TRANSCRIPT OF WEBINAR:

WHY INTEGRATED CARE PROVIDERS MUST ADDRESS VIRAL HEPATITIS 7-8-15

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BEGIN TRANSCRIPT:

MODERATOR: Good afternoon everyone, and welcome to the SAMHSA-HRSA Center for Integrated Health Solutions Webcast. [I entitle it] (ph) "Why Integrated Care Providers Must Address Viral Hepatitis." My name is Aaron Williams, Director of Training and Technical Assistance for Substance Abuse at the SAMHSA-HRSA Center for Integrated Health Solutions. And I am your moderator for today's webinar. As you may know, the SAMHSA-HRSA Center for Integrated Health Solutions promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance abuse conditions. [Whether it's seen] (ph) in specialty behavioral health or primary care provider settings. In addition to national webinars such as this one designed to help providers integrate care, the center is continually posting practical tools and resources to the CIHS website, um, providing direct phone consultations to providers and stakeholder groups and directly working with SAMHSA Primary and Behavioral Healthcare Integration grantees and HRSA funded health centers. Before we begin, I want to talk a little bit about a few housekeeping items. First, to download presentation slide, please click the dropdown menu labeled "Event Resources" on the bottom left of your screen. Slides will also be available on the CIHS website at www.integration.samhasa.gov. During today's presentation, your slides will be automatically synchronized with the audio. So you do not need to flip any slides forward to follow along. You will listen to audio through your computer speakers, so please ensure that they are on and the volume is up. You may submit questions through speakers at any time during the presentation by typing a question into the "Ask a Question" box in the lower left portion of your player. Finally, if you need technical assistance, please click on the question mark button at the upper right corner of your player to see a list of frequently asked questions and contact info for tech support if you need

it. So, for today's presentation, we are doing this presentation in partnership with the SAMHSA funded addiction technology transfer centers (ph). This webinar will share information about providing services to people with hepatitis C and to [those at] (ph) risk for infection in safety net settings. You will learn how to address both the hepatitis C related medical issues and the underlying behavioral health issues that increase risk of infection. You also learn about a new resource for continuing education for treating hepatitis C. So our speakers for the day include Marjean Searcy, Project Director, Central Rockies ATTC, Diane Padilla, Program Manager and Senior Staff Trainer at NDRI USA, and Dominique Saunders, Bio Hepatitis Prevention Coordinator for the Kansas Department of Health and Environment. For now, I'd like to turn over to our first speaker, Marjean Searcy. Marjean? [0:03:26]

SEARCY: Hello, I'm Marjean Searcy, I'm the director of the Central Rockies Addiction Technology Transfer Center, one of your partners today for this webinar. Our ATTCs or addiction technology transfer centers are funded through substance abuse and mental health services administration. The ATTCs have a network coordinating office, ten regional centers and four national focus areas, which include Frontier and Rural, Hispanic and Latino, Native American and Alaska Native, and the Screening, Brief Intervention and Referral to Treatment ATTCs. The HCV Current, which I'm going to introduce you to today, is a new initiative for the ATTCs, and it includes an online training, in person training provider tools, and regional and state resources for hepatitis C. Why is the ATTC focusing on hepatitis C? 2.5 to four million people who live in the united states are affected with hepatitis C, especially baby boomers and people with mental health and substance use disorder. Additionally, there's been medical advances recently, and this disease is curable. So why are the ATTCs involved? The ten regional centers that I spoke of are aligned with Health and Human Service regional offices throughout the United States, so that is a really nice combination for this initiative. Additionally, the ATTCs have disseminated evidence based practice into the field for a number of years, and they really worked to advance integration services, so behavioral health and medical services for individuals. And with the health reform, this really is a great opportunity to further work on hepatitis C. So the HCV Current initiative is available on a website where it houses the resources, and you can Google ATTC and get to it that way. It's up under the "Projects" on "HDB Current" or "Hepatitis C." So with that, we can move on the next presenter, Dominique. [0:06:01]

SAUNDERS: Good afternoon, everybody. As Aaron introduced me earlier, my name is Dominique Saunders, and I act as the Viral Hepatitis Prevention Coordinator for the State of Kansas, or rather the Kansas Department of Health and Environment, working within the section of HIV and STIs. This is a CDC funded position, and there are coordinators, at least one coordinator in every jurisdiction throughout our nation. I would like to begin, before I jump into the slides, I should also mention that I currently serve as a member of the Viral Hepatitis C specific stakeholder group for the Mid-America ATTC. And I'm one of the authors of the new HCV snapshot curriculum, which is one of the many products of the HCV Current Initiative that was just

mentioned funded by SAMHSA. So I'd like to begin first by thanking Aaron and his team at the Center for Integrated Health Solutions for asking myself and others to present today. As you can see here, there are a number of webcast topics that we'll be covering today. I don't want to suggest that this is a comprehensive training, however we really intend to give you a really good overview of some of the risks involved with hepatitis C as well as some of the new advances and also how to move forward with this particular type of work. [0:07:39]

