Hannabah Blue: ...about Hepatitis C and HIV Prevention Services Integration. Please throughout the webinar type your questions into the chat box, it should be in the lower right hand corner of your screen. Please select the "all panelist recipient" option so that we all can see your questions. Then at the end of the webinar we will have time to answer any questions that you have.

Hannabah Blue: Today we will be discussing how to integrate services related to Hepatitis C or HCV into your HIV services. In order to assist with this discussion we will be focusing on describing Hepatitis C risk factors and populations affected in relation to HIV. We will also discuss how Hepatitis C affects people living with HIV. Lastly we will list strategies for integrating Hepatitis C prevention and treatment services into current HIV services.

Hannabah Blue: To start us out we want to begin by getting your thoughts on the importance of integrating Hepatitis C into HIV prevention and treatment services. Would you please chat your answers into the chat box to the question, "Why is it important to integrate Hepatitis C services with HIV prevention and treatment?"

Hannabah Blue: Please type in your answers to the question on your screen and I will call them out as they come in. Great we have coinfection in common. Hepatitis C is often overlooked. Hepatitis C is an opportunistic infection. Coinfection is important. Many HIV patients are at greater risk of Hepatitis C.

Hannabah Blue: Also because we have a ton of "captive" audience, so why not comprehensively address all issues. Also same populations, similar populations have the same challenges. That's right.

Hannabah Blue: All right, we'll give a couple more seconds. Also, and we'll get into this, it's great. We have HIV knowledgeable participants today. Statistics show that one in four people living with HIV are also living with Hepatitis C, so integrating services may make it easier to reach the population. Yes, excellent. All of that is great information.

Hannabah Blue: We'll continue throughout the webinar to address all of those great points that you all made. So very glad that we have people who are passionate, knowledgeable, and just really into this topic as much as I am and I'm sure our panelists are as well.

Hannabah Blue: Let's start by reviewing what Hepatitis is first and foremost. Hepatitis means inflammation of the liver. Just some fun facts about the liver are that it is the largest internal organ as you can see on the picture from the slide. It also plays hundreds of different functions in keeping our bodies running. Including storing nutrients and removing waste products from the blood, so it's a very important organ. Hepatitis is most often caused by a virus, so therefore viral Hepatitis is a

serious and growing threat to the health of Americans. The most common types of Hepatitis are Hepatitis A, Hepatitis B, and Hepatitis C.

Hannabah Blue: Hepatitis B just to give you a little bit of information about that is transmitted similarly to HIV, including through blood, semen and other bodily fluids, but the biggest difference with this is that the risk for chronic infection is related to age infection for Hepatitis B. About 90% of infants who are infected become chronically infected, or affected throughout their lifetime, compared with only two to 6% of adults. That's a little bit about Hepatitis B, but this presentation is going to cover HIV and Hepatitis C coinfection given the overall burden of Hepatitis C and the high risk of coinfection with HIV.

Hannabah Blue: So, why is integration important for us in the HIV field? Well, the rates of HIV coinfection, just like somebody mentioned, with Hepatitis B & Hepatitis C is growing. The rate of coinfection of Hepatitis C and HIV is actually more than double that of Hepatitis B and HIV. Also, more recent CDC estimates suggest that one in four, which is an increase from the one in five that's shown in the graphic on the right hand part of your screen, of people living with HIV who have Hepatitis C. So, it's actually increasing.

Hannabah Blue: Also, chronic Hepatitis B and Hepatitis C infection, can persist for decades without symptoms. As well know, that's very similar to HIV. So, about half of affected Americans are unaware of their status, and not engaged in care treatment.

Hannabah Blue: It's also important to note that there are vaccinations against Hepatitis A and B, but there's no vaccination for Hepatitis C. So, testing is very important.

Hannabah Blue: As we heard, also, people living with HIV are disproportionately affected by viral Hepatitis. Once coinfected, people with HIV and viral Hepatitis can experience faster disease progression and mortality.

Hannabah Blue: All of these points, as well as the points that you provided in this sessions questions, lead for the need for integration. So, in this webinar, we will talk about areas of integration for HIV, and Hepatitis C, that span prevention, care and treatment.

Hannabah Blue: Let's compare HIV and Hepatitis C burden and risk. I'm sure you all are pretty well familiar with HIV information and many of you are probably are with Hepatitis C, but let's just compare and get that basis as we move forth with the webinar.

Hannabah Blue: Overall, the rate of annual HIV infections is decreasing. But, for Hepatitis C infections were declining, but diagnoses have increased in recent years. Also the

burden of prevalence for HIV is, in the U.S., is less than half of that for Hepatitis C. Both HIV, and Hepatitis C, can be transmitted through blood, semen, and other bodily fluids, but the list of transmissions varies between these fluids. So, in HIV prevention, here in the U.S., we focus on blood and semen as the primary fluids for transmission, but with Hepatitis C, the focus is on that blood-to-blood.

Hannabah Blue: So, now, let's look at the specific modes, or routes, of transmission. With HIV we focus on unprotected sexual contact first, primarily, anal, or vaginal sex. Usually with someone who has an unknown HIV status, or someone who does have HIV, or someone who is not using a condom, or taking medication to prevent or treat HIV. Then, the second route that we focus on is sharing injection drug use equipment. Then, the mother-to-child transmission. But, through advances in HIV prevention and treatment, the annual number of HIV infections through that mother-to-child transmission have really declined, by more than 90% since the early 1990s. So, it's less of a focus in the U.S. here.

Hannabah Blue: With Hepatitis C, it's a little bit different. First, is that sharing injection drug use equipment. Then there are lower risks for mother-to-child transmission and sexual contact. This is again because of that blood-to-blood contact that we focus on for Hepatitis C.

Hannabah Blue: Of course, we know that there are other factors that can affect these risks. About 6% of babies born to mothers infected with Hepatitis C become infected with Hepatitis C, but this risk increases two to three times, if the woman is coinfected with HIV. So, addressing coinfection, especially among women and those who are pregnant or may become pregnant is particularly important.

Hannabah Blue: Then for sexual risk of transmission of Hepatitis C, the risk increases for those who have multiple sex partners, have had a sexually transmitted infection, engaged in rough sex, or are coinfected with HIV, or sorry, infected with HIV.

