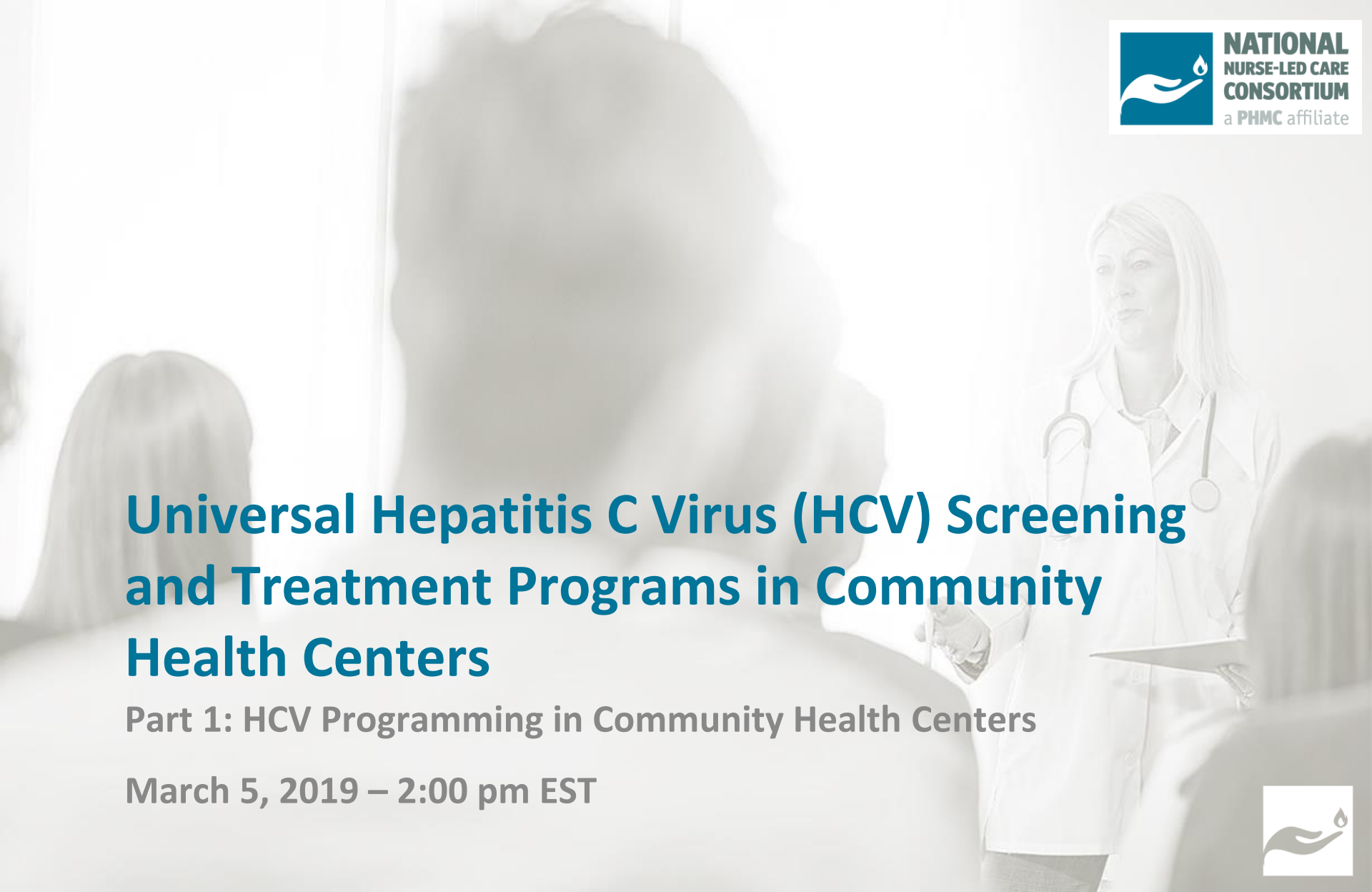


NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

Universal Hepatitis C Virus (HCV) Screening and Treatment Programs in Community Health Centers

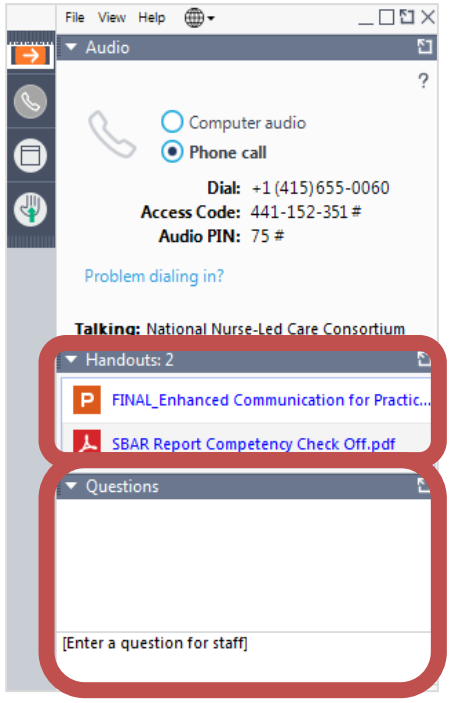
Part 1: HCV Programming in Community Health Centers

March 5, 2019 – 2:00 pm EST

Housekeeping Items

To **download materials**, go to the Handouts section on your GoToWebinar control panel.

To **ask a question**, type it into the Question pane in the GoToWebinar control panel and it will be relayed to the presenter.



National Nurse-Led Care Consortium

The **National Nurse-Led Care Consortium (NNCC)** is a membership organization that supports nurse-led care and nurses at the front lines of care.

NNCC provides expertise to support comprehensive, community-based primary care.

- Policy research and advocacy
- Technical assistance and support
- Direct, nurse-led healthcare services

NATIONAL NURSE-LED CARE CONSORTIUM
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HCV Learning Collaborative Overview

Part 1 (Today): HCV Programming in Community Health Centers

Part 2 (3/19/19): HCV Care Team Formation and Linkage to Care

Part 3 (4/2/19): Health Economics 101: Comparing Standard v. Enhanced HCV Screening and Treatment

Part 4 (4/16/19): Utilizing the HCV Cost Benefit Calculator to Evaluate Resources

You will receive a separate survey from CDN for credentialing.

NATIONAL NURSE-LED CARE CONSORTIUM
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HEPATITIS C AND OPIOID INJECTION ROSE DRAMATICALLY IN YOUNGER AMERICANS FROM 2004-2014

- Among people aged 18-29, HCV increased by 400% and admission for opioid injection by 622%
- Among people aged 30-39, HCV increased by 325% and admission for opioid injection by 83%

Any Opioid Injection (18-29)
Any Opioid Injection (30-39)
HCV Rate (18-29)
HCV Rate (30-39)

Source: Centers for Disease Control and Prevention and Substance Abuse and Mental Health Services Administration

Presenters

Katherine Huynh, PA-C, AAHIVM-S
Physician Assistant
Public Health Management Corporation
Care Clinic

Jack Hildick-Smith
Viral Hepatitis Prevention Coordinator
Division of Disease Control
Philadelphia Department of Public Health

Universal HCV Screening and Treatment

KATIE HUYNH PA-C, AAHIVM-S
PHMC CARE CLINIC
PHILADELPHIA, PA

Objectives

1. Who/How to test: Universal Screening?
2. HCV Treatment Cascade
3. Why to treat HCV
4. How to treat
5. Successes/Lessons Learned

Identifying Patients with Hepatitis C

- 4-5 million people in the US have hepatitis C virus (HCV) infection
- Most common blood borne pathogen in the US
- Up to 75% of people have not been diagnosed
- Risk-based screening misses many people
  - Stigma associated with IDU, even if use was decades ago

Smith BD et al. MMWR. August 17, 2012/61(RR04);1-18. Armstrong GL et al. Ann Intern Med. 2006 May 16;144(10):705-14.
http://www.iom.edu/Reports/2010/Hepatitis-and-Liver-Cancer-A-National-Strategy-for-Prevention-and-Control-of-Hepatitis-B-and-C.aspx