So to begin I really want to pose the question - or rather, where do we begin in thinking about engaging our clients in thinking about hepatitis C, talking about hepatitis C, so on and so forth. I'd like to begin by saying that I think it's really important to know that as providers - I know there's quite a few different types of providers on the call today, whether you're clinical providers or providers working in behavioral health or substance abuse - regardless, you're not working in isolation. I want to begin by saying that. There have been numerous federal efforts over the recent years that offer themselves as points of leverage for those of us doing this work already and moving forward toward it. So as you see here, (inaudible) in 2011 the Viral Hepatitis Action Plan was developed under the direction of the Office of HIV and Infectious Disease Policy as a collaborative effort between the representatives of particular participating federal agencies as well as the Department of Veteran Affairs, the Department of Justice, the Federal Bureau of Prisons, and also including the Department of Housing and Urban Development - all very relevant players to be able to pull this together. It was recently updated in March of this year, and the plan proposes several goals aimed at increasing the proportion of persons who are made aware of their current viral hepatitis infection as well as decreasing the number of new HCV infections. Now, there's a number of priority areas within the plan, however I really wanted to pull out ones that I felt were of greater relevance to those of you on the call today. So in doing so, I will mention that the plan seeks in part to address the need to reduce health (inaudible) by educating providers and communities alike, the reduction of viral hepatitis caused by drug use behaviors and the prevention of liver disease and cancer through testing, care, and treatment. Alright, below you'll see on the screen that in 2013 the US Preventative Services Task Force and CBC were able to come together and kind of synchronize their recommendations for HCV screening for those at high risk for infection. And this included a one-time screening for all persons born between 1945 and 1965 - we call this the baby boomer or the age cohort. And this is like we do to the productive (ph) probability of infection within that particular demographic. [0:10:01]

Also in that year, as a result of different surveillance outcomes, the CBC and the United States Preventative Services Task Force synchronized their recommendations in an effort to increase the frequency and availability of hep-C testing, or rather actually all viral hepatitis testing. And the outcome was recommended screening for Hep-C in all symptomatic adults at high risk for infection without any known liver disease or functional abnormalities. So this is really key, and again, one of these leveraging points that we can draw upon, especially as workers (inaudible) to kind of move our effort forward. So I want to take a look at which populations are at risk. And in

doing so, I know that Marjean mentioned a few moments earlier that a according to the CDC, it's estimated that approximately five to seven million Americans are currently living with hepatitis C and at least half of those persons are simply unaware of their status. It's also critical to understand that despite advances in serologic screening and testing in addition to other preventative strategies, there are still approximately 17,000 persons that are newly infected with hep-C in the US every year. We know that it's the leading cause of cirrhosis, liver cancer, and liver transplantation in our country and up to 37% of all infected people in the US will die of HCV related complications if they go untreated. So in thinking about more specific risk factors for hepatitis C, I highlighted here that our two real priorities and those that I will be highlighting today are persons with a history of substance abuse and then again all persons born between 1945 and 1965 or rather that age cohort. [0:11:56]

So another key consideration in thinking about how to engage clients in hep-C screening, of course, is their risk. So again, this is why we need to have a clear understanding. So in thinking about substance abuse, persons with any history of substance abuse - that would include injection drugs, sharing of needles and works even if it was once, even if it was many years ago, also snorting of any type of powder drug, so heroin, cocaine, etc. And this also includes sharing straws and other devices, and we'll talk in a few moments about why that is still relevant. We know that needle puncture exposure is really the most efficient mode of hep-C transmission, which identifies persons who have ever injected any type of substances even once at the absolute highest risk for hep-C infection. Most studies that we have access to at this point report a prevalence of almost 50% or more through injection drug use alone, so a few key points regarding injection drug use - again, it's the principal driver of hep-C incidence, (inaudible) the antibody prevalence among persons who inject drugs or substances is roughly between 30 and 70 percent. Anti (ph) HCV incidence amongst persons who inject substances is between 16 and 42 percent per year. And then also there's a growing epidemic amongst younger injectors - we're looking at the ages between 18 and 29 - that is between ten and 36 percent, so that's quite alarming. [0:13:37]

So, and looking at that age cohort, the folks born between 1945 and 1965, the US Preventative Task Force identified persons as I mentioned before to be at high risk and then again offered that one time hep-C screening...they don't conclusively identify risk factors for this population. And reports and studies show that during the early 80s - because it's a common question is to say, "Well then why? Why this particular demographic?" - there were likely higher rates of injection drug use...syringe exchange programs and of course other harm reduction strategies simply weren't implemented back then. Also we have to consider that universal precautions had not been yet adopted in clinical settings at that time and the current blood screening protocols weren't initiated until after 1992, resulting in further hep-C research. So other persons at risk are all persons with HIV infection. Actually there's (inaudible) guidelines around providing screening for anyone that is infected with HIV and then also vaccination for A and B for folks that are living with HIV. And then also persons presenting any types of symptoms of hepatitis or elevated liver (inaudible).

[0:14:51]

So going back quickly to injection drug use, I mentioned that I want to give you a better understanding of why that prevalence is so extremely high. So we see that, again 30 to 70 percent of injection drug users will acquire hep-C within the first one to three years of injecting. And the reason behind that is because, as you can see here, the hep-C virus can live up to 63 - in some studies - up to 63 days in the syringe barrel or that dead space that you see there, also 21 days in water in a plastic container or other types of containers. And then up to 14 days on inanimate spaces - so this includes cookers, injection surfaces. This also applies to clinical setting however, and we've seen outbreaks of hepatitis C in a number of different environments whether they be dental clinics or long term care facilities and things of that nature. It's just far more virulent than something like HIV. [0:15:52]

