

IMPROVING TREATMENT ACCESS BY BUILDING PROVIDER CAPACITY

- Dr. Joshua M. Liao, University of Washington Medical Center
- Dr. Carolyn Chu, HCV Warmline
- Michigan: Assessing the geographical distribution of HCV treatment providers in relation to HCV hot spots
- Virginia: Provider training





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IMPROVING HCV TREATMENT ACCESS THROUGH PROVIDER CAPACITY-BUILDING: **THE NATIONAL HCV WARMLINE**

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- *Why* a Warmline?
- *Who* operates the HCV Warmline? *How* does it work?
- Example cases





Provider capacity-building is a cornerstone for improving treatment access

- Valuable lesson learned: “low threshold” care models
 - Streamlined patient-facing processes

➔ *How can we apply this to provider-related concerns, opportunities?*

– Successes, challenges?



LESSONS LEARNED

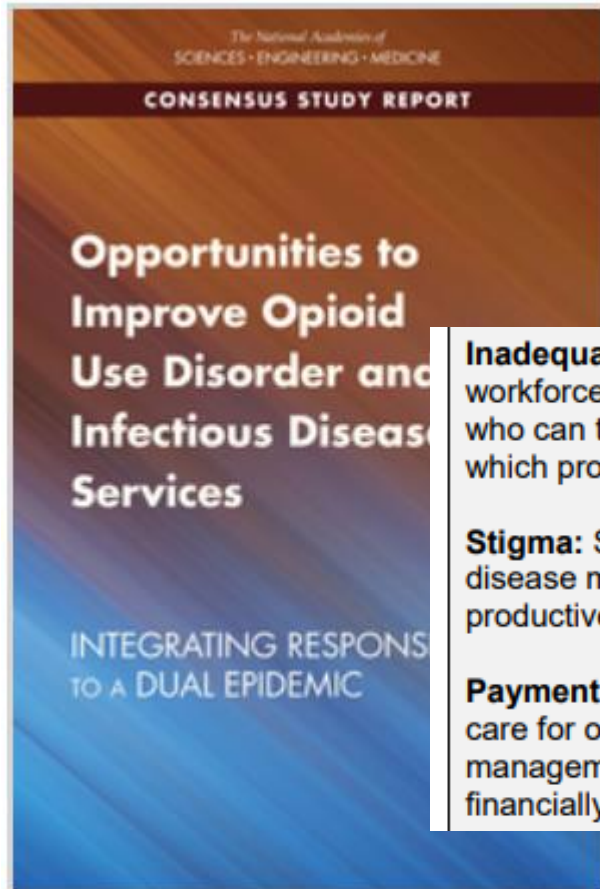


Guiding principles: “low threshold” support

- Same-day treatment entry
- Harm-reduction approach
- Flexibility
- Wide availability
- *Same-day (“in the moment”) support, training/education*
- *Practical strategies, respect for client*
- *Flexibility, agility: ability to assist providers with differing resources & experiences, from different practice contexts*
- *Readily-accessible subject matter expertise*



Hot off the press!!



Inadequate Workforce and Training: There are several barriers to integration from a workforce perspective, including the geographic distribution and inadequate training of providers who can treat patients with opioid use disorder and infectious disease and restrictions about which providers can deliver certain kinds of care in certain settings.

Stigma: Self-stigma and societal stigma surrounding both opioid use disorder and infectious disease may prevent patients from seeking or accessing care, and provider stigma may inhibit a productive patient-provider relationship.

Payment and Financing Limitations: Services that are helpful to patients seeking integrated care for opioid use disorder and infectious disease (e.g., harm-reduction services, case management, telemedicine, and peer-recovery counselors) are difficult to obtain or sustain financially.



The HCV Warmline is a national tele-consultation service, operated by UCSF & with support from the Health Resources and Services Administration, that provides clinician-to-clinician support for HCV evaluation & management



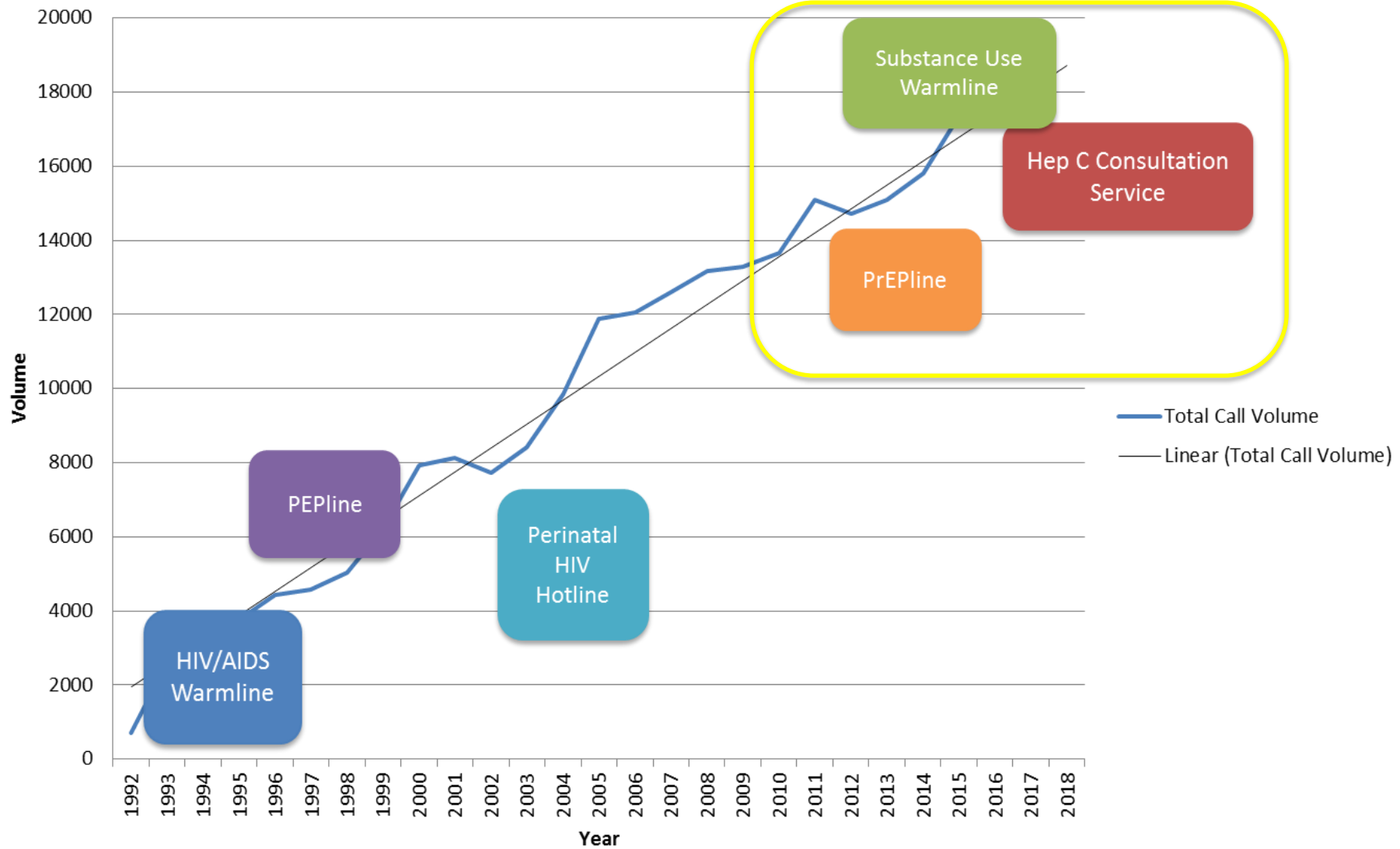
What does the HCV Warmline offer?

- Free, confidential tele-consultation & case-based education
- Consultants provide highly-tailored, evidence-based recommendations & expert support
 - Individualized for specific patient/case circumstances, cultural considerations, & provider practice settings
 - *General questions also welcome: clinical protocol development, guidelines updates & implementation in practice, newer approaches to care/treatment, etc.*

ANY clinician in ANY practice setting is welcome to call



Call Volume (by service-line), 1992-2018





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How do you reach the HCV Warmline?

(844) HEP-INFO, 9am-8pm EST | Mon-Fri

- Leave voicemail during evenings/weekends/holidays: call-back within 1 business day
- Online case submission available via nccc.ucsf.edu: same-day response if received during standard program hours, otherwise response w/in 1 business day
- Brief caller registration process to collect



caller/practice information:

no PHI involved





Things we cannot do...

- Provide direct assistance with patient referrals
 - *Can share provider locator resources*
- Give medico-legal counsel
 - *May be able to share some information on “best practices” (depending on specific question/scenario)*
- Speak with/directly advise patients
 - *Warmline is not a tele-medicine service (i.e. consultants do not directly evaluate, diagnose, or treat patients)*
- Limited availability for in-person trainings
 - *Happy to share information on other educational opportunities/resources!*

Who staffs the Warmline?



Principal consultants include highly experienced physicians (expert generalists & specialists), clinical pharmacists, advanced practice nurses: all have strong primary care background & commitment to supporting increased access to patient-centered care for hepatitis C, substance use, and HIV!



Our HCV Warmline consultants have...

- ...assisted with HCV screening & diagnosis algorithms
- ...clarified staging approaches, including offering decision support in cases with discordant testing results
- ...helped identify optimal DAA selection/duration: high-level review of data, “real world” experience
- ...provided medication interaction reviews & risk mitigation strategies
- ...walked through options in “grey-zone” areas (e.g. missed doses, abbreviated treatment courses)
- ...alerted clinicians to emerging issues (e.g., perinatal HCV)
- ...assisted with treatment planning for “special populations” (e.g. HIV or HBV coinfection, substance use, pregnancy/breastfeeding, chronic kidney/liver disease)



Warmline case vignettes

57yo with very high LFTs
Is something else going on? What work up is indicated?

69yo with obesity,
EOT viral load = 18 IU/mL
How do I interpret this? What next?