Who Should Be Tested for HCV

CDC Recommendations

- Everyone born from 1945 through 1965 (one-time)
- Persons who ever injected illegal drugs
- Persons who received clotting factor concentrates produced before 1987
- Chronic (long-term) hemodialysis
- Persons with persistently abnormal ALT levels.
- Recipients of transfusions or organ transplants prior to 1992
- Persons with recognized occupational exposures
- Children born to HCV-positive women
- HIV positive persons

USPSTF Grade B Recs*

- Everyone born from 1945 through 1965 (one-time)
- Past or present injection drug use
- Sex with an IDU; other high-risk sex
- Blood transfusion prior to 1992
- Persons with hemophilia
- Long-term hemodialysis
- Born to an HCV-infected mother
- Incarceration
- Intranasal drug use
- Receiving an unregulated tattoo
- Occupational percutaneous exposure
- Surgery before implementation of universal precautions

*Only pertains to persons with normal liver enzymes; if elevated liver enzymes need HBV and HCV testing

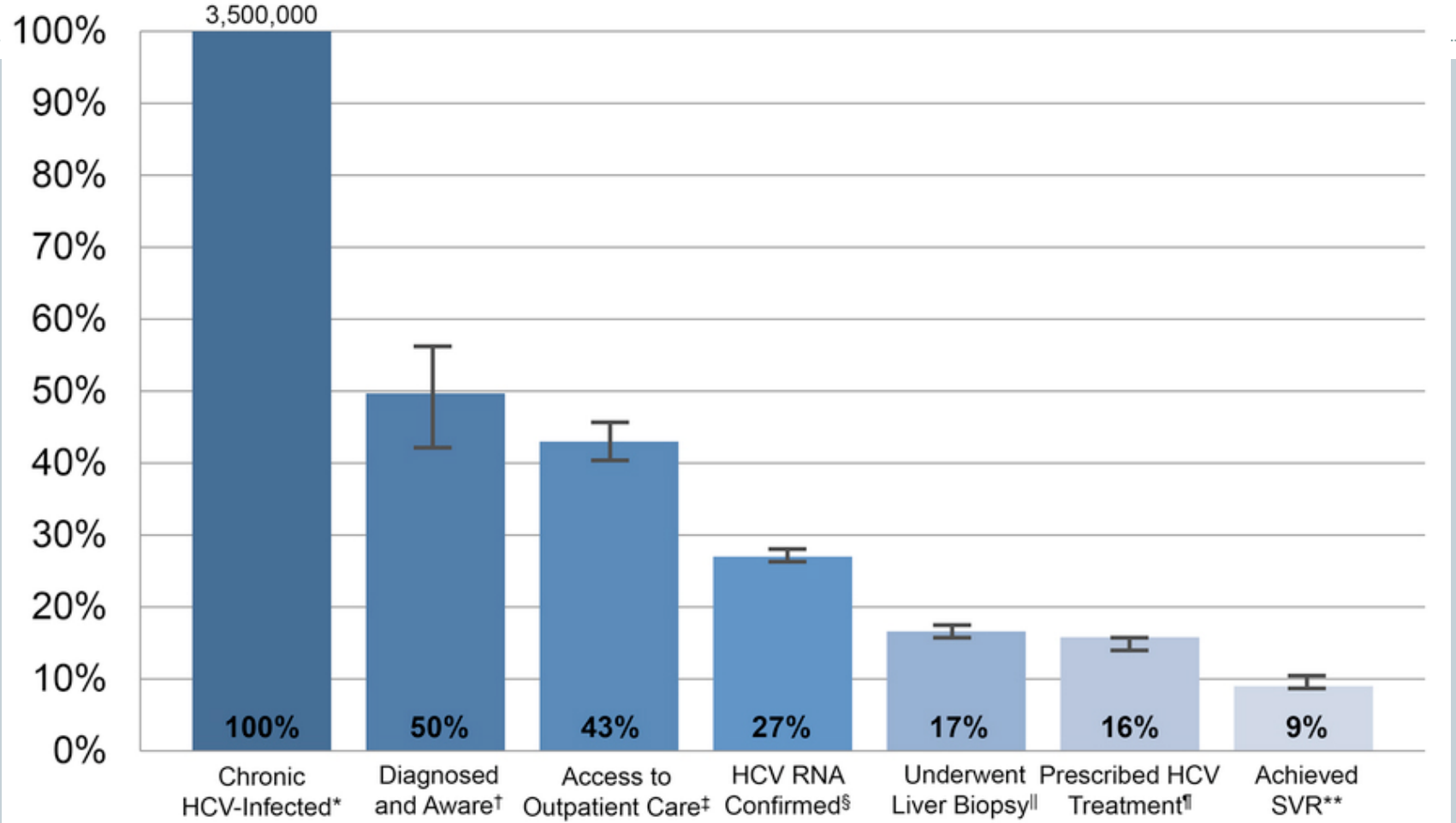
Smith at al. Ann Intern Med 2012; 157:817-822. Moyer et al. Ann Intern Med epub 25 June 2013

HCV Guidelines

-One-time HCV testing is recommended for persons born between 1945 and 1965,* without prior ascertainment of risk.

- Other persons should be screened for risk factors for HCV infection, and one-time testing should be performed for all persons with behaviors, exposures, and conditions associated with an increased risk of HCV infection.

Treatment Cascade for Chronic HCV[6]



Yehia, et al. Plos ONE. 2014

PHMC HCV testing Initiative/FOCUS grant

- NNCC (National Nurse –Led Care Consortium)-PHMC (Public Health Management Corp) partnership to introduce **universal dual routine HIV/HCV (opt out)** testing in PHMC's 5 Federally Qualified Health Centers (FQHCs):
- The test used for HCV screening was HCV Ab with reflex to RNA viral load
- This eliminated need for further labs and follow up visits
- Through grant, PHMC covered cost of test for uninsured
- Test was initially over $100, reduced to $60 through negotiation with lab
- Confirmed positives able to be quickly linked to care

HCV Positive Patient Data

- PHMC serves over 19,000 patients
- From 2012-2016: 15,000 patients tested
- 884 patients confirmed chronic HCV positive (~6% prevalence)

- **HCV positive patient data (based on testing data from October 2012-June2016):**
  - **73.7%** RNA Positive patients were male.
  - **53%** RNA Positive patients reported IDU (**19%** were missing documentation).
  - **90%** of the patients chronically infected were publically insured by Pennsylvania (Medicaid).
  - **63.7%** of RNA Positive patients had a history of mental health disease

HCV Testing in PWID

- Getting tested for HCV, reduces drug use in PWID
- One OST program showed reduced injection opioid use
  - 8.1% reduction in PWID if test positive
  - 6.7% reduction in PWID if test negative
- Benzo, cocaine and other nonRx drug use also reduced

H Farhang Zangneh, J Eibl, G Gauthier et al. The impact of hepatitis C diagnosis on substance-use behaviors in patients engaged in opioid substitution therapy. AASLD: The Liver Meeting. Washington, DC, October 20-24, 2017. Abstract 125.

HCV Testing in Clinic Setting

- Consider reflex testing as only HCV test offered
- Consider opt out routine testing for ALL patients
- Repeatedly assess risk for HCV
  - If risk factors continue, test every 6-12 months
- If patient clears virus on their own (15-25%) not associated with clearing again if re-infected with HCV.