Hannabah Blue: Recent research has shown that sexual contact among men who have sex with men or MSM, is emerging as a route of transmission for Hepatitis C. So, new data suggests that sexual transmission of Hepatitis C among MSM, and particularly, MSMs who are living with HIV or AIDS, occurs more common than previously thought. So, it's believe that maybe stimulant use, unsafe sex practices, and genital alterations contribute to these higher rates. But more research is needed to better understand how and when Hepatitis C can be spread through sexual contact.

Hannabah Blue: Let's look at mortality. We saw Hepatitis C deaths surpass HIV deaths between 2006 and 2007. Then, in 2012, Hepatitis C related deaths surpassed deaths from all other reportable infectious diseases combined. This includes 60 other infectious diseases, including HIV, pneumocele disease, and tuberculosis. But,

the actual number of deaths may be higher from Hepatitis C due to under-reporting on death certificates.

Hannabah Blue: So, let's pause here for a quote from Dr. Jonathan Mermin. "Why are so many people in the U.S. dying from a disease that is preventable and curable?" The high mortality rates from Hepatitis C stem from several factors. Including low testing rates, lack of access to affordable and quality treatment, as well as few noticeable symptoms. So, Dr. Mermin calls for routine testing and treatments, which we will talk about here in a little bit.

Hannabah Blue: Now, let's look at how HIV and Hepatitis C infections compare. Both viruses can be present in a person without showing any symptoms for years. As such, an estimated 85% of people with HIV know their infected, while only 50% of people with Hepatitis C know that they're infected. For everyone living with HIV, and most people living with Hepatitis C, it is a long term, chronic infection. And, about 70 to 85% of people with Hepatitis C, will develop chronic Hepatitis C while the rest will clear the virus from their bodies without treatment.

Hannabah Blue: Experts aren't entirely sure why some people develop chronic Hepatitis C, while other don't, but some of the factors that they have found to affect this progression include alcohol use, older age, and coinfection with HIV or Hepatitis B.

Hannabah Blue: So, while there's currently no vaccine or cure for HIV, current treatment regiments can help people living with HIV get their viral loads to and undetectable level that you equals you, right? Which means that they effectively, have no risk of sexually transmitting a virus to an HIV negative partner.

Hannabah Blue: While, there's no vaccine for Hepatitis C, there is a cure. New Hepatitis C treatments have become available in recent years that cured nine out of 10 people who complete them. But, a study published in 2014, estimates that only 9% of people who have been treated and cured of Hepatitis C.

Hannabah Blue: While these break-throughs and treatments for HIV and Hepatitis C have been game changes in recent years, there are still unfortunately limitations that limit access to certain populations, in certain areas. So, we'll discuss these challenges a little bit later in the webinar.

Hannabah Blue: Now that we've compared HIV and Hepatitis C, let's talk about coinfection, right? The reason we're all here. People living with HIV are at increased risk for Hepatitis C, as we mentioned. Specifically, of people with HIV in the U.S., about 25% or on in four are coinfected with Hepatitis C. This equates to about 300,000 people. Then, about 80%, or four out of five people living with HIV who inject

drugs, also have Hepatitis C. It's likely that some of the individuals that your organization serves, has Hepatitis C. With almost half of the individuals in the U.S. with Hepatitis C not knowing their status, it's important for organizations providing HIV services to consider also addressing Hepatitis C if they're not already. Especially, as somebody mentioned, it will improve the health of these individuals overall, more comprehensively.

Hannabah Blue: So, what risks does coinfection pose? Well, people with HIV who are coinfected are at increased risk for serious, life threatening complications. Infections progress more quickly, and coinfection more than triples the risk for liver disease, liver failure, and liver related deaths from Hepatitis C. In comparison with people only living with Hepatitis C, persons coinfected with HIV have higher liver related mortality as well as overall mortality.

Hannabah Blue: So, as I mentioned, advances in treatment have been game changers for people living with HIV and Hepatitis C, previously, Hepatitis C treatments were only effective among a much smaller percentage of people living with HIV. And unfortunately, more people experienced adverse events associated with treatment. But, the new direct acting antivirals now available, are much more effective, and generally safer.

Hannabah Blue: However, drug interactions continue to be a concern among individuals on life-long HIV treatment. But studies have show that medication interaction between HIV and Hepatitis C treatment is minimal, and often outweighed by the benefits of treatment.

Hannabah Blue: But, some clinicians may choose to defer antiretroviral therapy until Hepatitis C treatment is complete. But, really, these determinations are made on a case-by-case basis, and really have to take into consideration the judgment of the clinicians at that point.

Hannabah Blue: Also, a little bit more about the treatment side with coinfection, a recent study found that coinfection treatment was more successful with better outcomes for people living with HIV and Hepatitis C when their providers had a few characteristics.

Hannabah Blue: One is that they had experience or training treating people who were coinfected, and when they had positive expectations of treatment outcomes. Which are great qualities that we can help out providers to obtain.

Hannabah Blue: Also, I did want to note, that there has been a debate for starting people with Hepatitis C, particularly for people who inject drugs. Guidelines have previously advised providers to wait to start treatment until people have stopped using injection drugs, for the fear of reinfection. But, a recent study has shown, that

there is not a significant occurrence of reinfection among people who inject drugs.

Hannabah Blue: So, what about Ryan White HIV/AIDS program? The Ryan White HIV/AIDS program funding, the funding for it, or the funding from it, provides a great opportunity for addressing HIV and Hepatitis C coinfection. The Ryan White HIV/AIDS program provides HIV-related care for individuals who cannot otherwise afford treatment, including Hepatitis treatment for those who are coinfected.

Hannabah Blue: The Ryan White HIV/AIDS program funds are actually, currently, being used to address Hepatitis C among people living with HIV.

Hannabah Blue: In Rhode Island, for example, an HIV clinic used Ryan White HIV/AIDS program funds to improve adherence to Hepatitis C treatments among people who inject drugs. Some states are also using their Ryan White HIV/AIDS programs to treat substance use disorders. Between 2011 and 2014, the Health Resources and Services Administration, or HRSA, provided 29 programs, or supported 29 programs implementing focus interventions designed to increase access to, and completion of Hepatitis C treatments for people living with HIV.