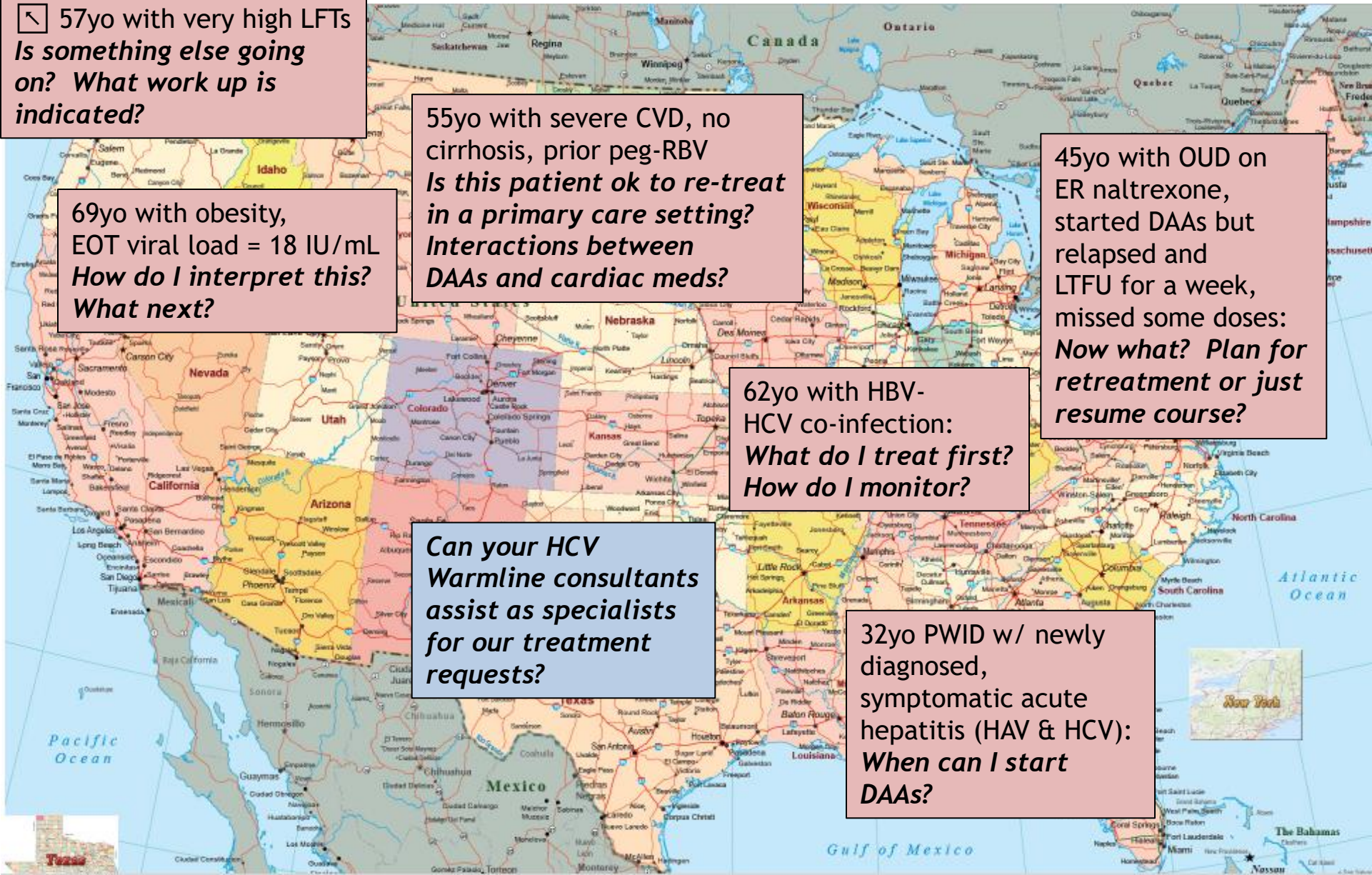
55yo with severe CVD, no cirrhosis, prior peg-RBV
Is this patient ok to re-treat in a primary care setting? Interactions between DAAs and cardiac meds?

45yo with OUD on ER naltrexone, started DAAs but relapsed and LTFU for a week, missed some doses:
Now what? Plan for retreatment or just resume course?

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

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

32yo PWID w/ newly diagnosed, symptomatic acute hepatitis (HAV & HCV):
When can I start DAAs?





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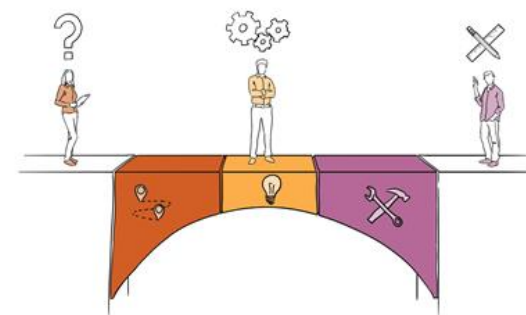
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Caller feedback

“The **value** of this type of **high-level expertise** for the **practicing, busy clinician** cannot be overstated. Your service is greatly appreciated!”

“The Warmline is an **invaluable resource** for me, especially as a doctor at a **community setting** where I really want **access to evidence-based medicine** and the **ability to discuss** these issues with my colleagues!”

“**Very thorough, up-to-date, balanced** info with the **rare gift** of presenting all that without saying there is only one correct answer. Thanks very much for your help.”





Warmline: benefits, value

Comment	Theme(s)
“In a <u>rural</u> practice, patients appreciate services like yours to maintain up to date information/consultation through their primary care provider.”	Isolated provider Staying up to date with HIV medicine
“You are providing a fabulous service, especially to docs like me in a <u>prison</u> where it is hard to find good HIV specialists who will see prisoners.”	Isolated provider
“The HIV Warmline is great for complex HIV issues because my <u>patients cannot travel long distances</u> and thus I must manage all aspect of their HIV disease.”	Isolated provider Complex cases
“As a <u>midlevel</u> practitioner I can’t imagine working in HIV medicine without it.”	Mid-level provider
“I have a few less than 25 patients, and it’s nice to be able to get answers to simple questions that would be a bit <u>embarrassing</u> to ask, and for complex questions where I prefer the advice of the Warmline to my local ID consultants.”	Low volume provider Concern about appearing unqualified in front of local colleagues
“By the time I call the Warmline, I have already used the Stanford HIV Resistance Database, but want a <u>second opinion</u> .”	Experienced provider Complex cases
“I find the Warmline useful when there is not consensus among my colleagues, when study <u>data is conflicting</u> , and when existing data is unclear or difficult, at least for me, to interpret.”	Help synthesizing multiple sources of information Complex cases
“I found the service excellent, and <u>not replaceable</u> with on-line research.”	Superior to on-line resources



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Looking for materials to share?

nccc.ucsf.edu



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CLINICIAN-TO-CLINICIAN ADVICE

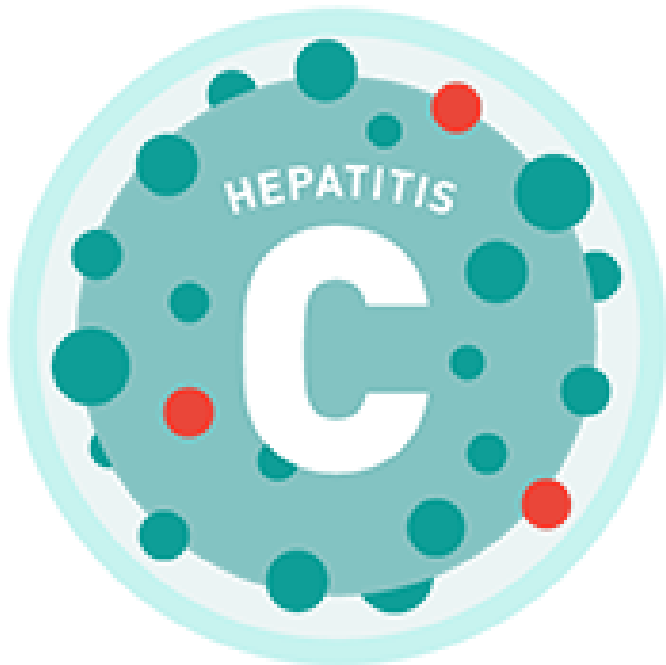
Thank you!

To learn more, please visit www.nccc.ucsf.edu

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Expanding Access to HCV Medications among Michigan Medicaid Beneficiaries

CMS Affinity Group In-Person Convening



Joseph R. Coyle, MPH

www.mi.gov/hepatitis

www.mi.gov/ssp



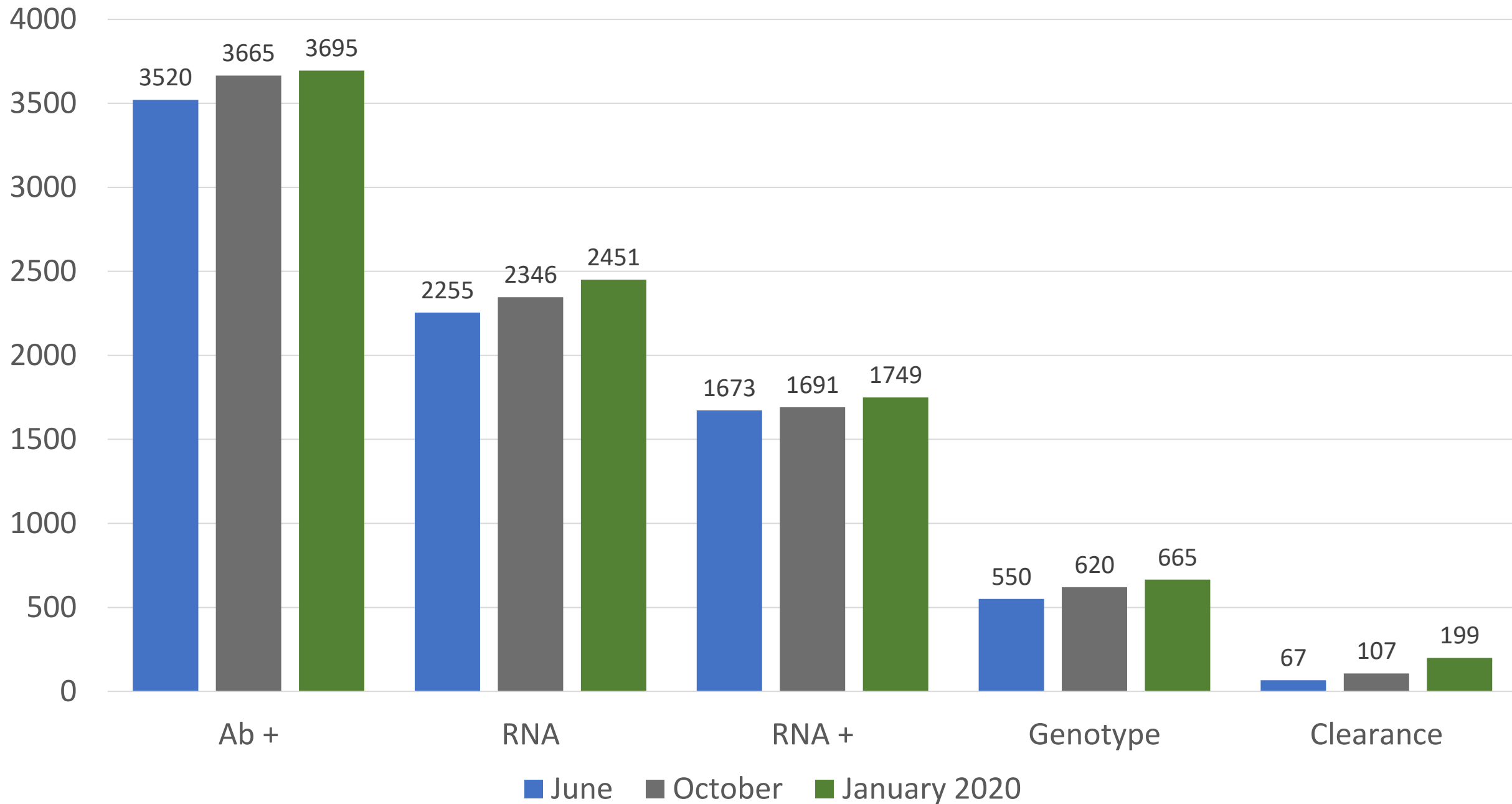
Outline

- Michigan HCV Affinity Group Goals
- Examples of HCV Elimination in Action
- Michigan Medicaid's History with HCV Directing Acting Antivirals (DAAs)
- Using Data and Maps to Evaluate Policy Priorities