538LB

High Efficacy of HCV Treatment by Primary Care Providers: The ASCEND Study

Sarah M. Kattakuzhy[1]; Chloe Gross[1]; Gebeyehu Teferi[2]; Veronica Jenkins[3]; Benjamin Emmanuel[4]; Henry Masur[5]; Shyam Kottilil[1]; for the ASCEND Investigators

[1]Institute of Human Virology at the University of Maryland, Baltimore, MD, USA; [2]Unity Health Care, Washington, DC, USA; [3]Family & Medical Counseling Services, Washington, DC, USA; [4]University of Maryland, Baltimore, MD, USA; [5]NIH, Bethesda, MD, USA

BACKGROUND

- Limited access to specialists and lack of provider expertise in hepatitis C (HCV) treatment remain significant barriers in the hepatitis C care cascade
- Given the advent of directly acting antiviral therapy, we conducted a longitudinal trial to evaluate the efficacy and safety of primary care driven HCV treatment

METHODS

- Multi-center, open label, phase IV clinical trial of 600 patients, with follow up ongoing
- HCV+ patients of three community health centers in Washington DC were identified by their providers, consented, and distributed in a non-randomized manner to receive treatment from either a:
  - nurse practitioner (NP),
  - primary care physician (PCP), or
  - specialist (BC/BE Infectious Disease or Hepatology)
- Providers underwent uniform 3-hour training on IDSA-AASLD therapeutic guidelines
- Patients were treated with ledipasvir and sofosbuvir (LDV/SOF) as per FDA label
- The primary outcome was defined as unquantifiable HCV RNA viral load 12 weeks after completion of therapy (SVR12)
- Adherence to visits at 4, 8, and 12 weeks (all -7 to +14 days), were categorized by a composite score of attendance
- Statistical analysis included chi-squared or Fisher's exact test and logistic regression using SAS, version 9.3

RESULTS

Characteristic	Total Cohort (n=600)	Treating Provider		
		NP (n=152)	PCP (n=156)	Specialist (n=294)
Age	59.7	59.2	59	59.7
Male (%)	416 (69.3)	109 (72.7)	114 (73.1)	193 (65.7)
Race (%)				
Black*	578 (96.3)	140 (93.3)	156 (100)	282 (95.9)
White	20 (3.3)	9 (6.0)	0	11 (3.7)
Other	2 (0.3)	1 (0.2)	0	1 (0.2)
Infection Status				
HCV	456 (76.3)	127 (84.7)	109 (69.9)	222 (75.5)
HIV/HCV*	142 (23.7)	23 (15.3)	47 (30.1)	72 (24.5)
Genotype				
1a	431 (71.8)	104 (69.3)	113 (72.4)	214 (72.8)
1b	169 (28.2)	46 (30.7)	43 (27.7)	80 (27.2)
Fibrosis				
0	80 (13.3)	22 (14.7)	20 (12.8)	38 (12.9)
1	90 (15)	23 (15.3)	29 (18.6)	38 (12.9)
2	212 (35.3)	54 (36.0)	50 (32.1)	108 (36.7)
3	97 (16.2)	22 (14.7)	29 (18.6)	46 (15.7)
4	121 (20.2)	29 (19.3)	28 (18.0)	64 (21.8)
Previous Treatment (%)				
Experienced	106 (17.7)	29 (19.3)	27 (17.3)	50 (17.0)
Naive	494 (82.3)	121 (82.7)	129 (80.7)	244 (82.9)
HCV Viral Load				
Baseline (IU/mL)	3.81m	3.22m	3.93m	3.64m
< 6 million	464 (80.7)	125 (83.3)	124 (79.5)	235 (79.9)
> 6 million	116 (19.3)	25 (16.7)	32 (20.5)	59 (20.1)
Treatment Duration				
8 weeks	29 (4.8)	7 (4.7)	3 (1.9)	19 (6.5)
12 weeks	537 (89.5)	136 (90.7)	146 (94.9)	253 (86.8)
24 weeks	32 (5.4)	7 (4.7)	5 (3.2)	20 (6.9)

Table 1. Baseline and Treatment Characteristics of Total Cohort and Patients by Provider Type. Provider cohorts were comparable with significant differences in race and HIV status (p<.01).

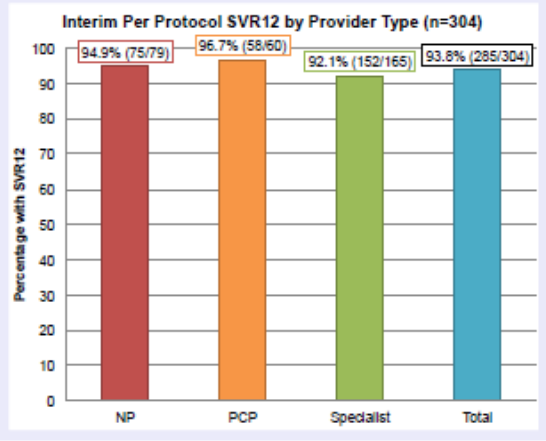


Figure 1. Interim Per Protocol SVR12 by Provider Type. Of 304 patients with available SVR12 results, 93.8% achieved SVR12. There was no significant difference in SVR12 between patients treated by NPs, PCPs, and specialist physicians

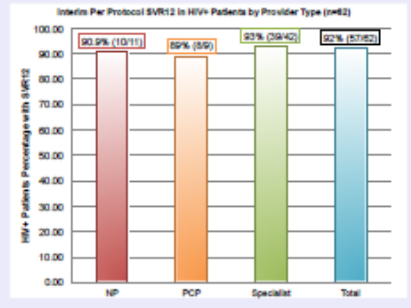


Figure 2. SVR12 by Provider in HIV+. There was no significant effect of provider on SVR12 in HIV+ patients

Baseline Characteristics	SVR12 (n=285)	Non-SVR12 (n=19)	p-value
Male	199/285 (69.8)	13/19 (68.4)	0.97
Black Race	275/285 (96.5)	18/19 (94.7)	0.51
Non-Hispanic	269/285 (94.2)	18/19 (94.7)	0.32
HIV/HCV Coinfection	58/285 (20.4)	5/19 (26.3)	0.56
GT-1a	199/285 (69.8)	19/19 (100)	0.003*
Cirrhosis	53/285 (18.60)	15/19 (21.1)	0.78
Treatment Experienced	46/285 (16.1)	4/19 (21.1)	0.53
HCV VL > 6 million	51/285 (17.9)	5/19 (26.3)	0.36
Treatment Duration			0.47
8 weeks	14/285 (4.9)	2/19 (10.5)	
12 weeks	269/285 (93.3)	17/19 (89.5)	
24 weeks	0/285 (1.0)	0/19 (0)	
Provider Type			0.46
NP	75/285 (26.3)	4/19 (21.1)	
PCP	58/285 (20.4)	2/19 (10.5)	
Specialist	152/285 (53.3)	13/19 (68.4)	

Table 2. Baseline and Treatment Characteristics Associated with SVR12 (n=304)

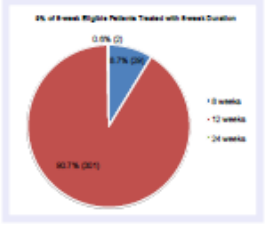


Figure 3. Treatment duration for 8-week eligible patients. Of the 332 patients who met label criteria for 8 week duration, only 29 were treated with 8 weeks.

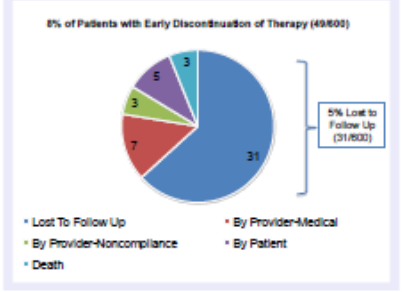


Figure 4. Early Discontinuation (d/c) on Therapy. 49 patients d/c therapy prior to treatment completion. The majority (n=31) were lost to follow up. 7 patients were d/c early by their provider for medical reasons.

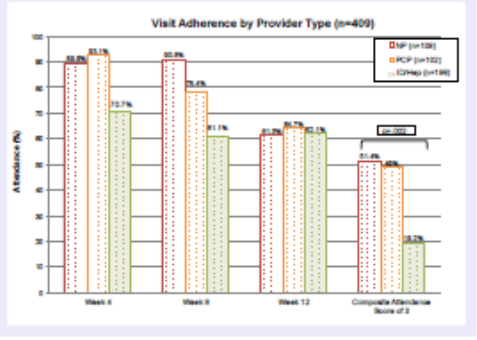


Figure 5. Adherence to visits by provider type in 409 patients who completed 12-week treatment. Composite Attendance Score of 3 was defined by attendance at all three visits (week 4, 8, and 12) with a window of -7 to +14 days per visit.

