher levels of care and get reimbursed for that for what we're doing with this total specialty care.

And of course as we all know prevention might save a lot of dollars but they don't seem to flow back down hill to us.

Training and staff wise this has been a major plus at our provider meeting consistently I have providers say, being able to do this kind of work is really increased my satisfaction with my job and wanting to stay as part of the community health center.

So in transforming our health care system these are the questions we have, right? How do we advocate so innovations that work are disseminated?

And I really think if you're a primary health care for putting this conference on because I think that's what this is about. And then how do we institutionalize programs so they grow beyond individual champions?

I'm going to finish rapidly with a couple of suggestions for the sites that you considering doing this start with a champion, get your administration to buy in early, involve multiple key staff members, key on staff satisfaction and retention, highlight the positive patient experiences and then highlight your program and organizational reports and newsletters.

Use this model to explore other areas to help transform your healthcare system. This is a final slide it's really a slide of public health this is in JAMA several years ago talking about what are the major things that changed health care and I think this is true though for all of us that the greatest impact on healthcare in this millennium will be from system innovations on healthcare delivered to include the health of our communities.

And with that I'm finished, thank you.

Dr. Seiji Hayashi: Great Dr. Sava. That was really inspiring to say the least. Thank you very much for that presentation.

So I want to first of all thank all five presenters today and get them back on line so that we can do a little few questions-and-answers.

It's three thirty right now and we'd like to go over about ten minutes and for the answers that cannot be answered right now we will put it on line with the

recording so that everybody will have a chance to have their answer --
questions answered.

So with that before we go I want to make sure that we have a sense of how
this Adobe Connect Webinar went.

So if we can put the whole up I understand that there was some audio issues
initially but the question is how helpful was it the TA session for you and I
understand that we haven't had the Q&As yet but.

Great feedback. And for those of you who have any suggestions for
improvement please let us know also.

And we'll compile those and try to improve for the next time. So thank you
very much.

So I'd like to move into the question-and-answer session and for those of you
who have Adobe Connect please type in your question in the chat box that you
have available.

And then Operator if you can ask -- provide instructions for those on the
phone.

Coordinator: Thank you very much. At this time if you'd like to queue up to ask a question
over the phone you may do so by pressing star then 1 on the phone.

You'll be prompted to record your name so that I may introduce your
question.

Once again that is star then 1 to ask a question. One moment please.

Dr. Seiji Hayashi: Great, thank you very much. And as we're waiting for folks on the phone there has been a number of questions there's there Internet already and some of it has to do with resources and I want to ask this question to Chris.

And when this time of, you know, really shrinking budgets how does state help habitat coordinators maximize the resources that are available so that more folks can get testing and care?

Chris Taylor: The money question, right? Yes. You know, it's tough and you're right I mean it has been, you know, we are in challenging economic times, you know, related to public health.

You know, both at the federal level and the state level as well and it's probably fewer than ten states that have actually allocated state general revenues to hepatitis testing programs.

So if you're in one of those jurisdictions you're lucky.

And Dr. Ward has talked a little bit about, you know, the hepatitis coordinators or CDC grantees, you know, I know CDC would love to be able to provide memory resources to, you know, provide core public health services at the community level.

Unfortunately their budget's about \$20 million, you know, so, you know, divide by 20 by 20 million by three million people with hepatitis and there's not a lot of money to go around.

So, you know, we have seen some games from the federal level and Dr. Ward references a little bit that, you know, we're hoping to see a little bit of an increase to CDC's division of viral hepatitis, really focus on testing.

And, you know, at a time when most federal programs are receiving cuts, you know, it is great that the division of viral hepatitis potentially could get some increased funds for this fiscal year.

Now in the advocacy side we're really working to increase, you know, the policy maker's awareness about viral hepatitis and, you know, mostly it's a national level but there's also some state level movement on that.

So we just need to get more money out there so that people can provide the (test).

Now the federal dollar isn't the only answer, of course, you know, if someone privately insured, if they're on Medicaid or Medicare that covers these tests, you know, that's great and we should be billing for those tests.

You know, I think we're all looking towards the full implementation of the Affordable Care Act and how is that going to impact the populations that we serve, you know, some of that still yet to be determined.

Particularly related to, you know, testing guidelines, you know, what's covered by federal dollars, etcetera.

But again, you know, public health folks and community health center providers are and then by necessity had to be very creative in how they provide services.