Michigan's HCV Affinity Group Goals

- Utilize routinely reportable HCV lab results to measure the cascade of HCV care
 - Match records to Michigan Medicaid beneficiaries to develop a cascade specific to the Medicaid population
- Use big-data machine learning algorithms to passively identify most critical patients
- Use HCV data to identify barriers to HCV treatment
- Engage with policy to evaluate feasibility to modifying HCV prior authorization criteria
- Evaluate prospects of a Netflix-like HCV medication purchasing agreement

Michigan Surveillance-based HCV Cascade (Jan-May 2019 Cohort)



We know how to eliminate Hepatitis C Virus



Prevention

- Harm Reduction
- Syringe Service Programs



Screening

- Assessing persons for HCV risk



Testing

- Lab tests to determine HCV infection



Linkage to Care

- Referral and navigation to a provider who can prescribe HCV treatment



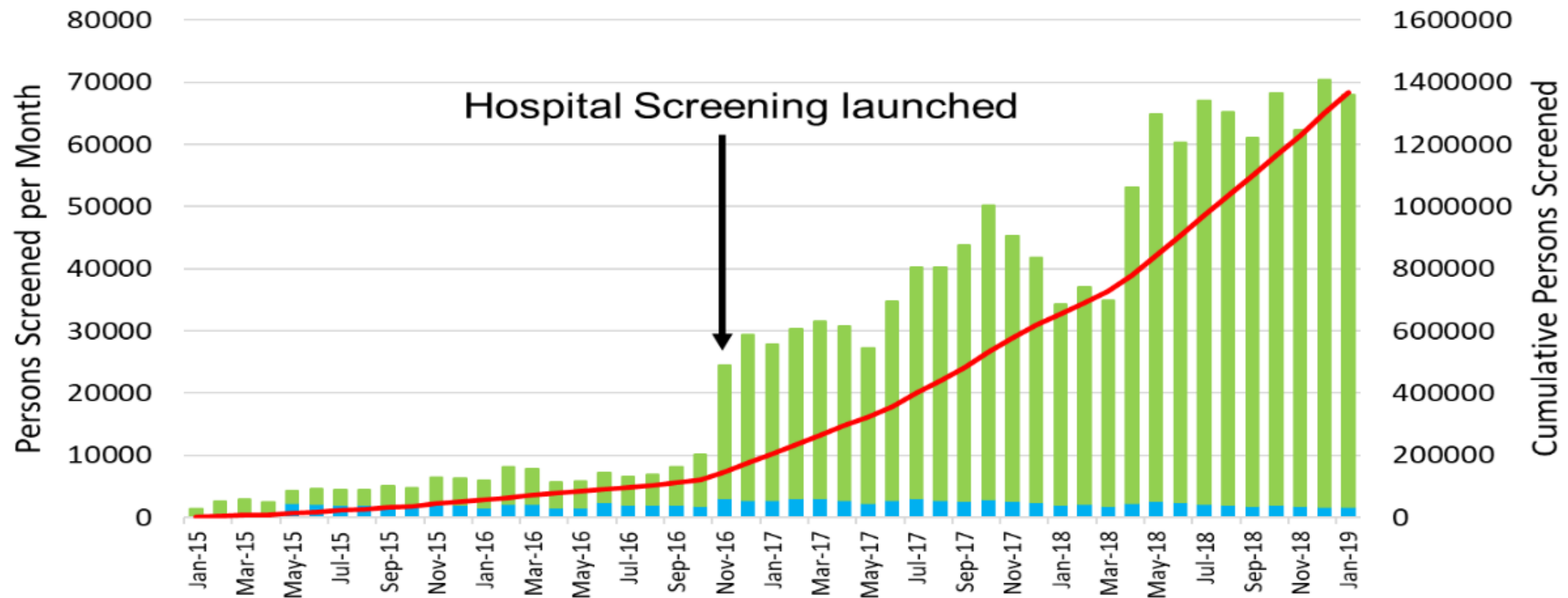
Treatment

- 8-12 week, single pill per day therapy that can cure HCV infection

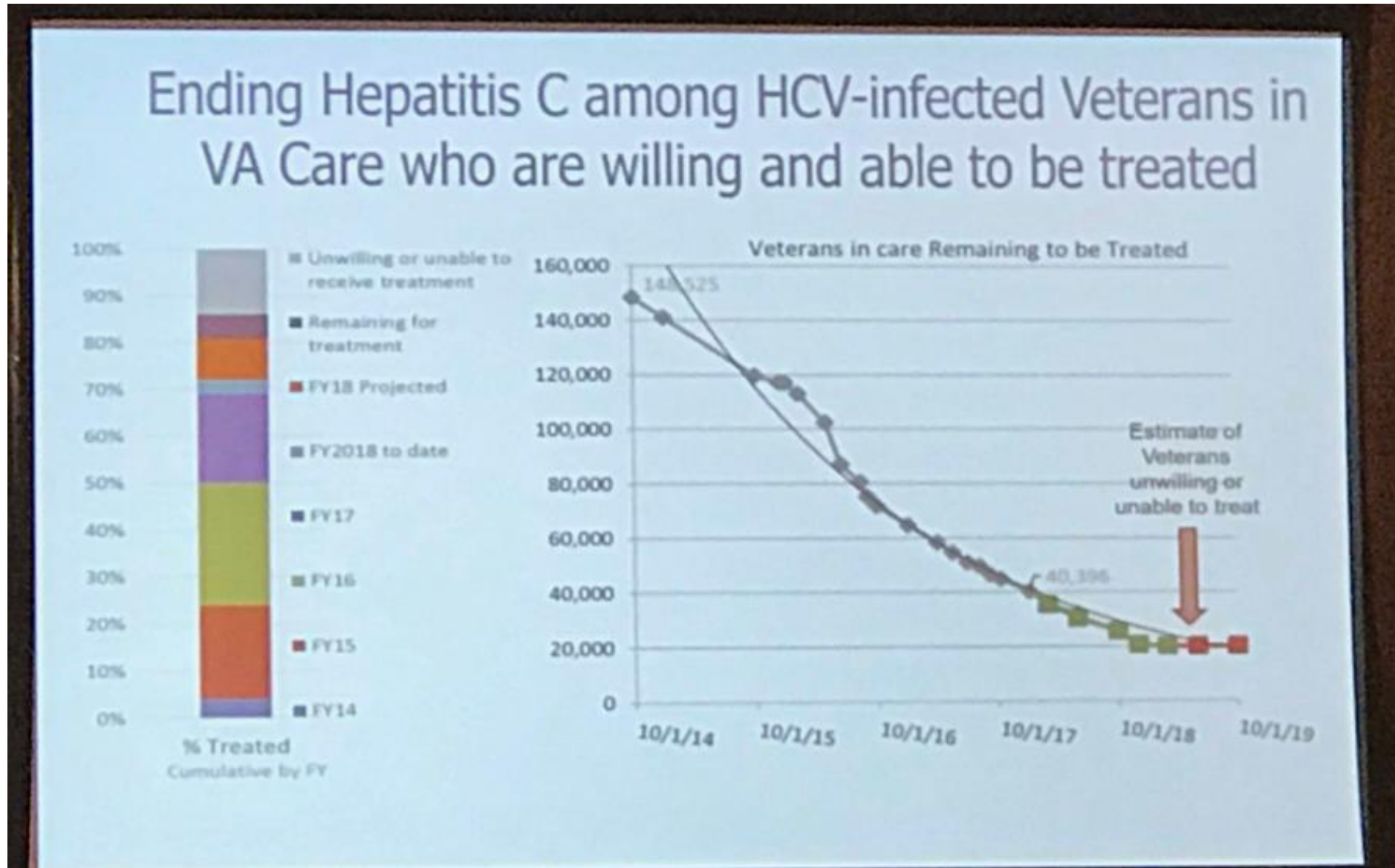
HCV Elimination Can be Achieved

- Some examples:
 - Country of Georgia, Cherokee Nation, Veteran's Affairs

Persons Screened by Month, Georgia, Jan 2015-Jan 2019

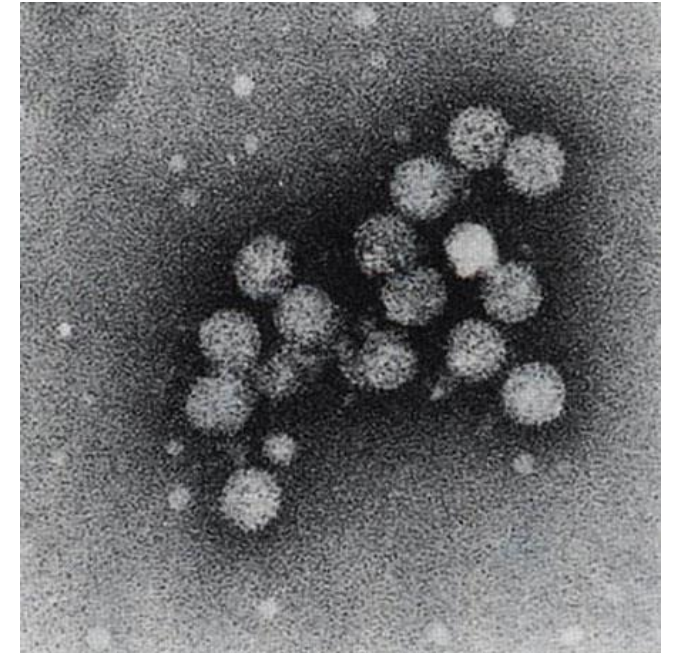


HCV Elimination Can be Achieved



Role of the Public Health Epidemiologist

- To help build capacity towards Hepatitis C elimination by using an evidenced-based and data-driven approach to advise on policy, identify gaps in care, track progress towards goals, and evaluate interventions
- HCV elimination cannot be achieved if there are barriers to patients receiving HCV treatment
 - But unrestricted access to HCV medications (while in the best interest of public health, individual health and is consistent with best practice clinical guidelines) is complicated by efforts to contain costs