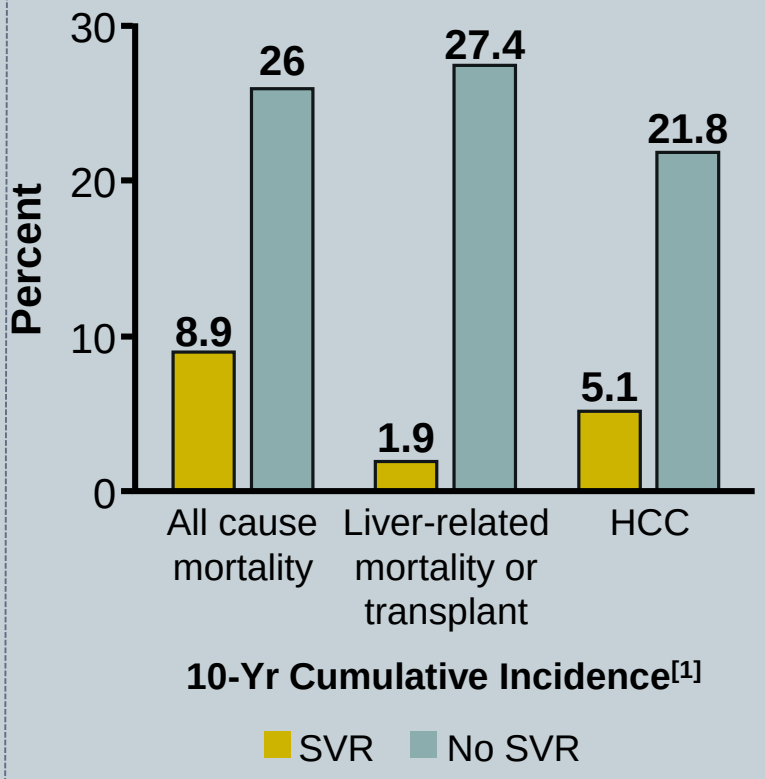
CONCLUSION

The ASCEND investigation demonstrates that HCV treatment administered independently by PCPs and NPs is safe and equally effective as care observed with experienced specialists, inclusive of challenging subpopulations of the epidemic, and within the largest African-American cohort described to date.

The ASCEND model could increase the availability of community-based, non-specialist providers to significantly expand the scale of HCV therapy, and bridge existing gaps in the hepatitis C care cascade.

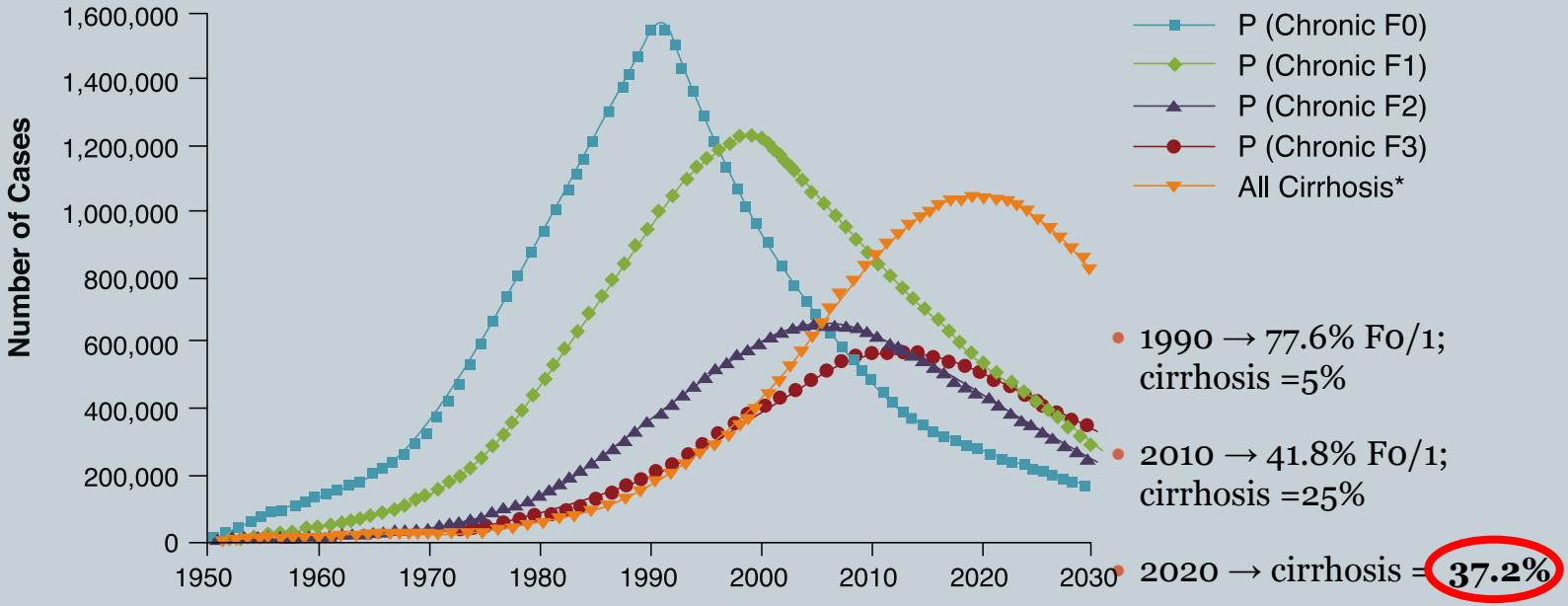
HCV Treatment Improves Health

- **Advanced fibrosis**
  - Multicenter study[1]
    - 5 hospitals (Europe, Canada)
  - 530 pts with HCV
    - IFN regimens 1990-2003
    - Advanced fibrosis or cirrhosis
    - Median follow-up: 8.4 yrs
- **Early-stage disease**
  - Extra-hepatic manifestations[2]
  - Health-related quality of life[3]



1. van der Meer AJ, et al. JAMA. 2012;308:2584-2593. 2. van der Meer AJ. Expert Rev Gastroenterol Hepatol. 2015;9:559-566. 3. Younossi Z, et al. Clin Gastroenterol Hepatol. 2014;12:1349-1359.

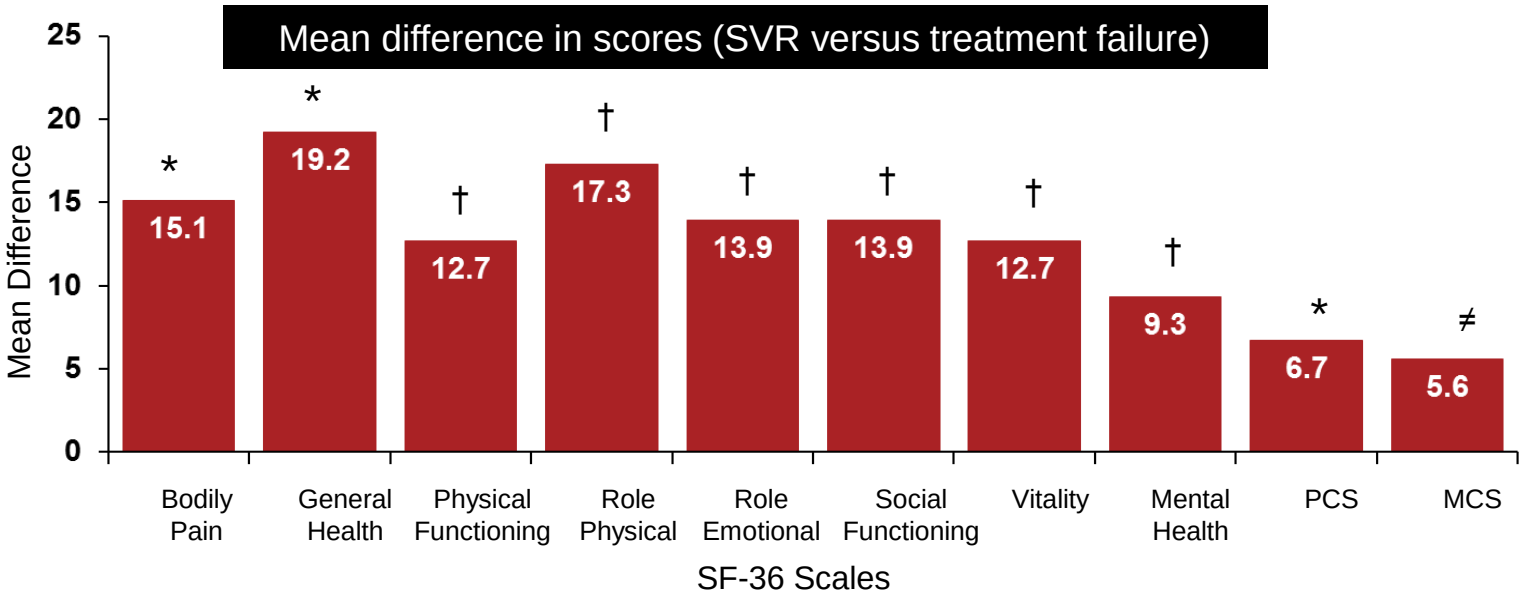
Projected Burden of Advanced Fibrosis Over the Next Decade