So in talking a little bit more about that baby boomer or that age cohort population, with more that 75 percent of infected adults in that birth cohort, it's truly imperative that we work to collectively identify those that are infected. Now like I mentioned a few moments ago, while the reason that baby boomers have higher rates of hepatitis C is not completely understood by researchers, it is believed that the baby boomers have become infected between 1970 and 1980 when those rates were the highest - again related to all the other variables that I just mentioned. So a few other risk factors - and I'll just kind of glean through these, not that they're insignificant, but statistically they are not quite as probable as the (inaudible) target area. So persons who received transfusion or blood products before 1992 - that does tie into that age cohort as well, potentially. Also persons who received clotting factor prior to 1987, persons who are ever on hemodialysis, and then again health care emergency, public safety workers, any type of (inaudible) exposures to any hep-C positive blood. Also, we do know that - I should mention that if you were to go to the CBC and look at all of the risk factors, there are other risk factors involved such as tattooing, body piercing, body art - we definitely see that that's becoming more of an issue, especially dependent upon what jurisdiction you're in and what the regulations are around tattoo parlors and things of this nature. So that is also a risk - it's not as high or as elevated a risk, but it certainly can be. [0:17:45]

So looking at emerging trends, I mentioned earlier that there is a rising rate of hep-C among young injection drug users. We see that over 5 million young people use pharmaceutical opioid medically in this past year. Also there was an increase of HCV infection among young white adults in that age range that I mentioned in both rural and suburban areas, so that's quite notable. So between 2006 and 2012, at least 30 states have actually experienced those increased rates within that youth population, and the overall prevalence of acute hep-C cases amongst people under 30 actually rose from 36 to 49 percent in just that six years. I wanted to provide a quick map of the prescription opioid analgesics in the United States just to further illustrate the growing concern related to opioid use and its connection to injection drug use and of course the increased probability of hep-C and (inaudible). So another emerging trend that we see here, though hep-C has not typically been seen

as a sexually transmitted disease, there has been research that looked at sexual transmission of HCV among HIV infected and HIV uninfected people through sex that is traumatic to tissue, so meaning that there's blood or any type of tearing involved. And then of course there's always concerns around health care exposure for the reasons that I mentioned. [0:19:28]

So I'm thinking about more generalized risk factors. I think it's really important to spend a few minutes talking about a social determinant of health kind of framework, and so in doing that, I just listed a number of factors that could actually increase a person's risk simply because of the environment in which they live and of course it's various implications. So we see that a reduced access to healthcare, also distrust or apprehension of any kind of institutionalized health care system, concentration of disease in a particular area, lack of knowledge regarding both risks and preventative strategies, and then of course a lack of support networks are just a few of the implications. As I mention here, economically disadvantaged, if there's been a history of homelessness, incarceration, behavioral health and/or substance abuse issues. Also immigration from regions of the world that have increased HCV prevalence and then any person of course, with an over representation of any of the above that I just mentioned. [0:20:37]

And because there's so many different risk factors to consider, offering a one-time screening for all populations is a standard of healthcare - this is my little plug - would really simplify integration of hep-C services for clinical settings as well as maximize healthcare opportunities for both the identification and engagement of persons at risk. It's also important to note that while I didn't list it here, we know that black Americans as well as Native American or Alaska Natives are disproportionately impacted. As well as we see higher rates among men as a gender and then depending upon one's veteran status. So in moving forward and looking at kind of the promotion of screening and testing, I wanted to take a quick moment and have each of you utilize the whole (ph) capacity of the system to answer - if you're aware - if your agency is currently screening for hepatitis C. [0:21:39]

MODERATOR: (overlapping voices) So we have the results in, and we have about...57 percent of the respondents clicked "yes." And about 42 percent clicked "no."

SAUNDERS: Ok. And not that I think about it in retrospect, maybe I should have had a C, which is "unsure," right? Because depending upon what capacity we work on in our agencies, we may not be aware of what policies exist. So that's excellent that there's so many doing this work, and even if not, becoming more aware, and then maybe can go back and really see if indeed that's happening, what that looks like within each particular agency. So thank you. [0:22:58]

So in identifying hep-C kind of outside the box, so to speak, in order to increase the identification of people living with hep-C, it's going to be really essential to screen and test for hep-C in non-traditional settings, and please understand that (chuckles) I have a deep appreciation for the

fact that this is simply...um, that not every agency or agency type has necessarily the resources or the infrastructure to do this, but I would like us to wrap our head around the possibility of increasing that in areas kind of outside of the box, as I mentioned. So whether we're in a clinical or a non-clinical setting, we can think about that as kind of missed opportunities. It's to say that regardless of whether we ourselves are in a clinical setting or referring a client to one, there can be opportunities for screening and testing at intake, when being seen for even things like ongoing diabetes care, in a dental clinic, etc. I know in our jurisdiction, there's quite a few people who are seen in a dental clinic in an area that is a high drug trafficking area, and that's where they're catching a lot of the folks that are injection drug users and at high risk for that particular reason. So a few things that I listed here - in obviously our substance abuse treatment centers, sometimes again it may be that you can't implement testing within your center, but even connecting to another community resource that could be aware of who can offer that can be a really beautiful (ph) opportunity for your client or patient. Also medication assisted treatment centers or methadone clinics and things of that nature. Also HIV/AIDS service organizations - for those of you on the call that have done HIV work, especially within community based organizations. HIV...folks working in HIV prevention particularly for counseling and testing, typically in my experience are really trying to offer as much integration for their clients as possible. Being able to...for their clients, especially when there's dual risk and often times even higher risk for hep-C, that's something that really moves their organization forward in what they can offer. So behavioral healthcare settings, homeless shelters, and then of course differing types of healthcare settings. [0:25:11]