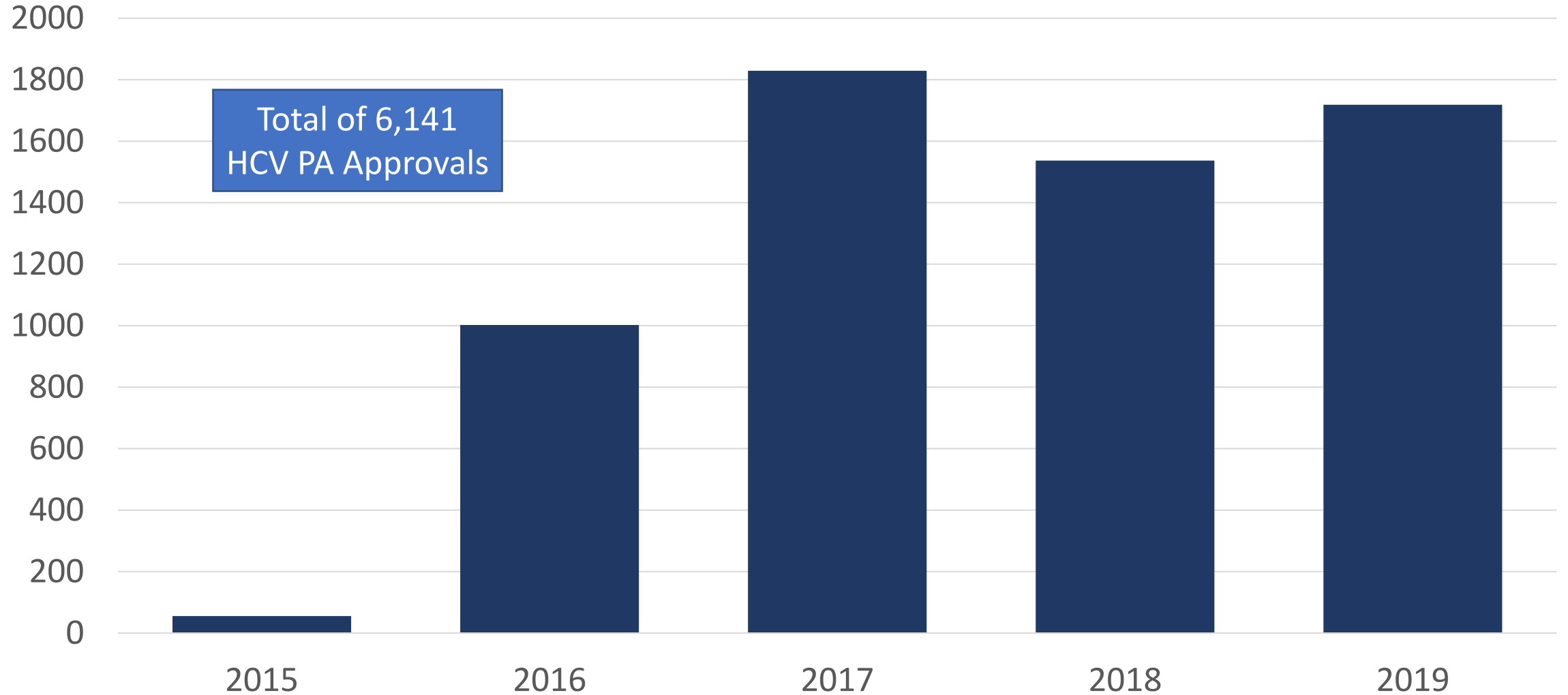
Michigan Medicaid HCV Coverage Background

- Initiated formal coverage of HCV Direct Acting Antivirals in January of 2016:
 - F3/F4 Fibrosis
 - Prescription must be from or in consultation with a hepatologist, gastroenterologist, or ID physician
 - Patient must demonstrate 6 months of sobriety
- 2017 – Fibrosis score lowered to F2
- 2018 – Fibrosis score lowered to F1
- 2019 – Fibrosis score requirement removed

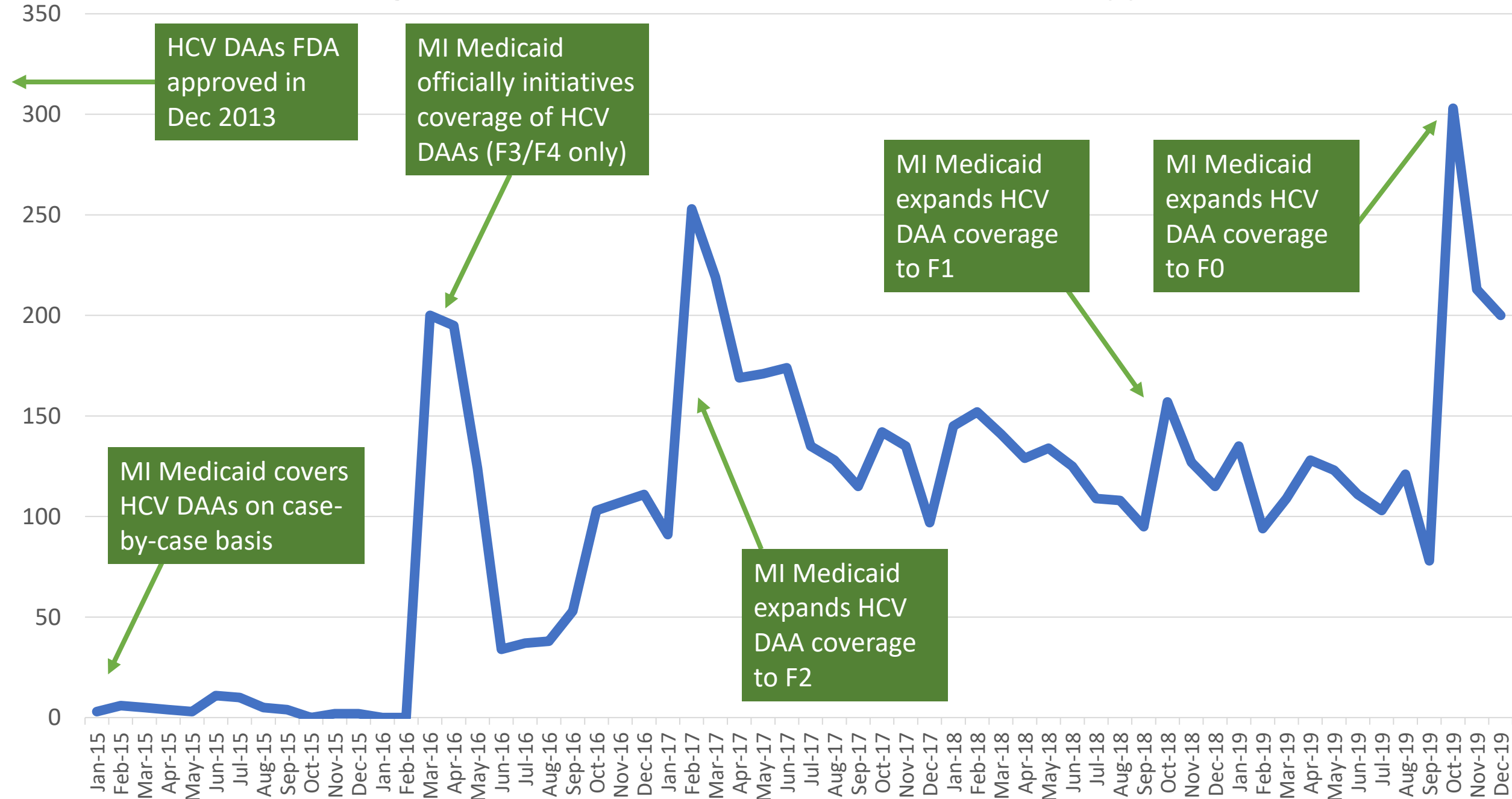


Impact on HCV DAA Approvals

Michigan Medicaid HCV DAA Prior Authorization Approvals by Year



Michigan Medicaid HCV DAA Proir Authorization Approvals



How close are we to getting to elimination?

- Michigan has about **2.5 million** Medicaid beneficiaries
- In 2018, **17,817** beneficiaries had an HCV medical claim
- Around **50%** of persons infected with HCV are unaware/undiagnosed
 - And national estimates suggest HCV prevalence in the general population to be **1-2%**
- Number of Michigan Medicaid beneficiaries impacted by HCV:
 - **35,000 - 50,000+**
- Number of Michigan Medicaid beneficiaries treated for HCV:
 - **6,141 (12-18%)**

What barriers still exist to HCV treatment?

- ~~Fibrosis Score~~

- **Sobriety Restrictions:**

- Documentation of the patient's use of illegal drugs or abuse of alcohol must be noted (i.e., current abuse of IV drugs or alcohol or abuse within the past 6 months) for the sole purpose of optimizing treatment.