- 1990 → 77.6% F0/1; cirrhosis =5%
- 2010 → 41.8% F0/1; cirrhosis =25%
- 2020 → cirrhosis = **37.2%**

SVR Was Associated with Improved Quality of Life in a Real-World Clinic Population

A study of community patients from hospitals in Vancouver has shown that sustained responders reported higher scores than treatment failures on each domain of the SF-36 and on utility measures



Sustained responders = undetectable HCV viral levels 6 months after therapy;
Treatment failures = detectable HCV viremia after therapy, or patients with an end-of-treatment response who relapsed.
MCS = mental summary score (0-100); PCS = physical summary score (0-100). *P<.0001; †P<.001; ≠P<.01.

John-Baptiste AJ, et al. *Am J Gastroenterol.* 2009;104:2439-2448.

Treatment in FQHC setting

- All patients receive primary care from primarily PAs/NPs with support from physicians
- Integrated care setting with Behavioral Health Consultants (BHCs,) case managers, as well as substance abuse support (medication assisted treatment program/peer recovery support)
- PCPs trained internally with experienced providers offering classes, mentorships and case study conversations
- Treatment Referral Coordinator works across all 6 FQHCs

First Provider Visit

- First Visit: Complete History and Physical including:
  - HCV
    - First and Last injection drug use, tattoo history, sexual history
    - Etoh and other substance use history
    - History of HCV treatment
    - Last negative HCV test
  - Medical History
    - Co-morbities (HTN, COPD, DM)
    - Last HIV test
    - HAV, HBV disease or vaccine history
  - Mental Health History

First Provider Visit continued. . .

- Full Physical Exam
  - Noting liver specific findings, ie hepatomegaly, skin changes, ascites
- Medication History
- Patient Education
  - HCV disease natural progression, fibrosis explained
  - Risk reduction practices
  - Expectations about HCV treatment
  - Life style modifications to reduce liver disease
- Refer to BHC for assessment
- Refer to social worker as needed for insurance assessment

Second Visit

- Lab Tests:
  - Confirm HCV, check fibrosis score, genotype, screen co-morbidities and immunity to HBV, HAV
  - Refer for ultrasound
- Education: Continue
  - Depending on first visit, refer again to BHC
- Discuss submitting request to insurance and possible denial

Submission to Insurance

- Labs and BHC consult given to treatment coordinator for submission to Pharmacy
- Pharmacy completes prior authorization
- Wait for response, which takes 1-2 weeks

BHC HCV Visit

- BHC evaluates readiness and motivation to start tx
- Psychological assessment and letter to satisfy prior authorization for HCV medications
  - Link to therapy and further mental health tx as needed
- Assess active substance abuse and refer to treatment if needed
- Check baseline HCV treatment knowledge and review basic liver health

Treatment

- New medications are very effective (>96% in all patients with or without significant liver disease and treatment in the past)
- Direct acting, therefore minimal side effects
- All require excellent adherence
- All have warning of HBV reactivation
  - If have HBV or history of HBV need to check labs more often
  - Nothing to be worried about, very rare
  - Black box warning may bother patients

Mavyret (Glecaprevir-Pibrentasvir)

- 3 tablets once a day
- Genotypes 1-6
- Up to 99% effective in achieving SVR
- If treatment naïve, no cirrhosis, for 8 weeks
- If experienced or cirrhotic, for 12 weeks
- May be longer if treatment experienced
- Most common adverse effect: headache, fatigue

Other Meds

- Epclusa
- Harvoni
- Zepatier

- All of these are one pill once a day and treatment course between 8-16 weeks.
- Variations depend on genotype, presence of cirrhosis, and treatment experience

Provider Resources

- ASLD:
  - https://www.hcvguidelines.org/
- University of Washington:
  - https://www.hepatitisc.uw.edu/page/treatment/drugs
- Clinician Consultation Center:
  - http://nccc.ucsf.edu/clinician-consultation/hepatitis-c-management/
  - **(844) HEP-INFO**

HCV Treatment Referral Coordinator

- Submits HCV treatment prior authorization and tracks medication adherence, ensuring patients return to pick up their medication from the clinic
  - Flags patients who need to be referred to outreach
  - Reminder Calls to patients
  - Reminds providers of patient visits, needed labs, etc.
- Manages communication between pharmacy, provider and insurance company.
- All-inclusive spreadsheet that tracks HCV patients through each step of the process (PA approval, start dates, medication pickup, and SVR achieved).

On Treatment

- HCV VL doesn't need to be checked during treatment but should be done at the end of treatment
  - But some plans require 4, 8, 12 weeks
  - Some patients and providers prefer to monitor treatment
- CMP can be added to CBC and VL to monitor LFTS or other markers of liver damage (Albumin, bili)
- If positive for Hep B Core Ab and negative HBV DNA, monitor LFTS at 4 and 8 weeks for HBV reactivation.

Post Treatment

- SVR is done as close to 12 weeks after last dose
  - If undetectable does **NOT** need to be checked again=cure
- Continue risk reduction conversation/prevention of re-infection
- Liver Health Education
- Set follow up for HCC screening as needed

Cure=SVR

- SVR= sustained viral response
- Viral load taken 12 weeks after treatment finished
- If HCV Viral Load is <15 (and reads “undetectable”) patient is cured
- Clearing HCV is not protective from getting HCV again

PHMC Care Clinic HCV Continuum

Measuring Impact: How the FOCUS Model Transformed Testing and Linkage to Care at a Philadelphia Health Center

Figure 2: HCV Treatment Continuum at PHMC Care Clinic (January 2015-March 2017)

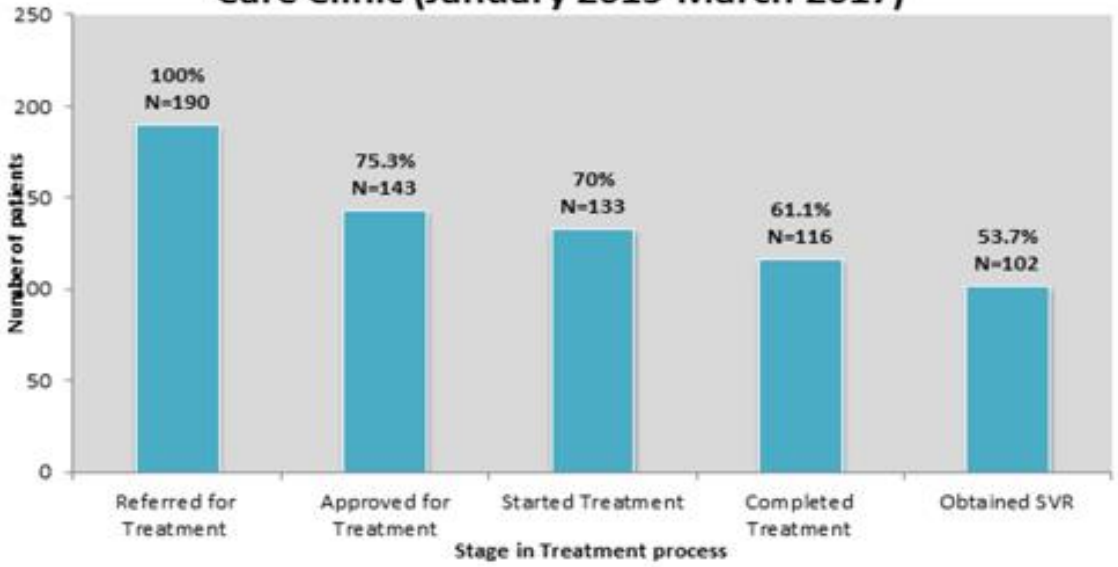


Figure 2 examines the treatment continuum for patients that received onsite HCV treatment at the PHMC Care Clinic.