It's also key (ph) to promoting hep-C testing - we want to keep in mind that patient factors such as fear, stigma, again lack of hep-C information and relatedness, (inaudible) relevant are things that we really need to consider as any type of providers in order to be able to initiate that conversation around the identified risk behavior for hep-C and then really helps folks to understand what is the benefit to them for screening and testing. We also want to make sure that as we're having that conversation that we discuss the entire testing process and what the possible test results could be and then following that up with provider support, any type of risk reduction counseling and then current treatment options. Again, I have a clear understanding that some of those pieces may not be relevant or possible in particular settings - it's a matter of creatively thinking how you can bridge with other types of providers within your community to offer something fairly similar (ph). [0:26:18]

So I just wanted to point out that there are a number of existing hepatitis risk assessments so you don't have to reinvent the wheel if you're not doing this work yet, or even if you want to augment...or just to kind of see what's out there. So the Center for (inaudible) Disease Control and Prevention and the Department for Viral Hepatitis has, obviously, a risk assessment. And then the state of Minnesota and then the New York State Health Department has excellent hepatitis C risk assessments that can be utilized. There's plenty of other ones in other jurisdictions, but these, I

would say, are most notable. There based upon the CBC recommendations for both testing and vaccination - so good jumping off point. So I'm just going to run through this again to give you a kind of general idea of what screening and testing for hep-C looks like without going into depth over the algorithm. So when screening for hep-C, there's a two-step process. Step one, you have your HCV antibody test, and you have two possible results - a non-reactive or a reactive or what we call a negative or a positive. If indeed that person is positive, they're going to move on to step two, which is an HCV RNA PCR test. The possible results there would be negative or positive, meaning it was detected or undetected...relatively simply. I wanted to point out the CBC has an excellent algorithm, but I wanted to highlight this particular algorithm. This was created by the Mid-America ATTC and is part of that HCV Current Initiative. It's a little pocket card, which providers can put right in their pocket and pull it out - it's two-sided. So again here, you just see that step one that I just talked about, depending upon what the results are, where you would go in the process in terms of confirming what the results are there and then what that follow-up would look like depending on the results. [0:28:11]

So looking a little bit closer at the HCV antibody test and understanding that... When a person is infected with hep-C, the immune system produces antibodies against the virus quite simply. It usually takes the immune system a few weeks to develop enough antibodies to be detected by antibody tests. The HCV screening tests are actually designed to detect antibodies in that window period...or rather that have that window period, and this is the length of time that it takes for an infected person's body, again, to develop those antibodies and then be detected with that HCV screening, which is usually six to eight weeks. So examples of HCV antibody tests currently would be the serologic antibody assays. We have the EIA and the CIA. There's also...OraQuick came out a couple years ago, and it was finally FDA approved to have an HCV rapid antibody test. It's a point-of-care test that can be done in 20 minutes. And it's not oral, so for those of you that have done the oral mucosa swab for HIV, it's a bit different. You use a fingerstick or (inaudible) puncture, something of that nature. [0:29:20]

So step two is the diagnostic process and again, you'll do that HCV RNA or a viral - there's both qualitative and quantitative, and as you can see here, they both provide something a bit different - mainly the quantitative is testing the amount of hep-C in the blood or the viral load, and often times that's what would be opted for. You'll get the confirmation with the viral load count. Some of this depends - and those of you that are clinicians would know this or (ph) work with your labs - there can be a price differentiation, so... So in looking at step two in working, so to speak, with those HCV RNA results, if your client or patient is negative, it simply means that there's no current infection, and sometimes you would recommend that another test be done in six months, and even if cleared hep-C infection in the past, of course we want to make sure that our clients and patients understand that they can get reinfected. If the results are confirmatory positive or detected rather, it's the diagnosis of an active infection, and then again, the next step would be evaluation and management. That individual will need to have genotype testing conducted in terms of being able

to evaluate treatment eligibility and what type of treatment is most appropriate if they opt for that. [0:30:42]

So this is just a quick glance - I'm about to hand it over to Diana in a few moments. I hate to rush through things, but this is a quick glance of the flip side of that algorithm card that I showed you. And what we thought would be really useful for providers is to have both types of test results, positive and negative, and then really some key language to help providers get more comfortable with what that dialogue might sound like with a client, depending upon how that test went. And then on the bottom there, you see kind of just a little boxed reminder of what risk factors are included. So again, just a tool for folks, especially as you move into this work if you haven't been doing it for quite some time. So this is just highlighting the positive aspect of that if indeed they were to be screened and positive. So again, we want to make sure that they understand preventing reinfection. No sharing needles or other injection equipment or anything with blood on it. That can be really tricky, right, because not all jurisdictions have needle exchange programs and things of that nature. But just so that they have that information, and maybe you can even assist them in problem solving. [0:31:58]

Also body modification from a licensed artist - let them know what they need to be looking for when they get bodywork done of any type and what they need to be concerned about. You know, are the autoclaves being cared for properly, so on and so forth and really try if they can to avoid not going to a licensed person and things of that nature, making sure that they're using a clean needle every time, so on and so forth. Also vaccination, it's something quite simple and really can assist...co-infection is not something that we want our clients to experience. And then safer sex practices, getting treated for STIs or STDs is a key component of that. Folks that have a history of sexually transmitted infections are at a greater risk for acquiring other sexually transmitted illnesses and are more susceptible to hepatitis C. I did get a question - before I move on - related to the pocket card that we looked at. those are available. I don't have those available, but they are available through the ATTCs, and so what I can do is send (ph) some information onto Aaron about how you might acquire some of those. So thank you for the question. Um, counseling the person with HCV - it's important... Not all clients... Diana's going to talk in length about new treatments, kind of the old gold standard and how we've moved forward and pipeline drugs and it is a very, very exciting time, and I know she'll do a wonderful job at really increasing your understanding, your motivation around that. However, not all clients will have the resources and/or...it just may not be appropriate. Regardless, I think it's important that we highlight for folks that there are certain lifestyle options that can have a huge impact on their overall liver health even if treatment is or is not a relevant option at that moment. So we're just saying that abstaining from alcohol is truly key, and if somebody struggles with alcohol abuse or addiction then, you know, then we can use really a harm reduction manner, you know, the least amount - if they can even reduce (inaudible), it's going to be significant for them. Also maintaining a healthy diet. Again being vaccinated for hep-A and hep-B, reducing the intake of certain painkillers, even things like