Hannabah Blue: I'm sure many of you are familiar with the HIV Care Continuum. Just a little bit of background, the Care Continuum is a system that guides and tracks patients over time, through the health services recommended for HIV, and Hepatitis C carried treatments. This graphic shows the percentage of people engaged at each step of the Care Continuum. From diagnosis to viral suppression, for HIV, which is in the red. And then for diagnosis to sustained virological response, which is for Hepatitis C, which is in the blue.

Hannabah Blue: It's important to note that the chronic Hepatitis C Care Continuum looks a little different than that for HIV, but the steps are very similar. What is notable, is that at the outset. So, on the left side of the graph, you'll see that the number of people diagnosed with HIV is higher, 85%, meaning that more people with HIV know their status, in comparison to only that 50% of people living with Hepatitis C. So, this starts the Continuum out at a lower level, which then continues from the left to the right throughout the subsequent steps.

Hannabah Blue: There are challenges that are common in addressing both HIV and Hepatitis C. These are challenges that we know are common for HIV and Hep C. Then we'll talk a little bit later about challenges for coinfection. But, we know that these are very common in addressing these.

Hannabah Blue: This includes increases in substance use disorders, particularly from the opioid epidemic. Which has increased addiction and overdoses in the U.S. Also, many

communities are also still facing stigma and discrimination, including around people living with HIV, and or Hepatitis C. This is around MSM as well, lesbian, gay, bi-sexual, transgender, and queer populations. Around substance use, mental health, and even racism.

Hannabah Blue: Additionally, the priority populations for HIV and Hepatitis C are often vulnerable and hard to reach. Such as incarcerated, or formally incarcerated populations, and youths. While increasing infections in rural populations and MSM or LGBT populations, or, sorry, with increasing infections in those populations. There is also a challenge around access to treatments as affordable, quality, and culturally competent.

Hannabah Blue: So, a largely known barrier to Hepatitis C treatment has been the high cost of medications. But how has that affected access now? Well, since 2013, highly effective, save, and curative treatments, known as direct acting and survival drugs for Hepatitis C has been available. This treatment has been more effective, and more tolerable as I mentioned, which has also increased the number of individuals wanting, willing, and able to be treated. Although these new drugs are becoming available and costs are continuing to decline, the initial costs that were tagged with it were between $83, and $153,000 per treatment course.

Hannabah Blue: Because of these high costs it prompted health plans and payers to institute restrictive policies and pre-authorization procedures for treatment. These policies vary, but have included things like restrictions on the stage of Hepatitis C progression, documented alcohol and substance use, and practitioners' clinical specialty.

Hannabah Blue: These high drug costs, in addition to the restrictive policies, have continued to limit treatment access, and create a substantial barrier to curing people with chronic Hepatitis C infection in the U.S. Currently, patient access to Hepatitis C treatment requires health plan practitioners and staff to be able to navigate this really complex authorization process.

Hannabah Blue: All right, I wanted to pause and really, also acknowledge the really great knowledge that we have within our participants. So, please chat in your answer to this question, and this is really around the challenges that you may have seen about Hepatitis C and HIV integration specifically. So, if you have one challenge that you've seen or heard about related to integration specifically, please chat into the box and we'll read it out as we go forward.

Hannabah Blue: (silence)

Hannabah Blue: Oh, yes, we have a medication adherence, that is a big challenge. Client buy in, yes that is also a big challenge as well. Yes, definitely. Services may not be offered at the same clinical location, that's right. Funding, oh yes, definitely. Funding to support integration. Yup. Sometimes reservations among clinical providers. Services not offered together, maybe in the same location. Lack of services in rural communities, absolutely. Great. Thank you so much. Again, we will continue to integrate this information as we go through out the webinar, a lot of the things that you all mentioned, we also have on this list as well.

Hannabah Blue: The key challenges include adhering to their medications and staying engaged in care, in part, due to the cormorbidities that people with coinfection face. So, these cormorbidities result from suppressed immune systems affecting the cardiovascular, renal, metabolic central nervous systems. There's also limited data, specific to HIV coinfections, in terms of race, prevalence or trends. Organizations that are focused on only HIV or only Hepatitis C may face competing priorities, or as said, a lack of priorities for specifically addressing coinfections.

Hannabah Blue: There's also the challenge of siloed funding streams. With a lack of specific funding for addressing coinfections, which often contributes to lack of integrated prevention services. There's also, again, the lack of providers who specialize in training patients who are coinfected with HIV and Hepatitis C.

Hannabah Blue: Great, thank you for your input on that.

Hannabah Blue: Let's talk about a case example. You've all probably heard about the HIV outbreak that occurred in Scott County, Indiana a few years go. But, did you know that the majority affected by the outbreak were coinfected with HIV and Hepatitis C? The opioid epidemic, unfortunately, has really put many communities at risk for Hepatitis C and HIV in infections overdose deaths, and other health problems.

Hannabah Blue: Just to give you some background on Scott County, Indiana, it's a rural county that usually, previously, had reported fewer than five cases of HIV per year. However, a total of 188 cases of HIV were identified by the end of 2015. More than 90% of people with HIV were coinfected with Hepatitis C. Almost all individuals who tested positive for HIV reported injection drug use, including frequent sharing of syringes in drug preparation equipment, and injecting four to 15 times daily, with up to six other people at a time. In many cases, multiple generations within a family were injected, including youths.

Hannabah Blue: So, CDC has determined that there's evidence that other states and jurisdictions are at risk for rapid spread of HIV and Hepatitis C, including whole states and specific counties. Actually, there's a really great report that gives information about that, we're gonna chat out that information and then we'll also provide

you with other resources at the end of the webinar and you can check to see if your area is included in that list.

Hannabah Blue: As you noted, and as we discussed, there are many challenges in addressing HIV and Hepatitis C coinfection. But it also means that in addressing it, there can be many benefits. There's an opportunity to integrate public health and clinical care services by providing Hepatitis services as the same location as other key health services, including HIV prevention and care. These types of efforts, the co-location, have been shown to be effective in identifying individuals at risk or vulnerable. Linking individuals to care, and supporting sustainable education and testing practices. Integrating services can can also improve diagnosis and treatment for co-occurring conditions, such as sexually transmitted infections, substance use, or mental health disorders. It can better meet the needs of people living in rural or under-resourced areas. So, it also enables providers to take a more holistic approach to health, as someone had mentioned before.