Keys to Success

- Treatment Restrictions lessning
- Patient comfort in PCP office
- Every visit discuss adherence at length
- Education of disease/treatment process
- Support/Education for treating providers
- PCP holding meds
- BHC involvement
- Outreach if missed appointments
- TRC

WORKING WITH YOUR LOCAL HEALTH DEPARTMENT

HEPATITIS C VIRUS

Jack Hildick-Smith,
Viral Hepatitis Prevention Coordinator

Department of
Public Health
CITY OF PHILADELPHIA

OVERVIEW

- Health Department Support
- Coalitions
- How to get started

CDC SURVEILLANCE INITIATIVE 1703

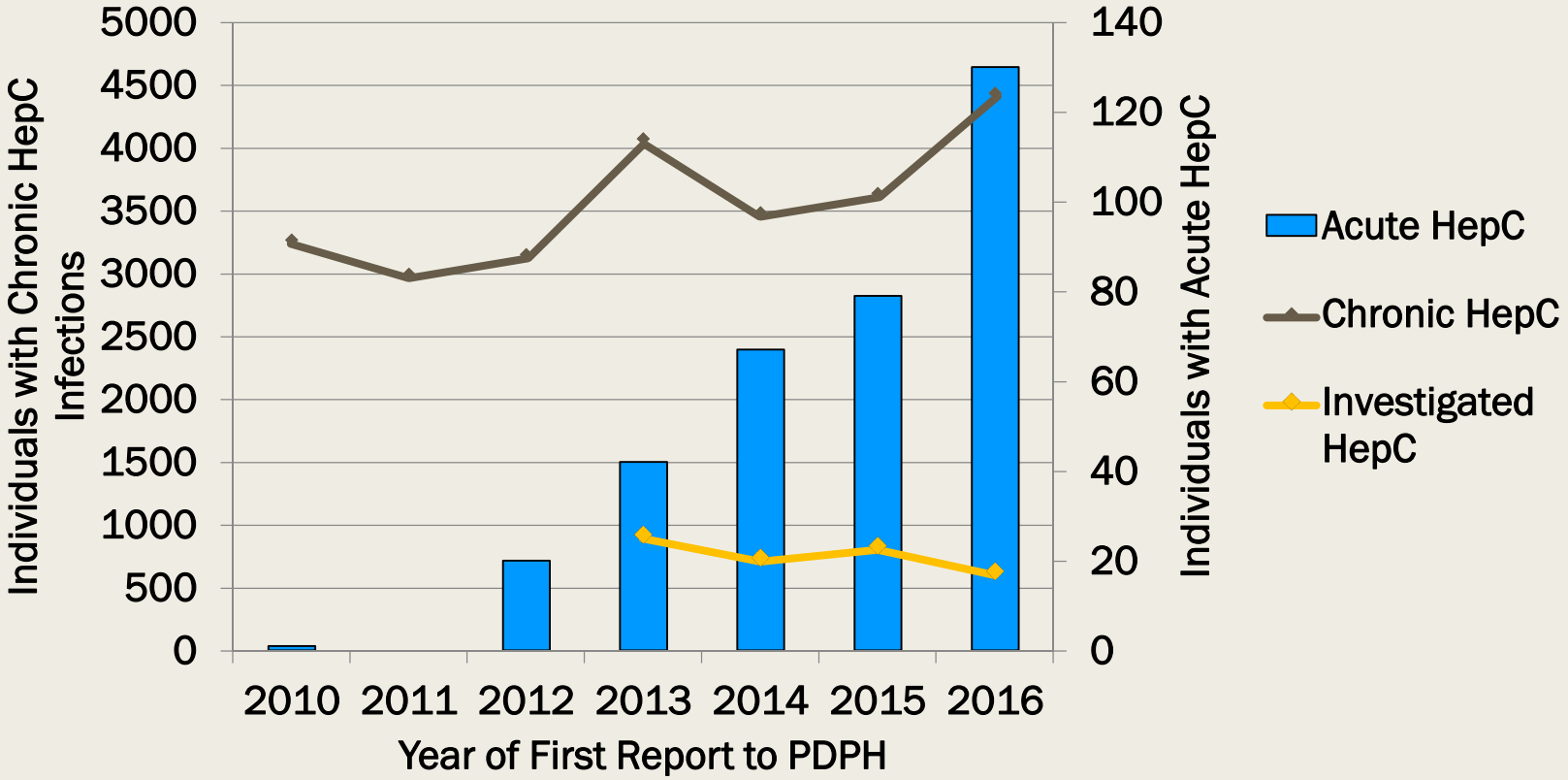
Program was launched in 2013

1 of 7 sites funded

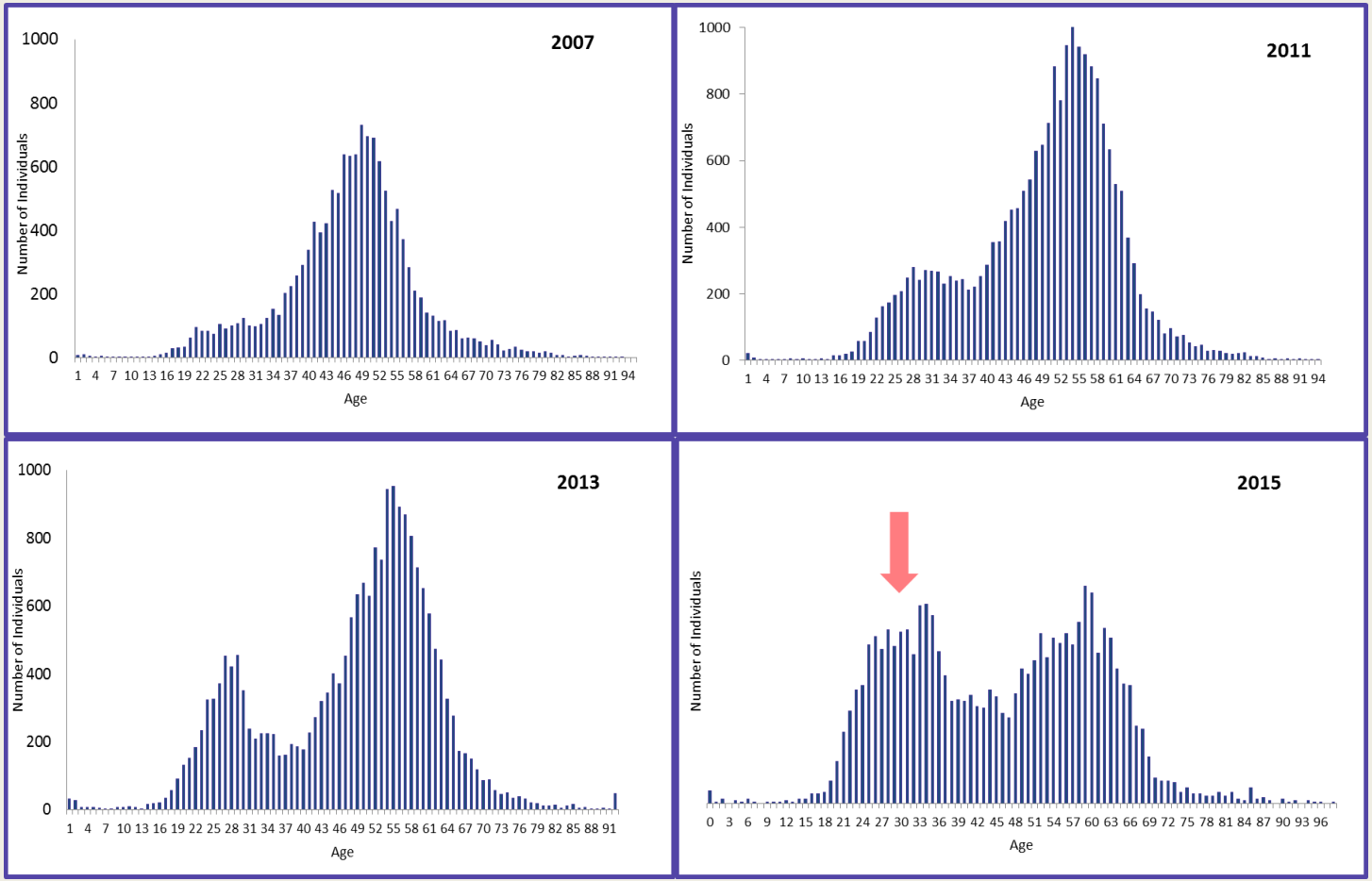
Surveillance of acute and chronic hepatitis