ibuprofen can be really damaging to the liver, especially if you have hepatitis C. And then also just getting a particular amount of daily exercise. I always laugh when I read these, because I think, "Well I think almost everybody could (laughs) benefit from these regardless of their living with hep-C or not." [0:34:38]

So I'm going to stop there and hand it over to my wonderful colleague, Diana Padilla, and she's going to talk to you more about the treatment landscape and what treatment looks like, so Diana, please.

PADILLA: Thank you, Dominique. Thank you Marjean (inaudible), Aaron, the whole team. I'm really privileged to be here and presenting with all of you. So I'm program manager at NDRI USA. We're a behavioral resource and training organization. I also serve as the hep-C specialist for the Northeast Caribbean ATTC, so that's housed here within NDRI, and we cover the regions New York, New Jersey, Puerto Rico, and the Virgin Islands. So...we were delighted we were part of this whole Hep-C Current Initiative where we developed all these products, and we were tasked with writing and developing the face to face curriculum. So everything that we're giving you here is current information, but it's just the overview is perhaps even understated because we have so much information to give you. There's so much more when you look at our products and what we can do and where we can go and facilitate a lot of these initiatives for free at your site, so that's something to consider for when Dominique goes over the resources after I'm done with you for a little while (laughs). So I've been in the of public health for over 18 years, but I've been able to develop or rather focus (inaudible) over the last ten years on hepatitis C. So this is really exciting for me, understanding that when I was working with clients at a time where traditional treatment was very...had such huge or expensive, intensive adverse (ph) effects and it was such challenge to get folks to treatment, and when you're counseling patients or clients, and providing hope is very, very limited. It was a really hard sell back in the day. So this is a very different time. So we do have a few things to talk about, and I will do my best to keep to keep within the time line. The best thing that all of you folks that attend this have is that you can download this information, plus we'll give you the other resources at the end. [0:36:48]

In terms of advancement for HCV treatment, I think for the average person, the average practitioner, I think the first thing we think of is the effectiveness of the treatment medications that are out there today. But advancements in treatment has also helped practitioners facilitate the clinical process for patients a lot more effectively. So there are advances in different areas that have helped us do our job even better and help make it just slightly easier to help motivate patients to be linked to care, and potentially to treatment and a cure. So some of those include...what some of the criteria is not in terms of treatment and eligibility. And I know Dominique spoke about it a little bit, and so you see some of it here. Let's have a look at the little enzymes. Um, function (inaudible) - these are different biomarkers that we see in the blood that we need to document (inaudible. The viral load, the genotype all have to do with understanding what type of

treatment...if a person is recommended to have treatment, what kind of treatment they have, the different medication, the different therapies available are contingent upon genotype, plus the other biomarkers. So some of the advancements that we've been seeing now for the last two or three years have included how we assess the degree of scarring in a liver that has already progressed with the liver disease. So traditionally, it had always been liver biopsy, so that's an invasive process where the practitioner will go in and actually insert a biospecimen as a marker to assess the extent the of liver damage in the liver. Now we have other opportunities available, so FibroSure is a serum assay or blood test that can help take the place of a liver biopsy, and collectively with these other criteria items, will give a very accurate diagnosis to the physician as to staging the progression of liver disease. There's also FibroScan, which is an electronic elastography - I always get tongue tied with those. What it is, it's just an imaging process that measures elasticity, so when the liver is pretty healthy, one of the many things that it does, it's pretty filtrous, it filters out the blood, it cleans it out, it redistributes it throughout the body. So understanding how elastic the liver is really correlates with the scarring amount that a liver might have in terms of where they are in their disease progression. So FibroScans can be very helpful. The thing is not everyone has it yet. It's still inexpensive...the way to go in terms of getting these machines and getting these assays in place, but a lot of clinical settings are starting to do that. Plus, the criteria for treatment eligibility also includes cancer screening. The nice thing about that is that screening cirrhotic patients for cancer can give a practitioner doing it regularly every six months - we may be able to pick up on someone who might be getting close to end stage liver disease and be able to put them on the transplant list a little sooner, perhaps treat them while they're on the transplant list. [0:40:16]