Hannabah Blue: So, what do we do now? Let's talk about strategies. First we want to start at a high level, discussing what has been taking place nationally around addressing HIV and Hepatitis C coinfection. This is where many states, and local organizations take directions for their strategies, and then we'll move into some specific local strategies that your organization can take to address HIV and Hepatitis C coinfection.

Hannabah Blue: So, we're gonna open up this poll again. Please let us know your experience in addressing Hepatitis C and please select all that apply. Should pop up a poll on the right-hand side of your screen, please click that, and then we'll share the results of that poll.

Hannabah Blue: (silence)

Hannabah Blue: All right, please continue to answer the poll question, and we'll share the results very shortly. And we'll be able to see what experience we have addressing Hepatitis C with us today. All right, last call. Last call to fill out the poll. Alrighty, we're gonna close the poll.

Hannabah Blue: And we'll display the results. So, for myself, its a personal passion, and I currently support organizations integrating HIV and Hepatitis C into their programs.

Hannabah Blue: So, let's see what everyone else on the webinar who has joined us has answered. It looks like we have a good amount of people who have not worked on it, also a good amount of people who have worked on it. For one person, it's a personal passion. For a seven out of 55 people, their organization has a separate Hepatitis C program, and then 10 people are currently integrating.

Great. Thank you, we really appreciate you joining on this webinar, we appreciate you sharing your experience. We hope everyone takes a little bit of something out of this webinar and can apply it to their organization.

Hannabah Blue: All right, so, let's look at the national strategies. There are three national reports that will help to guide our strategies to address HIV and Hepatitis C coinfection. These are, the National HIV/AIDS Strategy, or NHAS. The National Viral Hepatitis Action Plan, and the National Strategy for the Elimination of Hepatitis B and C.

Hannabah Blue: As many of you know, the National HIV/AIDS Strategy was originally released in 2010, and then updated in 2015, with strategies that go through the year 2020. It serves as a collaborative national response through shared national goals and align efforts across sectors.

Hannabah Blue: The National Viral Hepatitis Action Plan focuses on Hepatitis B and C, which are the two most common types of Hepatitis in the U.S. This action plan was developed by representatives from 22 Federal agencies and offices that work together. It was released in January of 2017.

Hannabah Blue: Finally, the National Strategy for the Elimination of Hepatitis B and C has two reports that were released last year. The phase one report determined the feasibility of eliminating Hepatitis B and C, and it concluded that these infections could be eliminated as a public health problem in the U.S. The Phase two report talks about how to do it. Talks about the strategies, and that's the one that we're gonna focus on right now.

Hannabah Blue: We're actually gonna chat out the links for each of those reports, and you can click on those and check those out if you haven't seen them. Along with these reports, while focusing specifically on addressing and eliminating HIV or viral Hepatitis individually, it lists addressing coinfection as a key strategy. I'll highlight a few goals and strategies specifically mentioned in these reports for affecting HIV and Hepatitis C coinfection.

Hannabah Blue: It's a pretty long report, so we decided to summarize some key themes across all three, and share those with you. Some of these we talk about are ready, such as sharing priority populations, and integrating services by providing Hepatitis C prevention and treatment at the same time, and in the same place as HIV, as well as thinking holistically to include mental health, substance use, housing, [inaudible 00:31:47], and other services.

Hannabah Blue: Each report also cited the need to address stigma around HIV, Hepatitis C, and substance use. Each report also mentioned the devastating impact on addressing coinfection, or addressing HIV and Hepatitis C from the opioid epidemic, and the need to combat it.

Hannabah Blue: A common strategy mentioned was the use of syringe service programs, or SSPs. A large number of scientific studies has found that syringe service programs actually reduce Hepatitis C and HIV associated risk, and are an effective component of comprehensive, integrated approach to prevention. So, many SSPs provide other prevention materials and services, such as risk reduction counseling, overdose prevention education, and they provide linkages to other health and human services, such as drug treatment referrals, housing support services, and STI testing.

Hannabah Blue: Studies have shown that these programs substantially reduce the risk of HIV infections, that they increase linkage to drug programs, sorry, drug treatment, and they do no, I repeat, do not, increase drug use.

Hannabah Blue: Another strategy in each report was around utilizing HIV and Hepatitis C indicators for prevention. For example, an HIV prevention organization can target or prioritize a community that is found to have high rates of Hepatitis C as an early warning to prevent an HIV outbreak and visa versa.

Hannabah Blue: Finally, another strategy was around sharing best practices. Hepatitis C elimination efforts could benefit from drawing upon the models for leadership, surveillance, testing, care and treatment from the HIV field and additionally, HIV experts could look to the work of many Hepatitis C prevention organizations, specifically maybe, in utilizing syringe service programs.

Hannabah Blue: These are some goals and recommendations in each of the strategies. I won't read them out, you can see them here on the scream, but just know, each of the reports points to the need for integration as a key strategy. But, that NHAS, you have goal one, which talks about the need for integrated testing, sorry integrated screening. Goal two for the National Viral Hepatitis Plan talks about improving treatment around viral Hepatitis and people living with HIV. And then, number three is around a comprehensive system of care. All three of these talk about coinfection and integration as a key goal or strategy within these reports.

Hannabah Blue: How can your organization, your HIV prevention or services integrate Hepatitis C? We've identified three, kind of, overall frameworks for integration of Hepatitis C into HIV services ranging from a more broad, to a more intensive approach. The first is to refer patients to Hepatitis C testing and other services at other organizations. Through this approach, HIV programs can partner with organizations providing Hepatitis C services and refer their clients to them, for education, testing, and treatment.

Hannabah Blue: The next approach is to provide Hepatitis C testing and services at your location by hosting Hepatitis C providers. This can build upon referral partnerships, in the previous approach, by hosting Hepatitis C organizations to conduct testing in

your organization, they can provide educational materials and intervention services. Even syringe program services, they can provide case management, linkage to care. Your organizations can also partner to cohost events outreach efforts.

Hannabah Blue: This approach, though, it's important to know, and in the previous one, rely on the existence and accessibility of available Hepatitis C organizations in your area.

Hannabah Blue: The last one, the more intensive one, is to build internal capacity at your organization to provide Hepatitis C education testing, intervention, case management, linkage to care, what have you, at your location. So, this last approach is the most ideal, since the services and information are more holistic in nature, you're able to provide them at the same time and place. It's also a more client-centered model of care, which is shown to provide the best outcomes for health and wellness.