So again the more folks we can have in a room or heads together talking about how can we provide these services I think that's great.

So please do reach out to advocates and health departments folks in your jurisdiction.

Dr. Seiji Hayashi: Great. Thank you very much, Chris with that answer. And I just have to sort of acknowledge Chris for being such an incredible builder or partnership in collaboration. So I really appreciate it.

We have a clinical question actually and I think I want to send this question to Su.

We had a question about, you know, your part of your presentation sighting the risk for a family members and close contacts with those who have hepatitis B.

What are precautions or things that, you know, we should be doing for family members of those with hepatitis C?

Dr. Su Wang: Yes that's a great question actually thought about that as Danielle was presenting because she mentioned some of the educational things that they provide to hep C infected patients.

So very similarly we tell folks who are infected that they need to not share razors, toothbrushes, nail clippers or anything that might, you know, potentially have blood on it.

But besides that like I mentioned before eating with, you know, family members sharing utensils, you know, casual contact, hugging, those are things

that are not an issue which we find a lot of patients actually think that they cannot eat with somebody who's a family member who has hep B.

So we try to dispel that myth. So that's one of the educational things we tell them including also for the infected member make sure you're protecting your liver, no alcohol.

Herbal meds are a big issue in our population we really tell them try to limit herbal medication intake because a lot of them can influence the liver increase the liver function tests and if you do take herbals please tell your doctor know.

So those are the things and then basically the most important thing is really to get your household contacts tested. A lot of them are afraid to talk about it with their family members and so we really have to encourage them to say if you love your family members care for them then one of the best things you can do is tell them you have the infection and that they should get tested.

Or if you don't want to tell them at least encourage them to get tested so they can get vaccinated if they're not already immune.

Dr. Seiji Hayashi: Great thank you very much for that answer Su.

Danielle there's a question actually sort of an applause as well as a question. It's incredible that you were able to afford some partnership with the local health department.

How did you do that? And what were some of the challenges in order to get the local health department to the table or was that an issue at all?

Dr. Danielle Robertshaw: Well I think actually in Baltimore we're pretty fortunate because we have worked with the health department on a number of other initiatives and I think that we found it to be a mutually beneficial relationship.

They were definitely concerned that they may not be able to reach certain populations just in terms of their staffing restrictions and populations that maybe in places that they can't go to, you know, into the shelters or under the bridges.

Where on the flip side we have the staff that was able to do that and sort of engage clients and but what we needed was the vaccine and the ability to test.

And so kind of combining resources I think we all felt like we were coming out as winners.

And I'm not sure how we ever approached them. We've had this partnership for a very long time and they've always been very wonderful to us.

They've supported us not only in the hepatitis vaccination but we've done a number of outreach educational seminars for patients and providers and different things we had a Hepatitis Hero Day where we celebrated some of the local providers who donated time and donated services.

And we've just a good relationship.

Dr. Seiji Hayashi: Great, thank you very much. Operator are there any questions on the phone?

Coordinator: Yes we do have a couple questions on the phone. Dr. (Lopez) I'll open your line now.

Dr. Seiji Hayashi: Go ahead Dr. (Lopez).

Dr. (Lopez): Yes, yes hi. Dr. (Lopez) calling from San Jose, California. But I just what I wanted to do is if these presentations going to be available and downloadable because that would be great for us to, you know, take to administration to present our case to see how we can, you know, start implementing some of these things that you guys did a wonderful job on this presentation.

So I just wanted to see if that was going to be available?

Man: Thank you Dr. (Lopez). These all the materials and all the handouts including the slides are on the (unintelligible) (ta) page currently so you can go to the (unintelligible) (ta) hrsa.gov/bphdtechnicalassistanceda.

If you have any difficulty getting any of that information you can email me directly. Be more than happy to send this to you. It's myannick@hrsa.gov. They're all the materials on our Website correct right now.

Dr. (Lopez): Great, okay thank you.

Dr. Seiji Hayashi: Next question on the phone.

Coordinator: Doug Hirano, your line is open.

Doug Hirano: Yes my name is Doug Hirano and I'm with a community based agency in Phoenix, Arizona and we're involved in a hepatitis B testing mainly for Asian Pacific Islanders.

So my questions -- and thanks to the speakers all really good presentations.

My question is around I think policy and if we're -- if there is more money coming to the CDC for screening and all of us in the communities and health departments are doing a better job screening for hepatitis B and C, the I'm wondering whether that will put pressure on the health care system?