So these are part of the advancements that weren't traditionally around back, say, before around 2000, 2001 when we were so limited with the information we had, so limited with the clinical processes we had available to us. Another change has been - and this is for anyone who hasn't done a hepatitis C webinar or training or online course in quite some time. Sustained virologic response is when a viral load test is conducted and no virus is found. Traditionally, this always happened, this was tested at the end of treatment completion and then 24 weeks afterwards. What we ideally wanted to find is also no virus found after 24 weeks of completion. So we've known and gained so much knowledge and have advanced as far as our capacity in terms of hepatitis C knowledge that we're able to understand [it is] (ph) accurate if we read it at 12 weeks. So 12 weeks after treatment completion, an SVR typically indicates a cure. So that's no virus at all. So what these treatments have helped to do is reduce liver failure, cancer, liver related deaths, so mortality is of course understandably impacted. Another challenge in terms of counseling clients and getting folks into treatment or into healthcare and potentially treatment - [all therapies] (ph) We no longer have the interferon injections to deal with. Also therapy is short in duration, so it can be as short of a time frame as eight weeks...up to 24 weeks, which is different from 46 to 48 weeks with previous treatment regimens. And another important factor is the treatment tolerability. It's a very, very different era where the treatments are not only effective, but the side effects or what we in the clinical setting call, "adverse effects." They're very tolerable, they're very minimal for most

persons, so it's easy to stay on treatment. So supporting patients and clients on treatment - it's a lot easier today than it was, say, ten years ago. [0:42:32]

So I think I'm going to take just a minute to really focus on this, and I'm going to see how I'm going to navigate through my time frame for the next several slides. I think this one is really important to understand the time line. The first (inaudible)...this time line I have here shows in 2001 the peg-interferon injections and Ribavirin that were the traditional...it was the standard treatment for genotypes 1, 2, and 3. In this country, we see 75 percent of...genotype 1 is 75 percent of what we see here. But we also see 2 and 3. And traditionally, those were easier to treat under...you know with peg-interferon and Ribavirin. But those injections and the combination of Ribavirin for low platelet counts were always challenging. At that time, successful outcomes were ranging between 45 and 55 percent. So it was a really hard sell to encourage a client to understand why the clinician is recommending that they go on a treatment, that they may have to undergo very severe side effects, particularly if they've seen other people in their circle, whether it's the neighborhood, the family, or their social circle having gone through this process and not go through an easy time. So those were part of the barriers that, as councilors, we had to deal with. So it was a particularly hard sell. And then after that, they had roughly a 50/50 chance of eradicating the disease - because that's what we called it then. We weren't allowed to say at that time. So we were very excited around 2011 when peg-interferon and Ribavirin would have a third treatment, a third medication that could be added and would increase the success for outcomes anywhere from 30 to 35 percent. That was exciting. Practitioners were waiting on this to be...knew that this was coming down the pipe, and they were waiting for it to be approved. The interesting thing that happened - and we started to see it within the first several months of folks getting treated with boceprevir or telaprevir - was the side effects, the adverse effects were almost as intense or worse than the traditional treatment that was the old standard treatment for 2001. So come to 2013, simeprevir and (inaudible) came out, and the adverse effects were minimal. The effectiveness were even higher than usual - they were over 90 percent successful outcome rates. So (inaudible) and simeprevir were two medications that came out and were very effective with genotype 1, and it seemed that genotype 1 was easier to treat. [0:45:10]

So you had other opportunities (inaudible) for genotypes 2 and 3. But the biggest issue we've seen then and we still see today is that the insurance started to be one of the biggest barriers. Accessing treatment because it was so costly started to become the biggest hurdle to get over. So in 2014 in October and November what we saw was Harvoni, the sofosbuvir and ledipasvir were approved. Um, minimal side effects. The duration of treatment was short. It didn't include interferon, which was wonderful, no injections, all oral therapies. And (inaudible) genotypes 1, depending whether they had got treated unsuccessfully in the past or they were new to treatment - you had options in 2014, including the 3d (ph) regimen with or without Ribavirin, which is really the (inaudible) for medications. So these two - these three actually - these are currently the latest philosophy in terms of treatment. [0:46:17]

So things are so much more exciting now because we do - We've been saying "a cure" for the last few years. The challenge is still how do you like folks into care into care to get them to this cure, how do we access the actual treatment itself? So in order to understand what I'm going to say (inaudible) in terms of treatment eligibility, part of the clinical evaluation slide that I presented initially also had...understanding the severity of liver damage or the amount of scarring that any given person who's infected with hep-C would have. So I wanted you to at least have a quick view or have this in your slides. I'm not going to explain it too thoroughly...um, about what can happen to the liver in the course of 12, 15, 20 years. Now a lot of folks who will go into healthy liver... A lot of folks who have hepatitis C who aren't aware of the infection - it has a lot to do with the fact that this has latent characteristics. People who have a headache who take aspirin, they take it because they have pain and the head is throbbing. People who have hepatitis C infection most times don't know that they have it because there's no observable symptoms for that patient - there's no symptoms of fever, there's no symptoms of physical disability (inaudible). It's pretty asymptomatic. It's not until it gets to the third and fourth diagram here where it has liver fibrosis and cirrhosis where clinical evidence of infection may be present, which is like flu like symptoms or the elevated enzyme levels that Dominique (inaudible) was speaking to. [0:47:46]

So understanding this has a lot to do with how the insurance coverage or how the payers - let me just refer to them that way - how they dictate who gets treatment, who gets approved for treatment and who doesn't. So currently - and this is going to change because there's something r(inaudible) that I have to let you know about. Currently, what it has been, the highest priority for treatment has been given to folks who have either an S3 - if you look at the slide, and S3 severe fibrosis or and F4 (ph) cirrhosis. So advance of scarring is at severe fibrosis and this is part of the criteria for treatment approval. It's part of what the documentation had to be at, and currently there are 532,000 people. There's also another high priority of folks - 500...5...13,000 who have F2 but have co-morbid issues. So these folks are the ones who have taken priority according to the most recent treatment recommendations. So this sets (ph) a lot of folks who may be unaware of their infection who we would start to screen and link them to care, but may not have access to treatment because they don't fit the current criteria. The idea here is to get you folks to understand how effective treatment is. So these clinical trials - there's a couple of slides here - folks who have not been treated before shows how efficient these...um, Harvoni and (inaudible) are. The ledipasvir and sofosbuvir and the 3D plus R which is Ribavirin. And then you have another slide here. In the interest of time, I'm going to just browse through this very quickly. So it also shows how effective it is for people who have gone on the treatment before and were not effective, and could not eradicate or cure the hepatitis-C infection. And this is what it looks like right now where this is the efficacy, the rates of efficacy for the different treatments that are available. Harvoni - up to eight even weeks, someone with less than six million universal units of viral load, which typically might be between F2 and F1...you know can actually get a short treatment time frame and get cured. Now I wouldn't actually think that this would be somebody who may not have to worry about insurance