Hannabah Blue: And, this can also work best, if there's not currently Hepatitis C organizations in your area, or that are accessible to your client populations.

Hannabah Blue: If you want to know if these approaches are not exclusive, as you determine what's best for your community, in your organization, and integrate with services.

Hannabah Blue: What about specific strategies? Those are all approaches, but let's talk about what are some tangible steps folks can do.

Hannabah Blue: The first is to provide integrated care and treatment at the same time. Everything that we've been talking about. Your organization can do that by training healthcare providers to test all people diagnosed with HIV for Hepatitis C upon diagnosis of HIV. Or for those who remain the most vulnerable at regular intervals.

Hannabah Blue: Additionally, you can develop electronic record prompts, and quality improvement activities to increase healthcare provider awareness of Hepatitis C testing recommendations. Particularly among people living with HIV.

Hannabah Blue: The next is to target or prioritize those who are most vulnerable to coinfection, particularly people who inject drugs. As well as previous priority populations that we mentioned.

Hannabah Blue: Another strategy is to create and distribute materials with combined HIV and Hepatitis C messaging. Actually, CBA JSI is releasing an integration fact sheet along with this webinar, you may have seen it with the announcement, and we

would encourage you to share information specific to your communities coinfection statistics, considerations, and information. You can also create awareness among people at risk for living with HIV, about Hepatitis C, and the shared modes of transmission. The shared strategies for prevention, and the recommended treatments that can control, or cure Hepatitis C in people living with HIV.

Hannabah Blue: Educate communities and individuals about substance use disorders, and available treatments, about risk factors who Hep C and HIV, and about other health dangers associated with substance use disorders, and particularly injection drug use.

Hannabah Blue: A few more strategies, you can integrate Hepatitis C into existing HIV coalitions, community planning, action, or advisory groups, or you can start new coalitions that specifically focus on the coinfection.

Hannabah Blue: You can also promote harm reduction approaches through education and outreach, as well as through syringe service programs. You can work to improve access to sterile needles and syringes in those areas that are ... In populations that are vulnerable to HIV and Hepatitis C outbreaks, and you can also work to destigmatize substance use disorders.

Hannabah Blue: Finally, you can seek funding that's available to use for both HIV and Hepatitis C. Include exploring any that you might leverage for the Ryan White HIV/AIDS programs funds. Any of those funds that you already have are, or might seek out for HIV, and look at how you might address Hepatitis C with them.

Hannabah Blue: All right, so I want to make sure that we get to our case presenters who we have on board here. We have some great experts who've been working in HIV and Hepatitis C integration for many years. So, we are going to have them join us, but please remember to chat in your questions for myself, or for any of the case presenters throughout, and we will make sure to get them to them at the end.

Hannabah Blue: We are now joined by Andrew Reynolds who is the Hepatitis C Education Manager at Project Inform. I will now hand it over to Andrew to share his presentation. One second, Andrew, we will pass you ... Oh, you should now be the presenter. Take it away, Andrew.

Andrew Reynolds: All right, thanks very much Hannabah, that was really an excellent presentation. Sets me up really nicely, so I appreciate that. First, everybody can hear me okay?

Hannabah Blue: Yes, we can Andrew, thank you.

Andrew Reynolds: All right, excellent. Just a quick blurb on Project Inform and who we are. We work in HIV, Hepatitis C, and healthcare access. We do both advocacy and education. The HIV and Hepatitis C side of things, we work around prevention and treatment education, writing a variety of fact sheets, booklets, and that type of thing. Doing a lot of presentations like this. We also do a lot of work around PREP. Pre-Exposure Prophylaxis. And then, on the advocacy side, doing a lot of work around both a local, state, and national level, on all aspects of HIV, Hepatitis C, and access to care.

Andrew Reynolds: What I've been charged to do is talk a little bit about the challenges that Hannabah gave a really nice intro around, then to move into some strategies. Then, with Clinton, you're actually gonna see a lot of really great real-world examples from the work that he does. Hopefully it will flow very nicely.

Andrew Reynolds: I always like to start, when I talk about Hepatitis C, by saying, in a perfect world, Hep C would be easy. In reality, it really is easy from a sort of treatment and medication side of things. The treatments are as simple as one pill, once per day for eight to 12 weeks with minimal side effects. Cure rates that range from the mid to high 90s to 100% in some cases. For those of you who have experience in Hepatitis C, and were around in the Interferon and Ribavirin days, in a very short period of time, we've made a dramatic leap in Hepatitis C care and treatment. It's really quite amazing.

Andrew Reynolds: But, we don't live in a perfect world. We live in a world with limited health resources, with a lot of stigma around some of the behaviors that lead to HIV, and Hepatitis C transmission. So, there's a lot of work for us to do.

Andrew Reynolds: The first thing that we need to do is screen more people with Hepatitis C. And Hannabah talked about that really, really well. You've done a very good job of screening around HIV, and having a lot of people know their HIV status. We haven't done such a good job on Hepatitis C. One of the significant barriers around Hep C screening is stigma.

Andrew Reynolds: Stigma and fear keeps people from disclosing the risk factors that may lead to Hepatitis C transmission. So, if I'm a patient living with HIV, I might be really afraid to talk to my medical provider about my drug use for fear that I might lose access to certain services or fears that people have around disclosing their drug use to other individuals, and that type of thing.

Andrew Reynolds: Making sure that we work ... Well, I'll get to the strategies in the next slide, but making sure that we work to reduce stigma, I think, is probably the single greatest thing we can do around Hepatitis C.

Andrew Reynolds: The next bullet that we need to work around, is the lack of understanding of Hepatitis C transmission, and risk. I think this has gotten much, much better over the years. But, there's still a lot of work to do. Particularly with the opioid crisis as we see this new cohort of individuals at risk for Hepatitis C. Individuals who maybe start with pills and then transition into injection drug use. The Scott County example, that Hannabah gave, is a perfect example of limited access to information around Hepatitis C transmission.

Andrew Reynolds: I think we've done a really good job of explaining to people that sharing a syringe can lead to Hep C transmission. But so to, does the sharing of other injection equipment. Letting people know that even if you use a brand new syringe, but you share a cooker, a cotton filter. If you share water that somebody with Hepatitis C has used. There's a risk of transmission there.