2 Epidemiologists, 3 full time investigators.
Endless students and interns

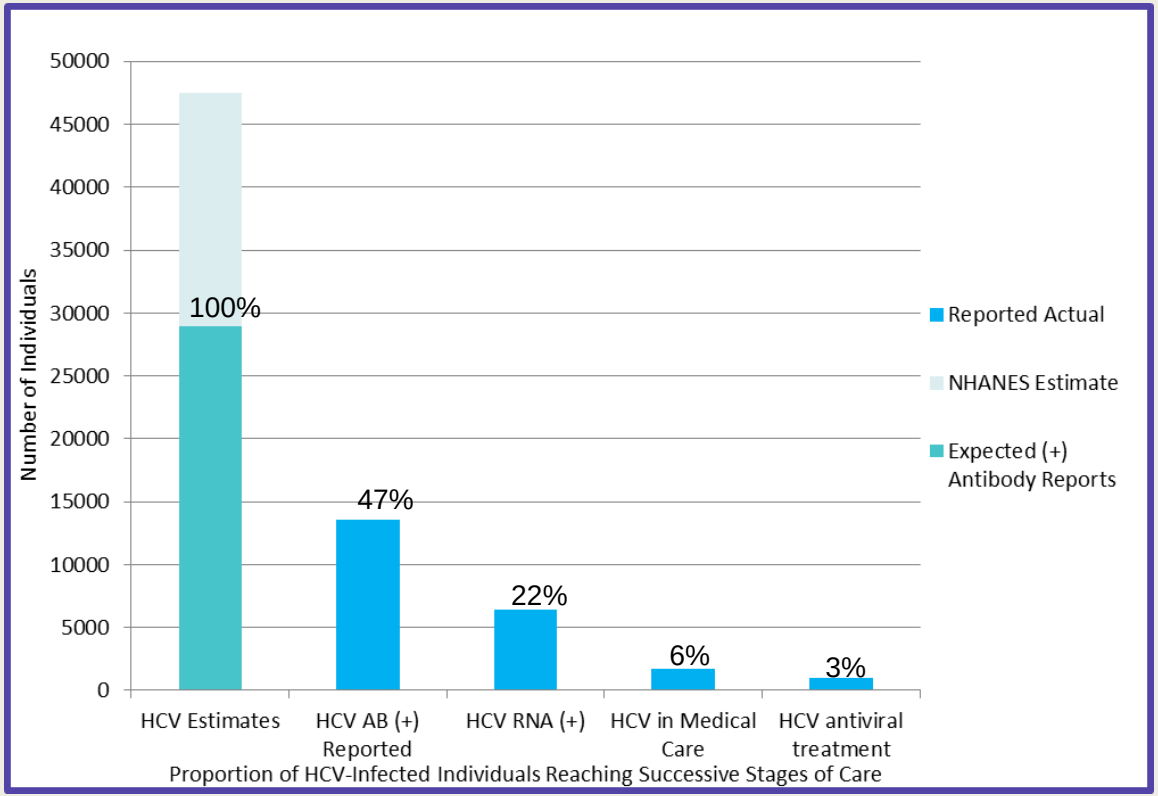
CDC SURVEILLANCE INITIATIVE 1703
Program was launched in 2013



CHANGE OF AGE DISTRIBUTION OF HEPATITIS C CASES OVER YEARS 2007-2015



HEPATITIS C CONTINUUM OF CARE: 2010 - 2013



VIRAL HEPATITIS INVESTIGATION

Surveillance activities to identify persons suspected of having or known to have viral hepatitis.

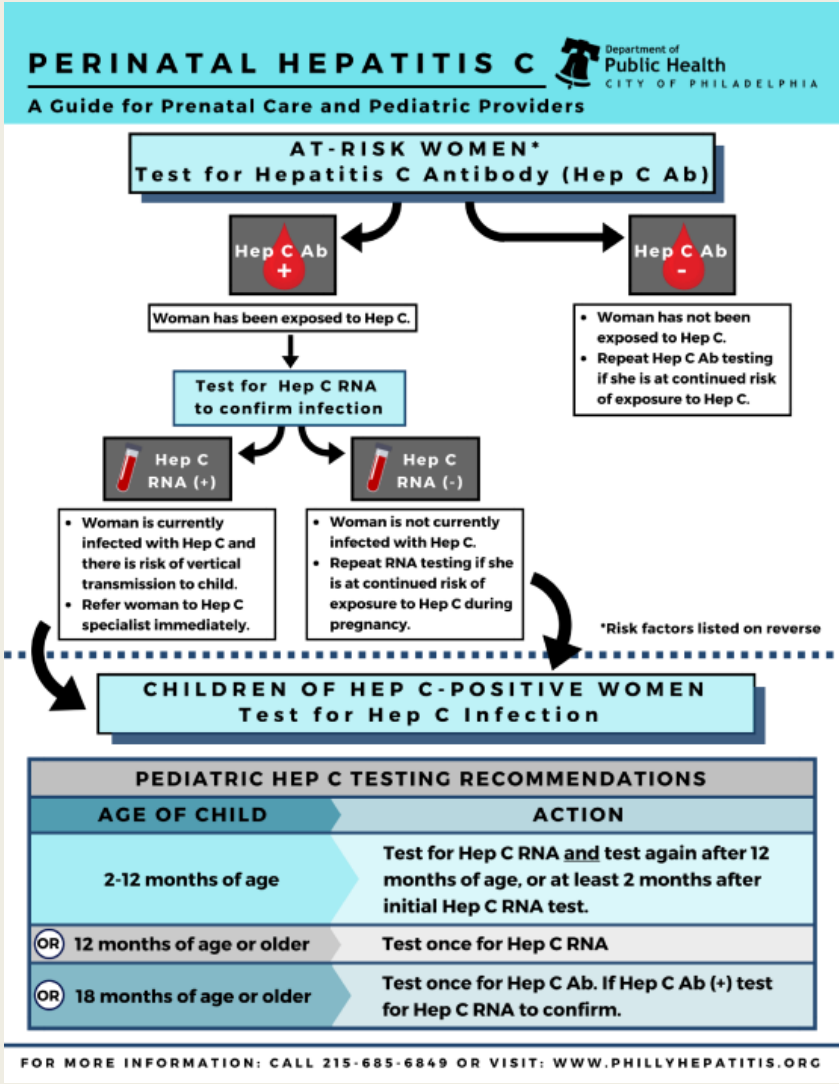
Field investigations to collect diagnostic and risk factor data on persons suspected of having or known to have viral hepatitis.

Informing persons of test results, counseling individuals on diagnosis, and assistance in linkage to care.