coverage, but for most folks...might need 12 weeks of treatment and...or up to 24 weeks if they need a double regimen, if they were treatment experienced before, they might have to go to one round of treatment for 12 weeks and then do it again for another 12 weeks. And they achieve the SVR or the cure. [0:50:24]

So more for you to look at. I kind of want to get through this, because I really want to talk about something very specific here. The nice thing about advances - this is another thing that has changed. Back in the day...so when I say that, I'm referring to like ten years ago with standard treatment options before we knew as much as we have in the last several years, HIV and HCV co-infection was a very difficult, um, infection to treat...people who were co-infected with HIV was a very difficult thing to do. The standard today, it's still recommended that the consultation and the treatment process happen between the collaboration between the HIV practitioner and the HCV specialist. And drug interactions should be assessed for obvious reasons. Some of these HCV treatment regimens do not necessarily work well with HIV antiretrovirals. But the wonderful thing is that the recommendations for someone who's mono-infected or only is hepatitis-C infected it's the same recommendations for someone who's co-infected. So their chances of achieving an SVR is just as well. Now what I want to do is just let you know, these are the current costs of medications, and you can follow up with some of the references down at the bottom. Traditionally, most insurance required that the patient be at an S3 or F4, advanced fibrosis or cirrhosis, you had to prove or send documentation that if a person had a history of alcohol or substance abuse that they would have been free of alcohol and drug use for at least six months. And they also had required that the physician...the general practitioner would be experienced with treating hepatitis. So this has changed a little bit in terms of...right now, what I'm going to ask to send you all is - I was just made aware this morning about how the recommendations have changed. Back when we were saying that the highest priority have gone to folks with S3 or F4. Now the experts are dictating that everyone who's hepatitis-C infected would benefit from that. This as part of the current HCV (ph) guidelines that practitioners and insurers or payers go through, follow, can change how we access treatment or access coverage for treatment . So I really encourage you to look for information on that within the next few weeks. So it really should update what I'm presenting here. I'm not sure exactly what it's going to look like, but it's really promising. It really speaks to how we're going to be able to access more...get more folks into care, but more folks into treatment, and not have to get so sick before you get the actual medication. [0:53:17]

So these are treatment resources in terms of copay programs because while the insurance pays the majority, there's typically a co-payment process for a lot of our folks who are insurers. Pharmaceutical companies also have resources payment programs. So I think what I want to do is take the last minute just to tell you that...just to show you what's here. I'm not going through... In terms of addressing hepatitis C... In terms of accessing a hepatitis C practitioner, you have - this is a wonderful website from the American Liver Foundation. You can find a hepatitis C practitioner in any setting that you are within the country. This is especially important for all of us who are

challenged with not necessarily having a wealth of resources available to us. You can go to the ATCC website that Dominique is going to cover now, and you can go to this website. Because I have actually no time left, what I'm going to do is, I'm not going to go over these last few slides - you do have them. I want to give it back to Dominique, so she can have an opportunity to tell you about all the resources you have available. And then I'm also bringing it back to the initial slide (inaudible) cover. (overlapping voices)

SAUNDERS: Thank you so much Diana. So again, we only have a few moments. And if we're rushing through this, and I'm fairly certain that you'll have access to this particular webcast offline. Also a lot of these resources that I'm going to go through with you, obviously they have websites, these are also on the CBC website and are considered very reputable resources. So just kind of going through the list, here I've highlighted Hepatitis C Online, um, you can get some great research. It's the University of Washington was funded by the DVH at CBC to develop the self-study kind of interactive course. It's primarily centered for medical providers, so note there. No Hepatitis, the second one on the list here is out of the University of Alabama at Birmingham, which is a national training center for integrated Hepatitis/HIV and (inaudible) preventative services. And this site really provides front line training for those working in HIV and STD prevention programs as well as community based organizations and clinics. Hepatitis Web Study at the University of Washington, Washington, Seattle rather - it does offer CME and CME credits and in its interactive case studies, they really cover kind of a broad array of topics related to anything from prevention, management, and also the treatment of viral hepatitis. There's also the Viral Hepatitis Serology Online Training. It's comprised of six animated tutorials with voice-overs and then eight specific case studies. And then I really want to spend a bit more time highlighting the ATTC HCV Current Initiative that we've alluded to so many times. This is a national initiative, as was mentioned, which was really centered to increase knowledge among (ph) medical and behavioral healthcare providers. Especially those working in within federally qualified health care centers. [0:56:35]