Andrew Reynolds: In addition to making sure that these folks know that injection equipment can transmit Hep C, we also need to make sure that we give them adequate supplies. The cookers, the cotton, the water and so forth, so as to minimize the need to share. This is a role that we can play as syringe access service providers, but potentially also within our clinics, our AIDS service organizations, and CBOs, and the like.

Andrew Reynolds: Again, improve our screening, improve our prevention education, and then we need to improve our education around what people know about the new treatments. San Francisco has a campaign going it's called, New Treatments Have Changed the Game. We want to let people know that the days of Interferon are over. And if you've worked in Hep C, and you've talked to people who have done the Interferon treatment, you know, it was a nightmare. It was a year's worth of treatment with severe side effects. It worked, maybe, 50% of the time, overall. A little bit better for certain geno-types, but it was not a very good treatment. So, the horror stories of Interferon are really part of the social memory of individuals who are at risk for Hepatitis C. They don't realize that those days are long gone. None of the currently available recommended treatments for Hepatitis C include Interferon, and actually, we're moving to a place where a lot of folks don't even need to do Ribovirin, which also carries a significant number of side effects. So, educating folks around the new treatments is a really big piece.

Andrew Reynolds: Then, finally, and this is something more on the policy and advocacy side, the high cost of treatment is a significant barrier to getting Hepatitis C treatment. We're much better now, than we were, say in 2013, 2014, when these medications first came on the scene. We have seen some new drugs that have come in at relatively low prices. Older drugs have dropped in price, in response to that. So, things are better, but it's still really difficult.

Andrew Reynolds: There just recently was an article presented that showed that a significant, I think it was 50 plus percent of individuals with private insurance, weren't able to access Hepatitis C drugs, because of various coverage barriers. We're seeing the same thing in public programs, like various state Medicaids as well.

Andrew Reynolds: They'll enact barriers to accessing treatment based on really, arbitrary decisions around disease state. "Oh, you've got Hepatitis C, but your liver isn't that damaged. So, let's wait until you develop significant liver damage before you'll get treated." Or, "You had Hepatitis C, you're still using drugs. You know, you're not gonna be able to take these medications." But all these challenges can be overcome.

Andrew Reynolds: Again, Clinton is gonna get into this in his presentation, so I'll whip through this relatively quickly. To reduce stigma, to improve access to care, we should incorporate harm reduction throughout the clinical and counseling process. Essentially, that's taking a non-judgemental approach. This should be the foundation for all of our work, and people living with HIV, Hepatitis C, and those who use drugs.

Andrew Reynolds: Creating a space where people can talk about their concerns and risks will lead to more testing and referrals to medication assisted therapy, and other services. I think it's also important to screen for Hepatitis C routinely. Especially if somebody's living with HIV. Even if they say they're not injecting drugs, that's fine, but if they're sexually active, you want to screen, at least, annually, per recommendations from the American Association for the Study of Liver Diseases. And if the risk is a little bit higher, I would even go every six months.

Andrew Reynolds: Then, finally, don't withhold Hepatitis C treatment regardless of perceived risk practices. People who use drugs can, and do, adhere to medications all the time. It's the same with Hepatitis C. Their treatment rates are essentially the same as individuals who don't use drugs, and their risk of reinfection is thought to be crazy high, but in reality, it happens, but it's not nearly as high as most people think.

Andrew Reynolds: So, I think if we improve access to syringes, while treating people who are actively using, or actively injecting drugs, and then providing services and linking them to medication assisted therapy, we'll reduce new infections, and improve everyone's health and quality of life.

Andrew Reynolds: The end.

Hannabah Blue: Thank you so much, Andrew. Great.

Hannabah Blue: All right, so please again, chat any questions you have for Andrew into the chat box, we will get to them at the end.

Hannabah Blue: Now, we will hear from Clinton Alexander who is the Executive Director for Sacred Spirits. I will now pass the proverbial microphone over to Clinton. Take it away.

Clinton Alexander: Can you hear me Hannabah?

Hannabah Blue: Yes.

Clinton Alexander: Just making sure. Okay.

Clinton Alexander: It's a great opportunity to follow Andrew on this. I think you nailed it on the head in so many different key points there with key strategies that we need to be embracing around this as well as we look at integration. I'm grateful to be on here, I'm glad Hannabah asked me to be part of this. I have been intimately involved with this work for over 10 years in our community.

Clinton Alexander: I'm just gonna go through a couple key issues that are contributing to the increase of the HIV and Hep C coinfection. Giving kind of a context and focusing on factors that really drove this home for us in our communities. And why integration was essential in looking at this when we look at incidents and prevalence of disease burden.

Clinton Alexander: Clearly, there are differences in the opioid abuse rates between urban and rural areas. A lot of it stemming from higher rates of chronic pain and injury in rural counties, and communities. Which, also then translated into higher rates of opioid prescribing rates. We continue to see that today. I know over the last 15 years, we know that for American Indians we saw about a 519% increase in overdose fatalities. For whites in rural communities, 343% over 15 years. Those are the two highest population segments affected by opioid overdose.

Clinton Alexander: Drug abuse has become a primary cause of death and injury in our rural communities. Overall, overdose and abuse rates are similar to our HIV and Hep C increases, that we're seeing across all demographics in the U.S. One of the main factors that we have been concerned with, as well as others, is there's a limited access to treatment options. One study indicated that almost 91, or 92% of treatment facilities are located in metro and suburban areas, where we see about 27.9 beds per 100,000, compared to 42.8 per 100,000 in metro areas. There's definitely unique barriers that we face in addressing the opioid epidemic. Limited transportation, geographical isolation, perceived stigma in smaller communities, and a lot of just different factors that contribute to these problems.

Clinton Alexander: One of the things that we have looked at in our integration model is the impact of social determinants of how socio-economic disparities complicate our access to substance use. Treatment, services, particularly in communities, and as we know, Healthy People 2020 has emphasized public health efforts to be focused on our social determinants of health, in order to help us achieve health equity. So, integration was important for us.

Clinton Alexander: Can you change slides, Hannabah? I'm sorry, I'm not on.

Hannabah Blue: Yup, go ahead.