PERINATAL HEPATITIS C PROGRAM

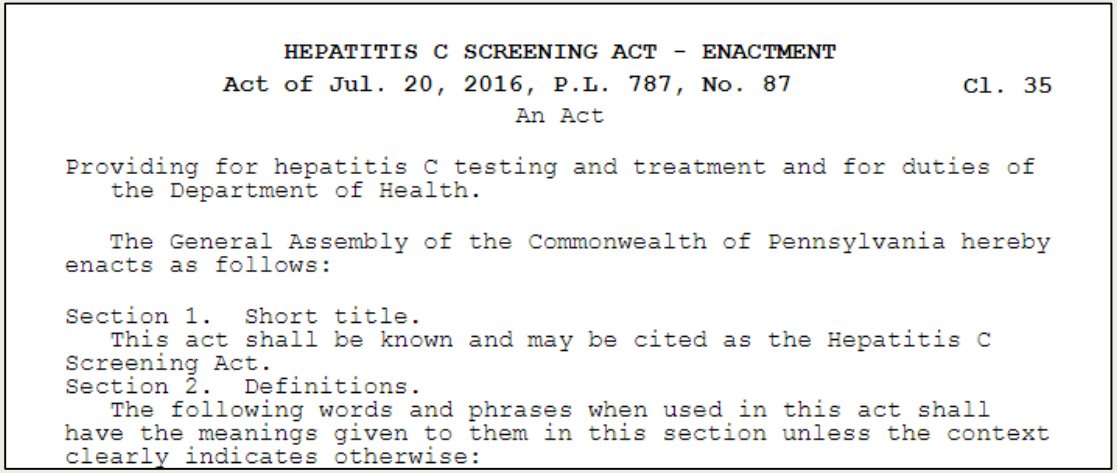
The first of its kind. Working to identify hepatitis C positive, pregnant women

- **Link newborn to testing and care**
- **Link mother to care for current infection**
- **Support prenatal and pediatric services**
- **Learn from population served**



PA - ACT 87

Mandates screening of Hepatitis C in Baby Boomers at Primary Care and Outpatient Settings



HEPATITIS C SCREENING ACT - ENACTMENT

Act of Jul. 20, 2016, P.L. 787, No. 87 Cl. 35

An Act

Providing for hepatitis C testing and treatment and for duties of the Department of Health.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the Hepatitis C Screening Act.

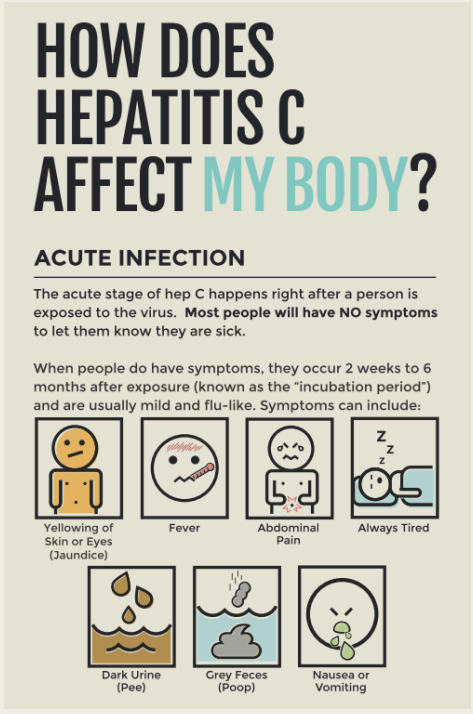
Section 2. Definitions.

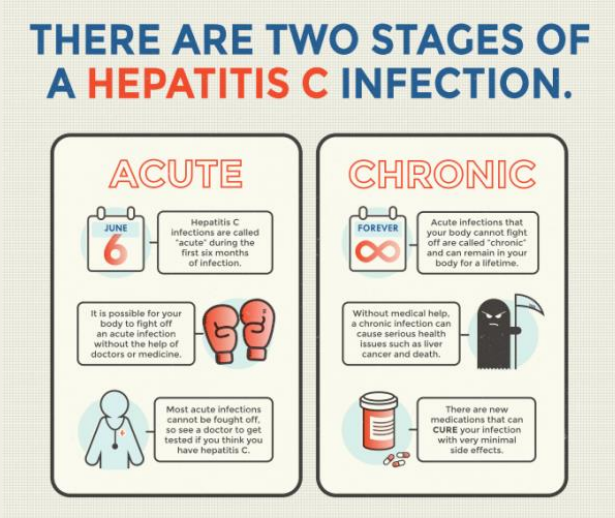
The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

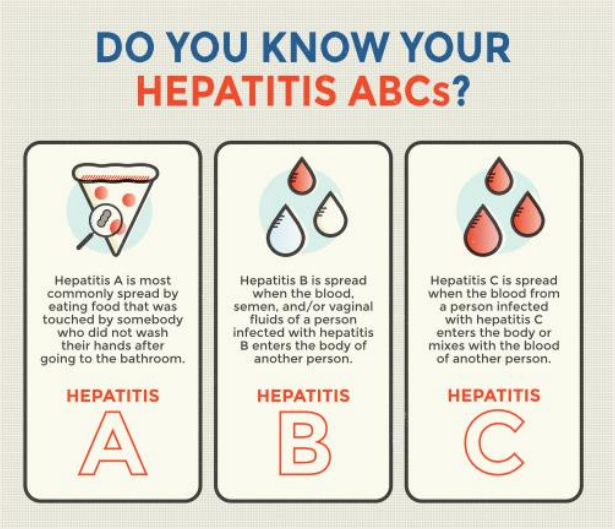
PDPH Resources

HIP.phila.gov – city health data

Educational Materials: Booklets, posters, wallet cards, perinatal







PHILLYHEPATITIS.ORG

PHILLY HEPATITIS

HEPATITIS B | HEPATITIS C | SUPPORT + CARE | GET INVOLVED

HEPATITIS IN PHILADELPHIA

Viral Hepatitis info for the City of Brotherly Love

QUICK FACTS | WHAT IS HEPATITIS? | NEXT STEPS | ABOUT US

HEPCAP

HEPATITIS C ALLIES OF PHILADELPHIA

a citywide collective dedicated to improving the continuum of hepatitis C prevention, diagnosis, care, and support services in Philadelphia.

Bi-Monthly Meetings

Advocacy: Treatment access

Elimination Project: C-Change

Website: Information exchange

HEPCAP.ORG

Date of Policy Change	Sobriety Requirement	Fibrosis Score Limitation	Experienced Provider	Behavioral Health Screen
12/2013	Yes	F3-F4	Required	Required
5/2015	~No	≥F2	Required	Required
7/2017	~No	≥F0-F1	Required	Required
1/2018	~No	≥F0	Primary with consultation	Required

TX ACCESS TIMELINE

HEPCAP

HOME COALITION ACTIVITIES COMMUNITY TOOLS PROVIDER RESOURCES JOIN

eliminating Hepatitis C from the City of Philadelphia.

JOIN

What are you looking for?

Coalition Activities

Find out what HepCAP is up to: Past, Present, and Future!

Community Tools

Resources relevant to patients, advocates, harm reduction and hep C policy

Provider Resources

Guidelines, trainings, and continuing medical education for hepatitis C providers.

TOWN HALLS


YOU'RE INVITED!
TOWN HALL ON
HEPATITIS C IN *SOUTH PHILLY*
Dinner will be provided
February 4th, 2019
6:00PM - 8:00PM
South Philadelphia Library
1720 S. Broad Street
LEARN about the silent epidemic affecting 55,000 Philadelphians
HEAR from hep C advocates and champions
DISCUSS next steps in improving hepatitis C services in South Philly
MAKE YOUR VOICE HEARD
PLEASE RSVP AT: HEPCAP.ORG/RSVP
This will be the first of four region-specific town hall meetings in Philadelphia to discuss the Hepatitis C Epidemic. If you live in another part of the city, please visit our website to learn about your community's upcoming meeting.
HepCAP
HEPATITIS C ALLIES OF PHILADELPHIA
a program of the
HEALTH FEDERATION
OF PHILADELPHIA
FOR MORE INFO:
HEPCAP.ORG
@HEP_CAP

HOW TO GET STARTED

- Reach out and learn local reporting requirements from your health department.
- Learn state treatment access laws
  - *stateofhepc.org*
- Reach out to your state hepatitis prevention coordinator
  - *https://www.nastad.org/*
- Reach out to Aids Education and Training Centers
  - *https://aidsetc.org/*
- Opioid groups, make sure hepatitis is represented
  - *Harm reduction coordinators*


Questions
NATIONAL
NURSE-LED CARE
CONSORTIUM
a PHMC affiliate

Next module: March 19, 2019 at 2:00 pm EST

Part 2: HCV Care Team Formation and Linkage to Care

Jillian Bird
Nursing Training Manager
National Nurse-Led Care Consortium

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

What to fill out…

1. Survey from CDN within 1-2 weeks for 1 CNE or CME credit

2. Follow up NNCC survey if you want to join our newsletter

Contact Information:
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Public Health Project Manager
Email: csimon@nncc.us
Phone: (215) 731-2177