So I just wanted to provide you with some visuals here. So to provide some context, the ATTC initiative that I wish to highlight...in 2011, SAMHSA was actually charged and funded the ATTC regional centers to assist both clinical and behavioral healthcare providers to again be able to more effectively address hep-C. Each regional ATCC center collaboratively kind of responded in specific ways, and then the whole initiative really is just in my opinion a brilliant provider resources. The capacity building for both clinical and behavioral health. So the Mid-America ATTC, which is in region 7, which you saw earlier covers four different states, developed a regional stakeholder group, which I mentioned that I'm a part of to act as content experts in addition to assisting in kind of the guidance and development of product outcomes. So this in particular is one of the primary products that is within that initiative that we created regionally. It's a free online training. You learn all the basics of hep-C. It's extremely interactive. It's about 90 minutes self-paced, again for both behavioral and medical providers. You can receive 1.5 contact

hours for a very small fee. And then there I've listed where you can register. It's extremely seamless and very fluid in the process of registering and then actually going through it. You can start and stop it as well. [0:58:01]

So the HCV snapshot, again, is that introduction. The other piece to that, as I already alluded, while Mid-America ATTC played a real key role in developing and launching part of that initiative and led the development of some of the key aspects, which include the online course, the coordination of the marketing campaign, and then a national website. The Northeast and Caribbean ATTC, which is in THIS (ph) region 2, who Diana represents responded as well to this funding and supported those developments. And through the creation of an in-person curriculum, I've had the privilege of being able to act as the trainer for that curriculum. It's intended to be a six-hour, face-to-face, as I mentioned here. Again, same target population, behavioral healthcare and medical providers working in hep-C. And it can actually be tailored to about a three hour curriculum. It consists of five modules. And you can download the curriculum itself. And much like I was saying, that kind of seamless process of registering for it. Same thing, you can go to the website and you can go specifically to whatever region you're in or what state you're in and see all of the different in-person trainings that are being offered. You can also opt to contact one of the providers within that region. There's a map on the ATCC website. And that will allow you to request training if need be. So they really thought through all of that to create something that's very accessible to providers. [0:59:33]

So quickly... Anyways, I just wanted to show a few examples, but I can't seem to find the slide. I apologize. There are just a few examples of what's on the HCV Current website. I know I showed you the RNA provider card, which is that small pocket card. I did receive a question earlier about where that can be received and if it's a free resource. It can be downloaded for free on the products and resources page of the ATCC website, and then hard copies were printed in the limited edition, but it's my understanding that they can be distributed at those live training events that I just mentioned. Also, you can't see it here, but I do want to highlight that even though it's not a part of the HCV Current Initiative, tip 53 which addresses viral hepatitis in people that are injection drug users is simply an excellent resource intended to assist behavioral healthcare professionals. Training those with substance abuse issues and really understanding the implications of a diagnosis around hep-C. It also discusses screening, diagnosis, and referrals, and then really helps the provider explain how to evaluate their own program's hepatitis practices. And then other regional resources to address local conditions and kind of the needs of each of your communities, the ATTC regional center has compiled very region specific hep-C resources and contact information, as I mentioned. [1:01:09]

So again, I'm not quite sure where those slides (ph) jotted off to (laugh)... Oh, I think this is it here. Ok. So just some informational resources. Again, I won't go through this entire list, but you'll have it available to you. NASTAD, which is the National Alliance for State and Territorial AIDS

Directors, have a viral hepatitis program. It's excellent, and just overall all of the work they do is really excellent. Obviously, CDC, the viral hepatitis program is really the foremost place that you could go, and then there's just a whole other host of things. I've included both hep-C related websites and then also things related specifically to substance abuse, much like the harm reduction coalition, USO (ph) model, which is for teen and drug issues and then other just very generalized liver health resources. So with that, I think I'll hand it - Thank you, everybody. And thank you to the rest of the presenters. I'll hand it back over to Aaron. [1:02:14]

MODERATOR: Ok, Thank you. We're a little bit over time, but I do want to take the time to address at least one question here...here that came in, and we'll address this one, and then we'll end the webinar. At one point, I believe this question is for Diane...about the new announcement of the recommendations that all clients are... You said that [prior to cases] (ph) (inaudible) for all patients, not just F3 or F4, and so we want some clarification about who announced that.

PADILLA: The recommendation are provided by the American Association of Study of Liver Disease and the International Association of Study of Liver Disease. It's on hcvguidelines.org. Those treatment recommendations are typically what insurers, payers go by, what practitioners go by and currently it's been updated, it's even been highlighted. Before, what happened was the treatment recommendations had the highest priority, which is the (inaudible). Now what you will see when you go to the portion that says, "Home (ph) and what to treat," it will say, All HCV would benefit from getting treated. And then it has for highest priority, it is prefaced by, "Contingent upon available treatment resources." So that changes quite a bit. It would be interesting to see how that's going to impact how that's going to impact how many more people can access treatment through the insurance coverage. You know, which has really been the biggest barrier in terms of folks that we already have in healthcare. So go to the hcvguidelines.org. You'll see it there. Medscape - if you get alerts from them, that's a good source also. A few days after any new article or journal is published, they will also provide information. [1:04:18]

MODERATOR: Ok. Thank you. I just wanted to make sure all of our listeners heard that about the new recommendations there. So it looks like that is all the time we have today. I want to thank our presenters for the wonderful presentation we've had. Once again, we have a recording and a transcription of this webinar that will be available on the CIHS website, WWW.integration.samhsa.gov. Once you exit the webinar, you'll be asked to complete a short survey. Please be sure to offer your feedback on today's webinar. You're input is important to us. It informs the development of further CIHS and National Council webinars. Again, I'd like to thank the presenters for this webinar and thank the audience for participating. And please join us for our next webinars on topics related to behavioral health and integration. With that being said, "Have a nice afternoon, everyone."

FEMALE SPEAKER: Thank you.

END TRANSCRIPT