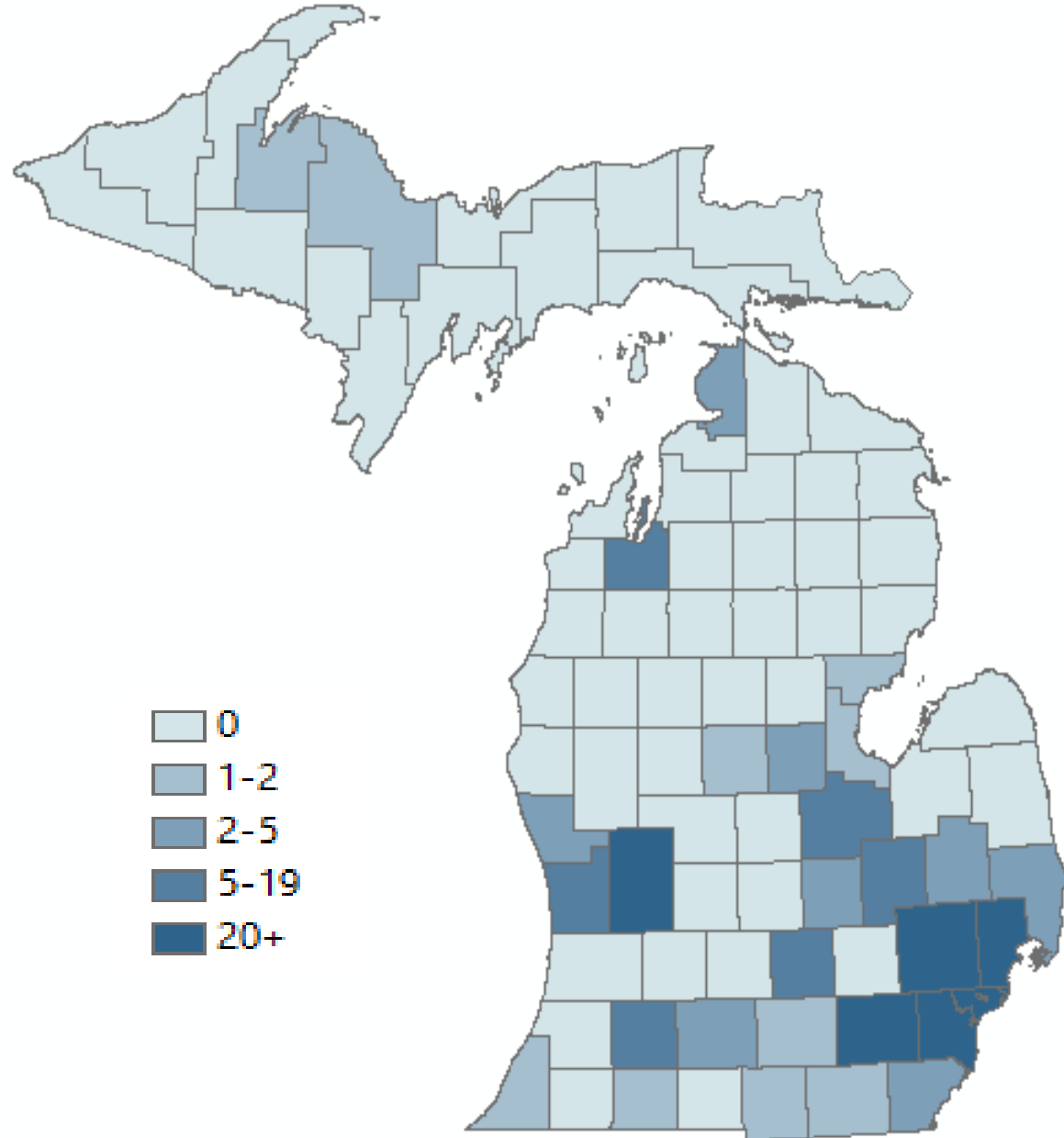
- **Prescriber Restrictions:**

- DAAs must be prescribed by a gastroenterologist, hepatologist, liver transplant or infectious disease physician. If the prescribing provider is not one of the identified specialists noted, the prescriber must submit documentation of consultation/collaboration of the specific case with one of the aforementioned specialists

Using data to demonstrate impact of prescriber barriers

- Anecdotally, we have heard this is a barrier, but how do we show it?
- We sought to map HCV infections as well as where services can be accessed
- Low tech approach:
 - Compare location of HCV DAA PA submitters and HCV surveillance data
- High tech approach:
 - MDHHS partnered with Michigan Medicine to share HCV data from our communicable disease surveillance system by zip code and county to model areas of greatest need

Number of HCV DAA Prior Authorization Prescribers by County, June 2018 - August 2019

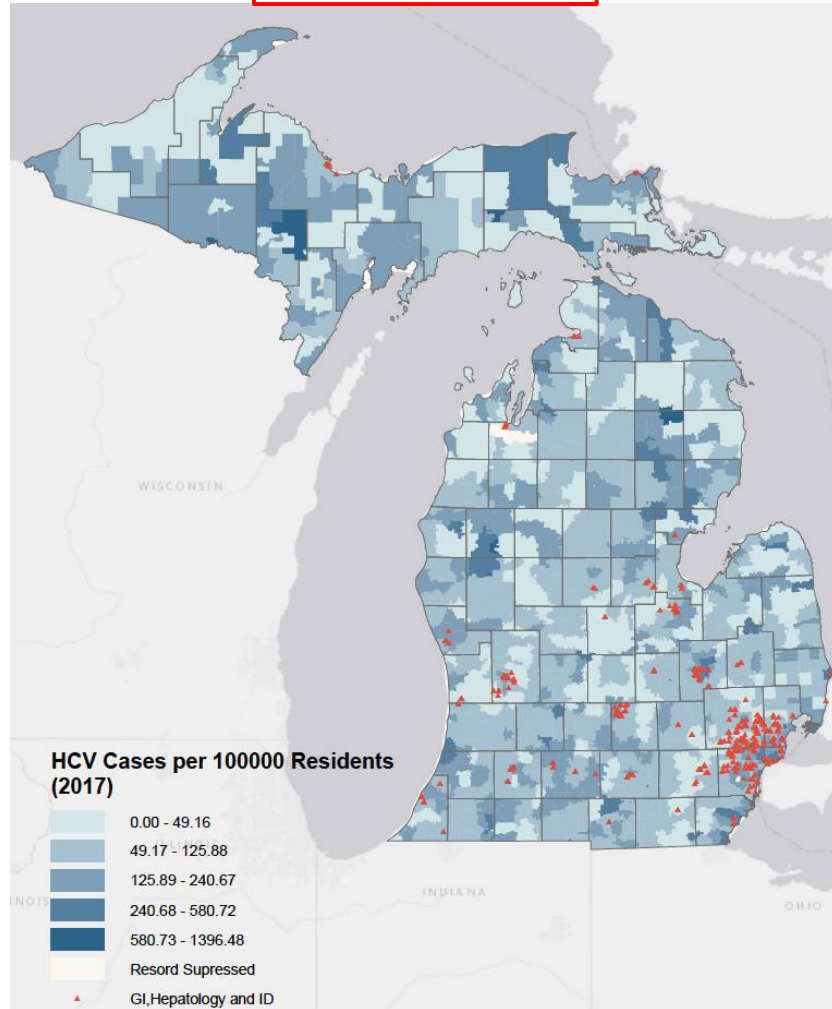


- No prior authorizations submitted from providers in **54** of Michigan's 83 counties (**65%**)
- **3** prior authorization submitters from Michigan's Upper Peninsula
- Since 2010, there have been **~2,800** persons in Michigan's Upper Peninsula reported with HCV

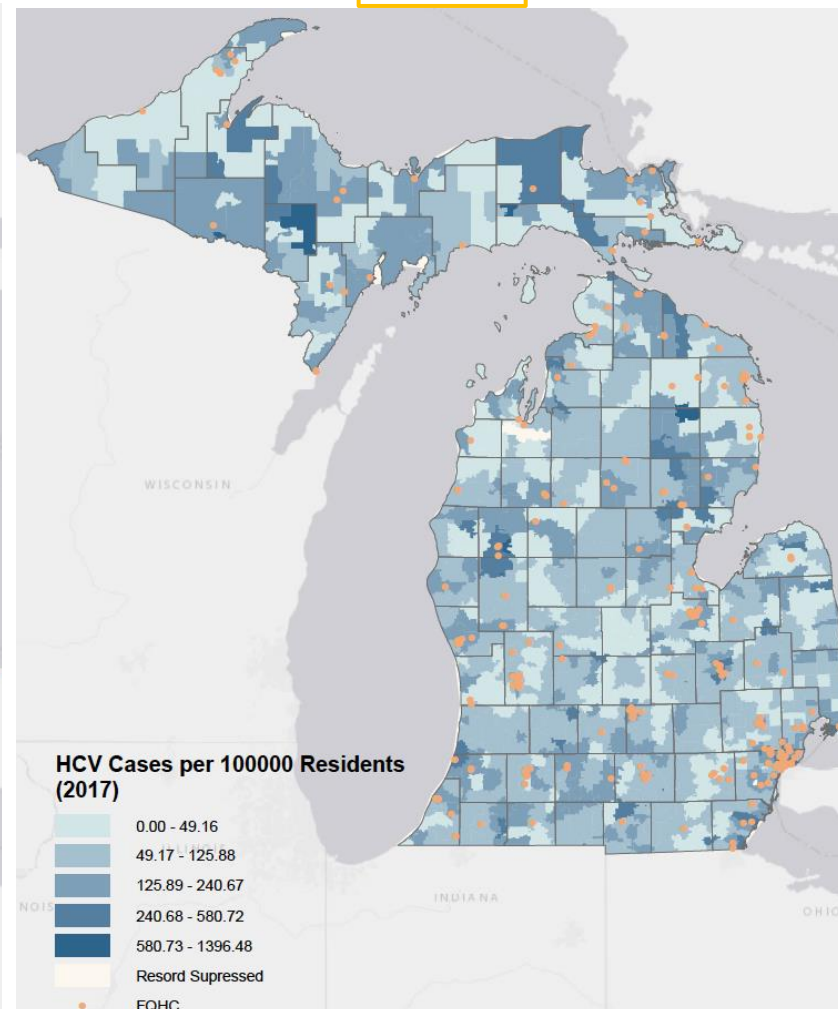
Assess the geographical distribution of HCV treatment providers in relation to HCV hot spots in Michigan.

Identify variables associated with areas of high HCV rates (e.g., drug overdose deaths, rural vs. urban).

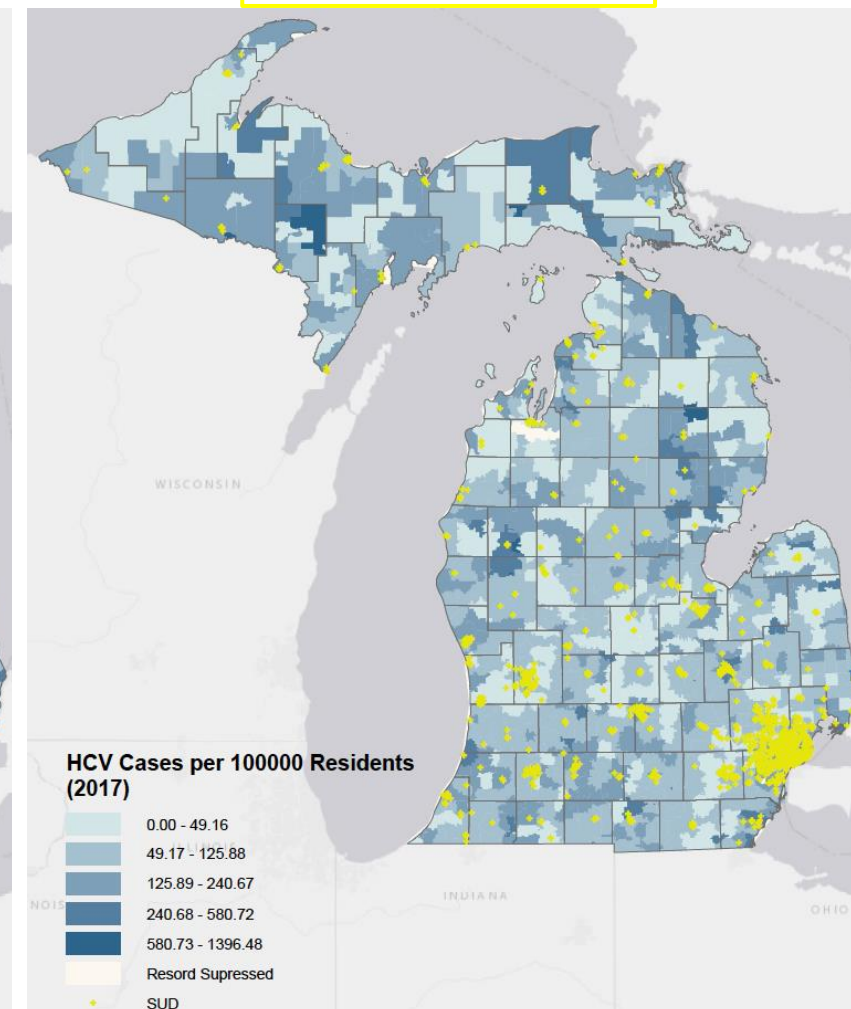
Specialist Providers



FQHCs



SUD Treatment Facilities



Building on these efforts

- 1) Restrict these analysis to the Medicaid population, by matching HCV records with roster of persons continually enrolled in Medicaid
- 2) Inspired by work previously done by Wisconsin:
 - Calculate current drive time to a specialist to receive HCV treatment
 - Re-calculate drive time to receive treatment if prescriber restriction removed
- 3) Identify geographies where the biggest impact could be made
- 4) Assess interest and develop training curricula for non-specialist providers to treat HCV infection
 - Telemedicine consultation model?