Clinton Alexander: Okay. Sorry, everybody. I am traveling between my reservation and the state tribal opioid summit on the other side of the state, and I've pulled into one of the biggest cities between here and there. A population of 900 people. So, I don't have access to internet here.

Clinton Alexander: So, American Indians, Alaska Natives, has experiences a 25.4% increase in new diagnoses of HIV between 2010 and 2014. For Hepatitis C the largest increase of acute Hepatitis C among American Indians, Alaska Natives from 2010 to 2015 was among people from 20 to 29. The Hep C strategy we talk a lot about baby boomers, this was a trend that we saw in our community. People under the age of 30 who were affected with Hepatitis C which was clear indication of activity associated with injection drug use. In 2015, acute Hepatitis C rates among American Indians was 1.8 per 100,000, which was twice as high ... Higher than the rate for whites.

Clinton Alexander: In 2015, American Indians, Alaska Natives had the highest Hep C-related mortality rate compared to any other racial group. The main risk exposure or behavior was from injection drug use at 64.2%. Alcohol abuse contributes to Hepatitis C with 14% and 36% of people who use alcohol are infected with Hep C.

Clinton Alexander: Another trend we have been watching over the years is our sexually transmitted infections. Gonorrhea, for American Indians and Alaska Natives was 242.9 per 100,000. Which is a rate that was 4.4 times higher than whites. Chlamydia rate 749.8 per 100,000, which was almost four times higher than whites. And Syphilis was 8 per 100,000, 1.6 times higher than whites, and if you're like Minnesota, we've seen a significant increase over the last couple of years, particularly amongst our drug using population.

Clinton Alexander: Next slide.

Clinton Alexander: Both, Andrew and Hannabah referenced Scott County, and this is where I felt a very personal connection to this in the context that over two decades ago, we

had an elder from one of our villages talk about this issue and something that we needed to be looking at was high rates of STDs, community information that people were injecting drugs, and for a long time, our coalition that really was at the heart of our integration efforts, really wanted to understand what was going on with this.

Clinton Alexander: Because Scott County really provides that context for understanding our development, we were concerned about the increasing STI rates, we knew with our injection drug use, that was being discovered through focus groups, as well as something I'll share in a little bit with an HCB cluster. We knew that we needed to increase our efforts to increase the awareness about HIV testing and prevention.

Clinton Alexander: We knew that our public health programs were doing work in the communities, but a lot of that was limited again, by the same factors that drive the issues around stigma. So, we needed to develop our capacity to increase knowledge about HIV status. That became one of our main priorities. So, with our coalition, we started with our Indian health services, our tribal programs, both behavioral health, and public health, as well as incorporating a lot of the community-based organizations, their efforts. In order to align them, to leverage our resources, and impact and prevention. Because again, incident numbers were low, our prevalence was low, so, to get the dollars and the resources we needed, we had a long way to go, so we really worked together to really make that case.

Clinton Alexander: In 2010, we had a Hep C cluster that was in one our villages which impacted several individuals within one close network. Very similar to what we saw with HIV in Scott County. That brought HCB into the focus of our coalition. So, the prevention efforts that we were engaged in with our community, led to developing universal screening protocols, and strategies to collaborate across the spectrum of prevention. At the heart of our efforts, coalition development became one of our most formal approaches to increasing awareness that would allow us to also leverage resources, and identify the opportunities, and need for policy and systems change. We actually asked for a resolution from our tribal council, essentially, enacting us by law, in recognizing us as an organization some of the work that we needed to do.

Clinton Alexander: Within all of this, we worked with our community to make sure that they understood what harm reduction was and the buy in from our community really was critical to getting that awareness out there, as well as just broad acceptance across the board of harm reduction as a evidence-based, and a solid approach to this. From this, we have continued to develop partnerships across local and regional community-based organizations working with national capacity building partners, federal agencies, and community members.

Clinton Alexander: Today, I'm honored to serve as our Harm Reduction Integration Manager. I work between our public health and our behavioral health programs. Working with a staff of incredibly talented passionate individuals who are committed to this work from both the public health side, as well as the behavioral health side. So addressing conditions of use along with the use itself.

Clinton Alexander: We are now running an integrated harm reduction program through our public health clinics and community outreach that incorporates the syringe exchange programming. The things that Andrew touched on, are so critically important that as you look at integration models, that those are there because the national strategies are based on the cascade of care, and people knowing their status, and we know for rural and tribal communities, status, a lot of people don't know. So, these efforts are incredibly important that we incorporate screening, as well as the linkage to care and supporting pathways to recovery, and other types of linkages into supportive care that people might need.

Clinton Alexander: Within our community, we've also broadened this to include efforts to increase our overdose response capacity. The systems that we are doing incorporate work with our law enforcement, first responders, emergency rooms, really looking the systemic picture and saying, "How do we work together collectively, to address these needs?" And the work just continues to grow, over, and over. I think of my life, my job as such an incredibly amazing experience to be a part of and to see what we can do with the individuals that have inherited this work.

Clinton Alexander: Next slide.

Clinton Alexander: This I could probably just say what Andrew said, and what Hannabah was talking about. Syringe Exchange Services, or Syringe Service Programs are highly effective. They don't increase use. We have gone through our communities year after year, now, for the last three, four years and we are finding very little to no syringes in public spaces. Whereas before, we would find those all the time. I think those are incredibly important pieces for community buy in. But, it also talks about the number of people who are accessing our services.

Clinton Alexander: I kind of skim through a little bit faster than I thought I would. I think that's my last slide, right Hannabah? Since I don't have the computer in front of me. I apologize.

Hannabah Blue: No worries. Thank you, Clinton. Yes, your last slide were your citations, which I've just displayed on the screen.

Clinton A.: Okay. Perfect, thank you.

Hannabah Blue: Thank you so much. Thank you to both of our panelists, for sharing this very valuable information and perspective. Especially their experience in working in these different areas that we've talked about.

Hannabah Blue: I apologize for being a little bit over time, but as Chris sent out to the folks online, again, we apologize for going slightly over, but we will stay on longer to address any questions you have. If you are unable to stay with us past this time, please feel free to email us at CBA@JSI.com. You may also chat your questions personally to each panelist, and provide your email address so that they can, and we can reach out to you, if you'd like.