And whether they'll need to be a program similar to Ryan White for HIV for hepatitis B and C whether there's some planning around federal support for additional care and treatment dollars for people with viral hepatitis?

Dr. Seiji Hayashi: Thank you very much for that question. Dr. Ward would you like to answer that question?

Dr. John Ward: Sure, I briefly alluded to some of the options for, you know, basically leveraging the, you know, health system particularly as it's envisioned in the era of full implementation of the Affordable Care Act.

And, you know, because, you know, at the end of the day once I mean the screening needs to happen. These persons do have a chronic disease that threatens their, you know, quality of life, and length of life and so they need care.

And so that burden on the health system needs to be there because it's the good public health thing to do and there's multiple economic models that show it's a very cost effective enterprise to do screening and linkage to care for these populations we're talking about.

So, you know, we're sort of good there. And so we've been talking about, you know, how do you just once you get these people persons in the care who need it then to have that, you know, that care paid for as it's laid out in an era of health reform grant it that you'll always have challenges with marginalized

populations such as homeless and others who are going to need special attention

So I think, you know, we talked about various ways of integrating care so it can be paid for, you know, in through Medicaid through, you know, as accountable care organizations are established, etcetera.

I'm sure, you know, the city probably has their own, you know, next stories to tell about how to get reimbursement.

And, you know, there has been some talk about, you know, or including this and the Ryan White program going forward but I think that's very sort of, you know, envisioning way down the road.

But I think all of that to be said, you know, we, you know, we have an under recognized population that's fairly large. They're progressing to severe disease.

We have an opportunity to get them into systems and then have providers be trained to be aware of how to detect, manage them in a way that, you know, that's, you know, recommended by, you know, multiple organizations including, you know, the federal government and agencies.

Dr. Seiji Hayashi: Great. Thank you very much Dr. Ward for that answer.

And along those lines, you know, whether there was more funding or not and with more people being potentially being insured through either the Affordable Care Act, you know, the need for care is going to increase.

And I want to ask Dr. Matt Burke who is the Senior Clinical Advisor for the Bureau of Primary Healthcare to offer the quality and data to describe and how do you because we don't have enough providers to begin with.

We need to make health centers more efficient and more effective.

What are we doing around patient-center medical homes, you know, from HRSA to facilitate that?

Dr. Matt Burke: Thank you Dr. Hayashi that's a great question. And both HRSA and the Bureau of Primary Healthcare have the patient-centered medical home as sort of broad policies and broad priorities at the current time.

There is the strong indication that the medical homes will offer individual practices that are requisite infrastructure to think very deeply about how to better coordinate care and track individual patients over time.

Dr. (Long)'s comments about impaneling patients and doing registries and understanding what the specific needs are for patients both from a disease standpoint and a practice management and follow up and delivery to specialty care standpoint should all be enhanced by the whole medical home infrastructure.

As a result we have three elements that are occurring right now. Only one of which is still available to all providers and we would encourage folks on the phone to look into this more and consider this as an option.

But last year we did have one thing which was the patient-centered medical home supplemental funding opportunity which provided a one time \$35,000 booster to help centers looking to increase one of their capacity in one of the

six medical home domains as at least understood by the National Committee for Quality Assurances model.

So this is as good time I think to say that the Bureau is very agnostic about which medical home models that clinics are, you know, should be seeking to pursue but we chose that because we also have the patient-centered medical health home initiative which can be found at the Bureau's main Website for more information and application details.

And that is a full financial support for the enrollment into and the taking of the survey process for the NCQA.

And so far we've had over 240 of our 1100 grantees enroll more than 800 sites under this process.

Many of which are on the waitlist and ready to go in at this point but that represents the huge percentage commitment on behalf of the health centers and their clinical leadership as well as the dual commitment on behalf of the Bureau to supply funding and resources and to make this happen.

Dr. Seiji Hayashi: Great thank you very much Matt. With that I realize that there are many more questions in the queue but we're going to have end here.

I want to thank all the speakers for the incredible presentation and insights or comments that has been presented today and most of all thank you very much for the audience.

We look forward to continuing our partnership and improving the care for those who have hepatitis and preventing people to be infected in the first place.

So thank you very much.

Speakers if you can stay on the line.

Coordinator: Today's call has ended please disconnect at this time.

Man: Terribly sorry I'm late for an interview.

END