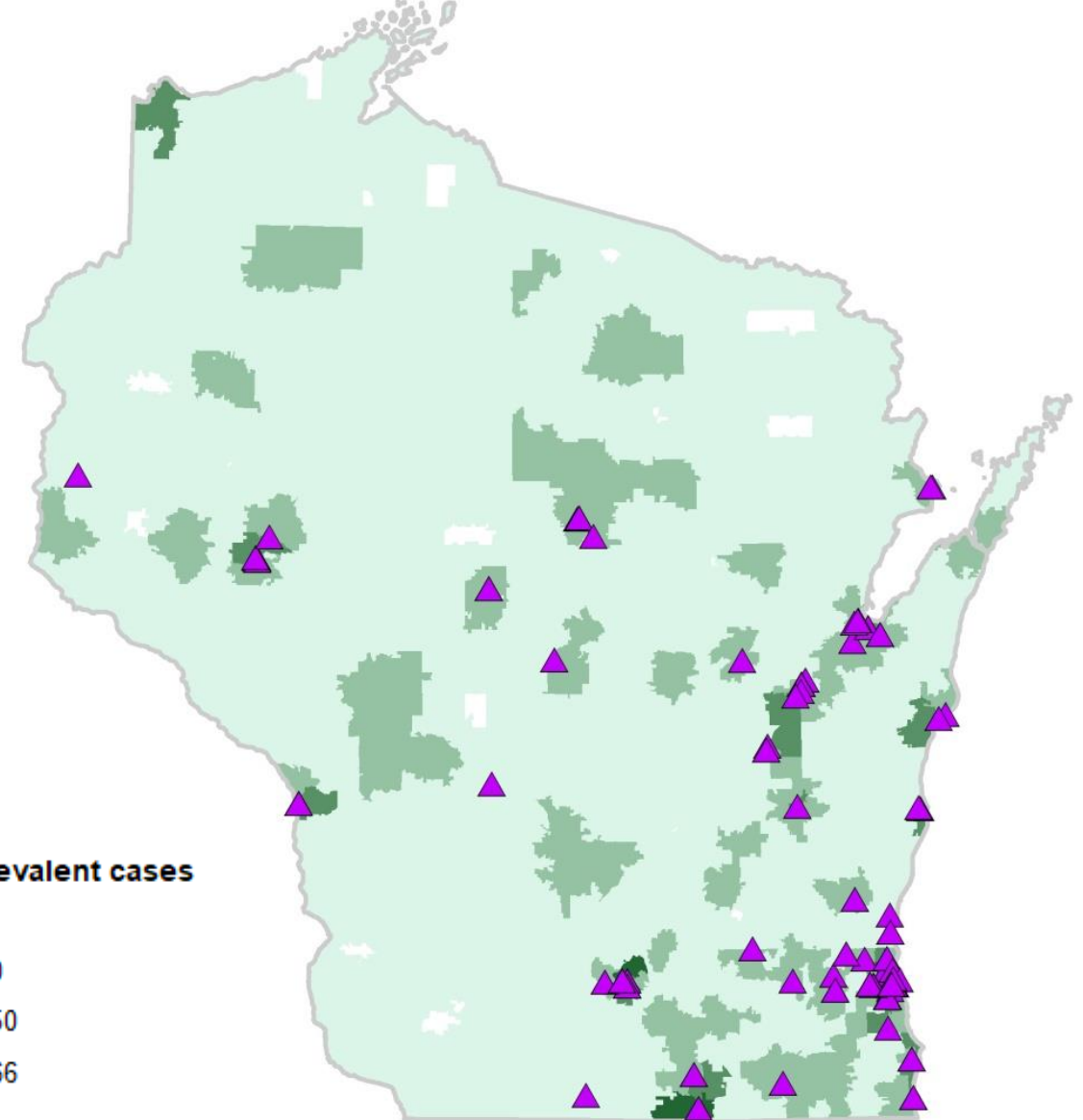
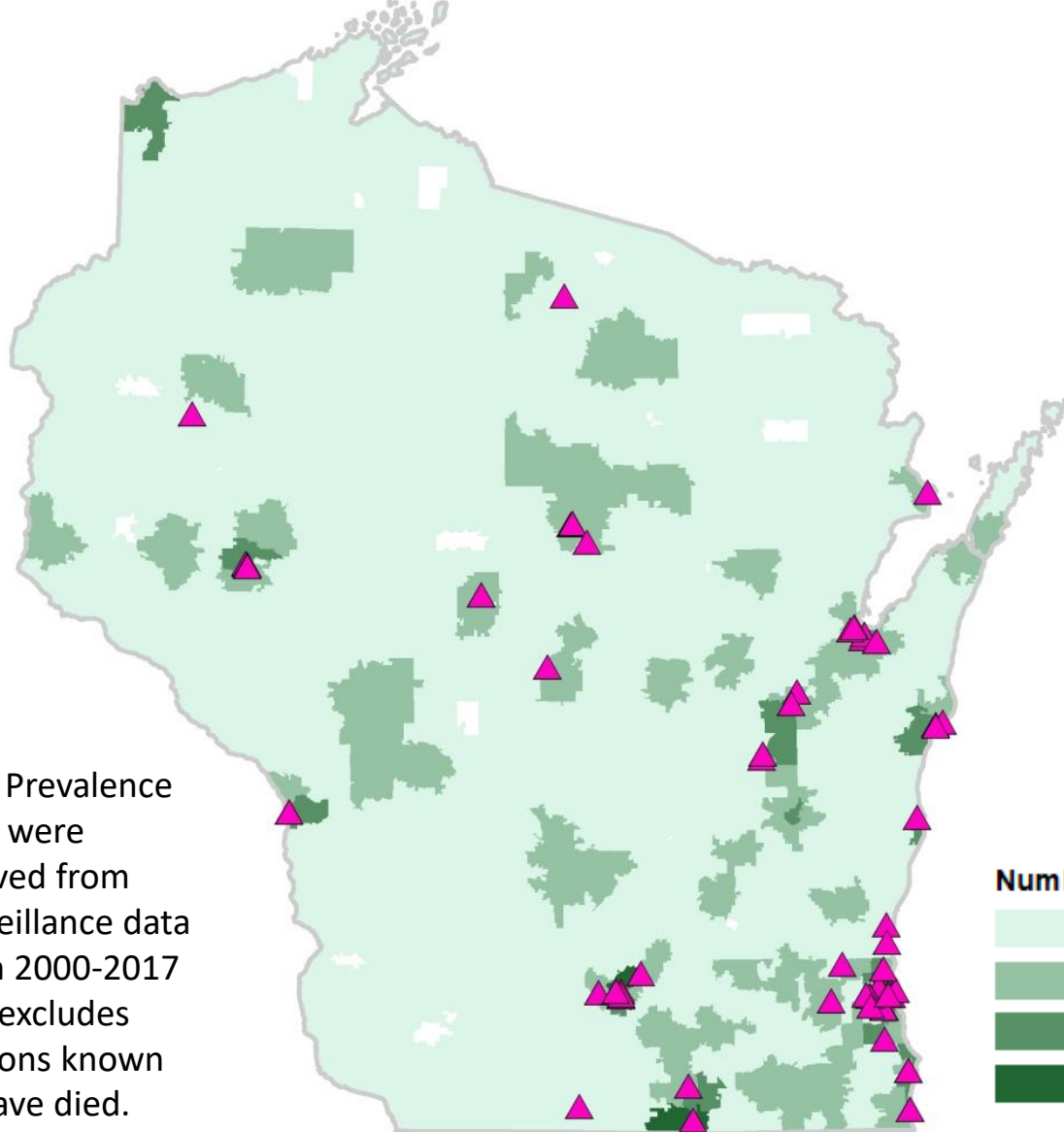
Time 1

120 DAA providers

→ + 58 providers

Time 2

178 DAA providers



HCV Prevalence data were derived from surveillance data from 2000-2017 and excludes persons known to have died.