Hannabah Blue: Thank you so much. We will answer some of the questions that we've gotten into the chat box at this time. So we'll start with the question from [Nicky Harp 01:03:55] it was a question that said, "Is staging still a prerequisite before treatment?" And actually, I'm gonna have Andrew Reynolds provide the answer to this question.

Andrew Reynolds: Cool. Thanks. Yes. That's a great question. And the answer is medically no. Staging should not be an issue for Hepatitis C treatment. Anybody infected with Hepatitis C per the AASLD/IDSA guidelines should be treated, unless you have a terminal illness that can't be improved by curing Hep C, or liver transplantation. So, if I've got a minimally diseased liver, and I have pancreatic cancer, it might not make sense to treat my Hepatitis C. Focus on my quality of life. But, otherwise, everybody should be treated. That's the medical answer.

Andrew Reynolds: But, unfortunately, there are a lot of insurances that don't listen to medical professionals. So, dependent upon what state you're in, Medicaids might say you need to have a fibrosis score, which is a measurement of scarring of the liver, of 2, or worse, or 3 or worse. We're starting to see changes in that. A lot of states are getting rid of these types of restrictions. But, they're still out there.

Andrew Reynolds: What I'll do is, I'll get Hannabah, and Chris, a really nice resource from the National Viral Hepatitis round table, and Harvard that shows various states, and what their restrictions are.

Andrew Reynolds: Again, medically, no staging shouldn't matter. If you got Hep C, you should be cured. But unfortunately, from an insurance perspective, it can still be a barrier.

Hannabah Blue: Thank you, Andrew. We also got another question in also from Nicky, "Is a geno-type still necessarily? Isn't there a drug that treats every geno-type?"

Andrew Reynolds: Yeah, there actually now are a couple of drugs that treat every geno-type. You know ... it's still recommended that you do the geno-type test. So, yeah, it's still something that is done. So, I would say yes, you still want to do the geno-type.

Hannabah Blue: Great, thank you so much. Just to let everyone know, we will be sending out these slides, as well as the resources that we mentioned. We also will post this recording on our website. And we did have another question. That was from Franklin Hood, "What was the first way to integrate?" I'll just review quickly the three ways that we mentioned around larger approaches to do integration.

Hannabah Blue: The first is to refer clients to HIV testing and services at another organization. So, that's the first way?

Hannabah Blue: The second way is to partner with an or to provide Hepatitis C testing and services at your location.

Hannabah Blue: Finally, the third way is build the internal capacity to provide Hepatitis C testing and services, and training.

Hannabah Blue: Again, noting, that these are not all mutually exclusive, they can happen with different areas simultaneously. But, just as an overall, we do, as we've noted, the third way in terms of building that internal capacity, is really gonna be the most effective, and is also helpful in areas where there may not be those resources available.

Hannabah Blue: All right, so we'll leave it up a little bit longer for some more questions, again, you can please feel free to email us, at CBA@JSI.com. We do have some key considerations that we wanted to mention. And just to kind of bring home the information, remember those priority populations. Think about the feasibility of your model, which one you want to take, and what's gonna be the most helpful and appropriate for your organization. Think about your internal capacity, and how you might provide staff training. Consider those benefits, as well as those challenges.

Hannabah Blue: Then, think about the approaches. So harm reduction, specifically, which we heard a lot about. And then integration. Keeping on top of, and in track of the different advances that happen in each of these fields.

Hannabah Blue: Finally, here's our resources. Again. We'll actually post this as a specific page resource for people. This includes resources that we sourced all this information from. We want to be able to provide that all for you. This includes information specifically for coinfection, that can be really helpful.

Hannabah Blue: Then we also wanted to shout out a infographic that we created and also have currently available on the CBA JSI website if someone wants to chat that out to all the participants. You also may have seen it when you received an invite for this webinar.

Hannabah Blue: Then we do want to let you know about some free resources that we have available for you. So, again, CBAJSI is a capacity building assistance provider, funded by the CDC and we're available to provide free, tailored, technical assistance and training to community-based organizations. Including those serving Spanish speaking, or Native American communities, and in order to support the HIV Continuum. So, you can request CBA services on topics discussed through this webinar. And specifically around HIV and Hepatitis C integration.

Hannabah Blue: So, to request CBA, please visit us CBA.JSI.com, or write to CBA@JSI.com.

Hannabah Blue: I do, before there are other folks log off, I do want to share our contact information for each of the panelists.

Hannabah Blue: Here's my email address. Andrew Reynolds' email address, and Clinton Alexander's.

Hannabah Blue: We do have one more question, and I don't know if you can see this one, Andrew, but, "Are needles the only way Hepatitis C is transmitted for drug users?" And, actually, I'm gonna take that, we talked about how there are injection drug equipment that also can transmit Hepatitis C for injection drug use. Not just needles, but the cookers, the cottons, other things that are available, or utilized for injection drug use.

Hannabah Blue: Just wanted to see, anything you would want to add to that, Andrew?

Andrew Reynolds: No, yeah, that's definitely anything that can come into contact with Hep C infected blood. So, again the cookers, the cotton, the water. Also, it's important to point out that sharing of straws for shorting drugs could potentially lead to transmission of Hepatitis C. And there's some evidence to suggest that even the sharing of pipes.

Andrew Reynolds: So, we're talking a lot about opioids, opioids, opioids, but we still have people who smoke crack, who smoke crystal meth, and if I've got bleeding lips, and bleeding gums, and I have Hepatitis C, my blood could get on the stem of a pipe, and then somebody else smokes that pipe, and they've got bleeding gums, there's a risk of transmission. It's not the same as sharing of injection equipment, but it's still high enough that I think it warrants ... If somebody tells you that they snort drugs, or smoke drugs, screen them for Hepatitis C as well.

Hannabah Blue: Excellent. Thank you so much. Again, thank you all for joining us, we really appreciate your time, and we apologize for going over time, but we appreciate those folks who were able to engage with us, and ask questions. Please feel free to reach out to us, email us, also, utilize the CBA@JSI.com email address, to

reach out to us. Visit our website, and please keep in touch, and thank you so much, [inaudible 01:12:12] for all of the amazing work you all do. Thank you so much, take care, and have a great day.

Hannabah Blue: And please fill out the evaluation that comes up on the screen, as you're closing out the application. We love evaluations. Thank you so much. Bye-bye.