Number of prevalent cases

- 1 to 65
- 66 to 200
- 201 to 450
- 450 to 866

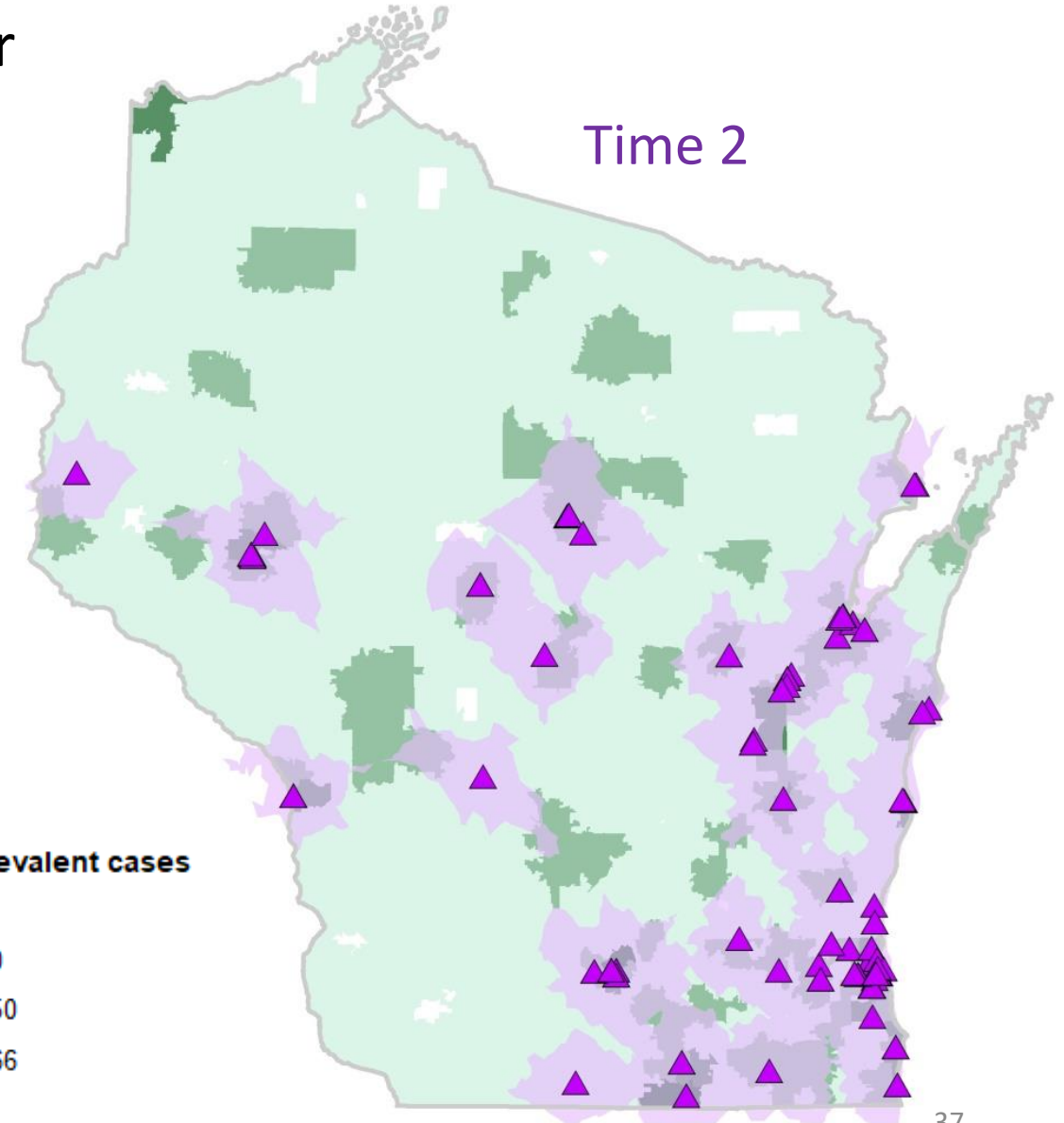
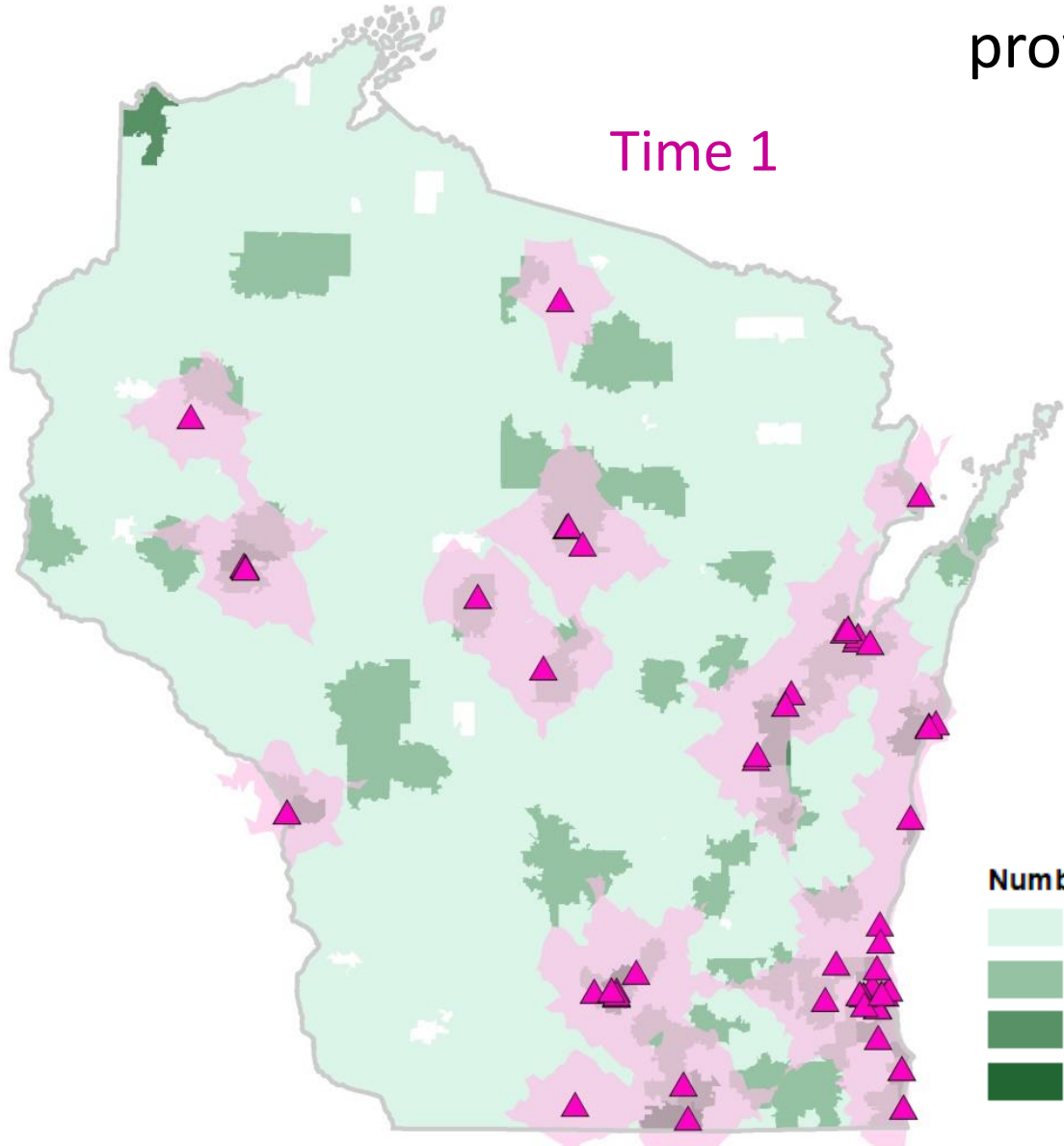
77% lived within 30 min

8,250 cases did not

Prevalent cases living
within 30 minutes of DAA
provider

81% lived within 30 min

6,899 cases did not



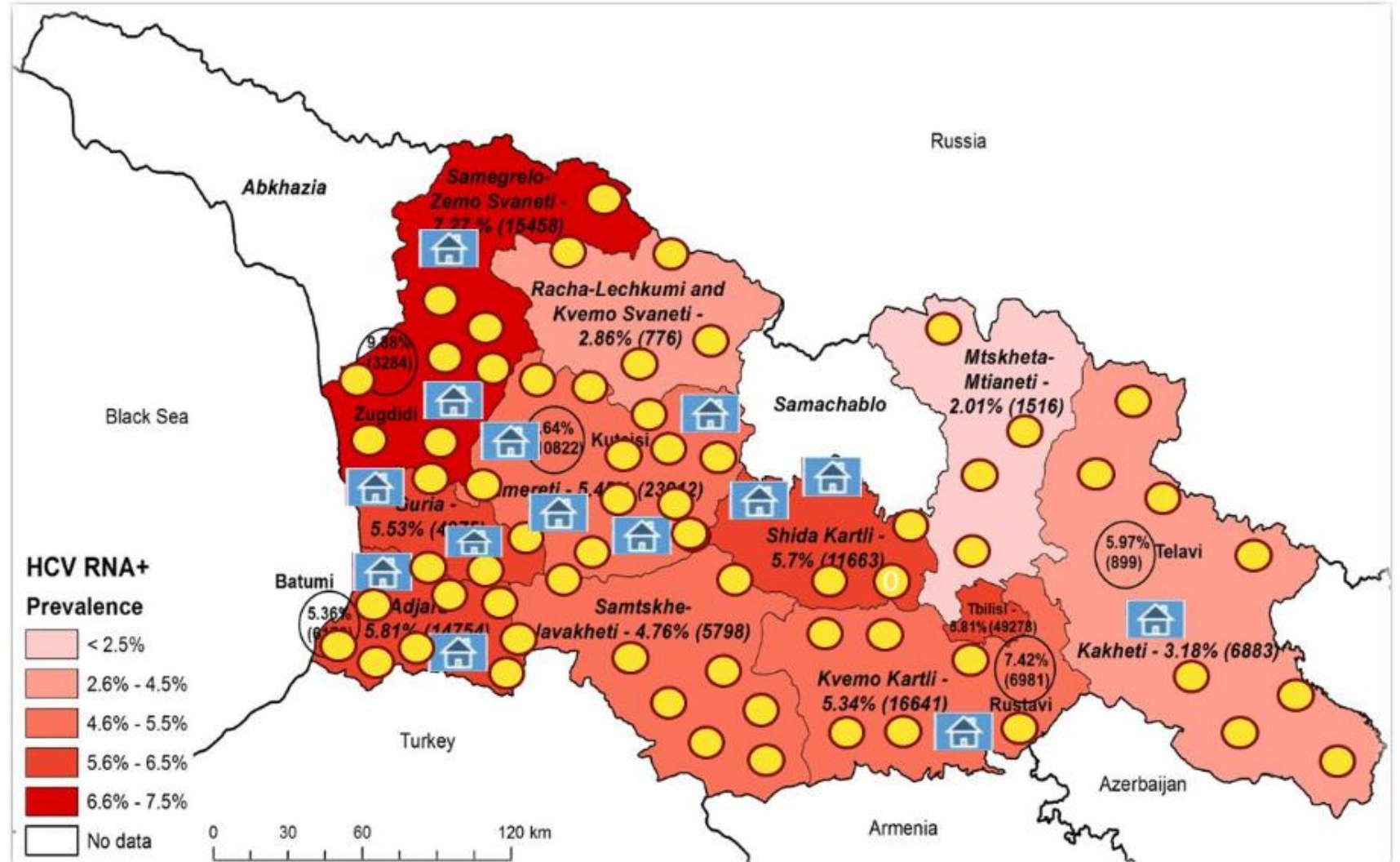
Number of prevalent cases

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Decentralization of HCV Services among Primary Care Physicians, Georgia

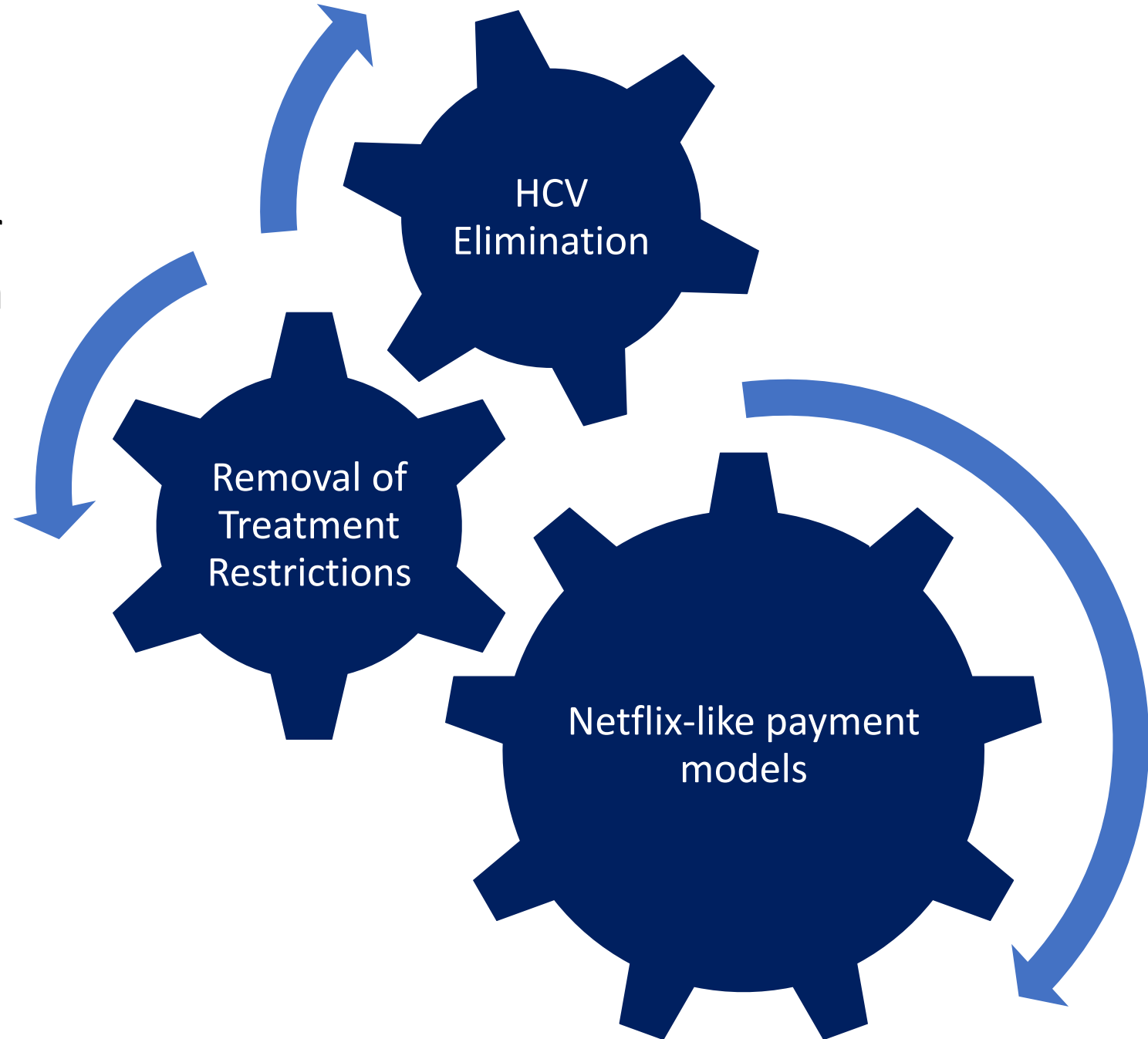
 After Decentralization in all regions and municipalities of Georgia at least one site

 At present -41 sites
 8 regions from 10 and 16 municipalities from 69 are covered



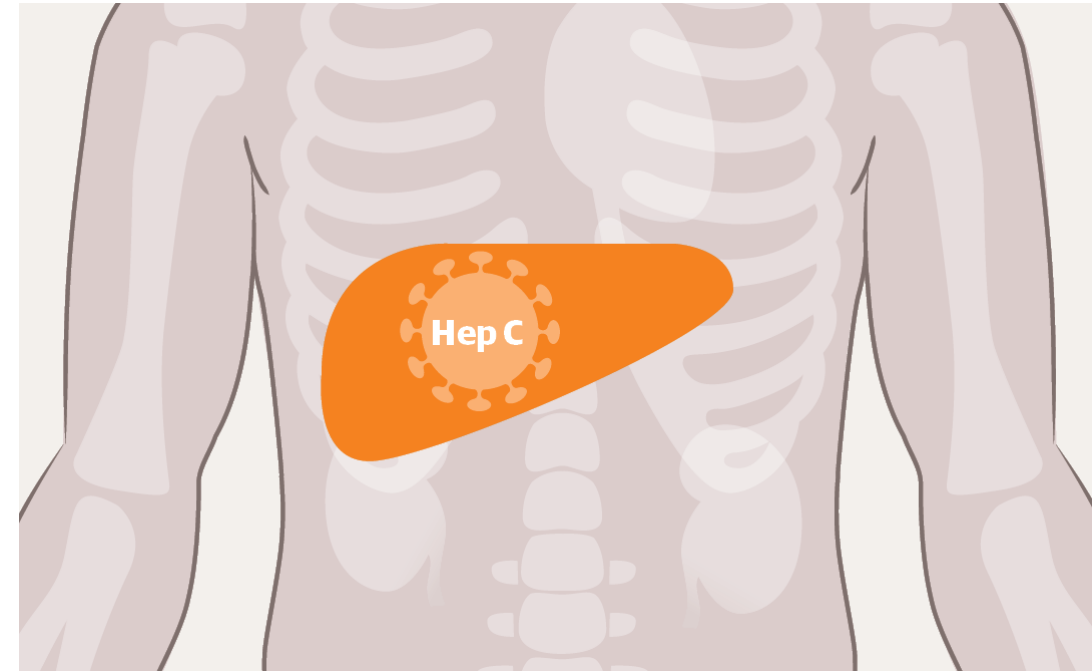
Intersecting Themes

- Netflix-like payment models for HCV can have a huge impact on public health while having cost containment built-in
- But to get the most bang for your buck, there needs to be infrastructure and programs to get persons treated as quickly as possible (i.e. restrictions need to be removed)



Benefits of HCV treatment are clear

- Reduction in cirrhosis, liver cancer, liver transplant, mortality, and HCV transmission
- But the benefits on health and public health are highest when there is little delay in initiation of treatment
- If we continue to treat 150 Medicaid beneficiaries per month for HCV (and HCV incidence is stagnant) it would take us **17-25 years** to eliminate HCV in the Michigan Medicaid population



Thanks! Questions?

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www.mi.gov/hepatitis

www.mi.gov/ssp



Hepatitis C Treatment Pilot: Virginia

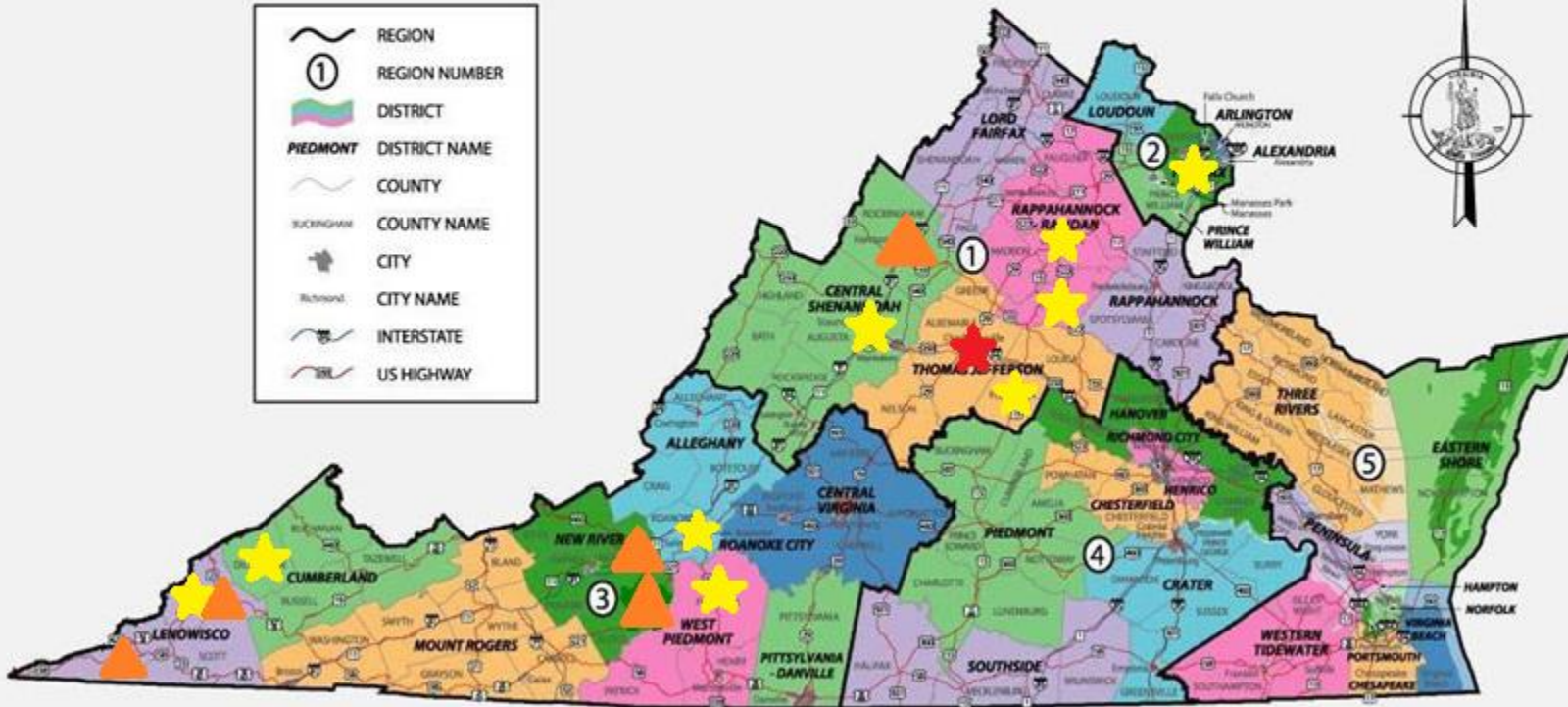
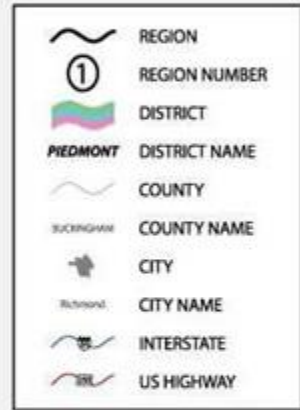
Hepatitis C Treatment Pilot

- Began in July 2018
 - Initial goal: to treat and cure 70 patients infected with HCV
 - Initial focus: Southwest Health Region due to limited resources & vulnerable counties with high incidence of mono-infected HCV patients
 - Contract with UVA included state general funds for staff time (Dr. Rebecca Dillingham and Terry Knick, BSN), labs, & Provider Trainings
- Data through January 22, 2020 (bar graph on next slide):
 - 212 HCV treatment referrals and 181 appointments attended
 - 172 prescriptions written
 - 40 clients are currently “in-progress”
 - 116 patients completed their medication and 51 are currently awaiting lab results to assess sustained virologic response (SVR), there is a 12 week waiting period between the completion of medication and SVR
 - 65 achieved SVR
 - 2 treatment failures due to adherence issues
- 11 Primary Care providers who attended a training are treating on their own and 13 providers attended the training and are using UVA as a referral (Dr. Dillingham is the ordering clinician)

Commonwealth of Virginia - Department of Health

Health Planning Region

① Northwest | ② Northern | ③ Southwest | ④ Central | ⑤ Eastern



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