Julie Hook: Good afternoon, and welcome to this webinar on incorporating hepatitis C services in integrated HIV prevention and care planning. My name is Julie Hook from JSI and the Integrated HIV/AIDS Planning Technical Assistance Center, or the IHAP TAC. I want to thank everyone for making time to be on today's webinar.

Julie Hook: During the webinar, we'll present on how to best integrate hepatitis C viral services into HIV prevention and care planning to better address community needs, leverage resources, improve efficiencies and enhanced coordination of service delivery.

Julie Hook: Speakers from our partner HealthHIV and the Hawaii Department of Health will discuss challenges and promising practices on leveraging HIV prevention and care programs to including hepatitis C viral services within health departments.

Julie Hook: The slides are available now for download on our IHAP TAC webpage on the TargetHIV website, which we'll chat out in a moment. And the transcript and recording will also be made available on our webpage early next week.

Julie Hook: We hope that you're familiar with the IHAP TAC. But if you're not, we're a HRSA HAP funded TA center to support Ryan White HIV/AIDS Program, Part A & B recipients and CDC grantees and the respective planning bodies and councils with their overall integrated planning efforts and the implementation and monitoring of their integrated HIV prevention and care plans.

Julie Hook: We provide both national and targeted technical assistance and training activities. The IHAP TAC is led by JSI with our partner HealthHIV. We provide support in the areas outlined on the slide and encourage you to visit our website to view our resources or follow up with us to discuss TA needs you have around integrated planning.

Julie Hook: We'll be answering questions at the end of the call, and we'll answer as many as time permits. If you have questions, please chat them into the chat feature. And I also want to let folks know that after the webinar ends, an evaluation will pop up immediately and we hope you'll fill this out as it helps us to improve and inform our future webinars.

Julie Hook: Following the webinar, participants will be able to describe rationale and strategic framework for incorporating hepatitis C virus services into state integrated HIV prevention and care plans. Identifying strategies for inclusion of HCV services and programs to better address community needs, leverage resources, improve efficiencies and enhance coordination of service delivery, as well as discuss methods for monitoring and evaluating HCV services as part of integrated plans.

Julie Hook: Now I'd like to introduce our speakers today. Marissa Tonelli is the director of Health Systems Capacity Building for HealthHIV. She leads their technical

assistance programs that enhances abilities of health departments, CBOs and other health organizations to conduct enhanced data collection and analysis to make better informed programmatic decisions around the delivery and sustainability of HIV prevention services.

Julie Hook: And she also works with the JSI as part of the IHAP TAC team. Thaddeus Pham is currently viral hepatitis prevention coordinator for the Hawaii State Department of Health and the Harm Reduction Services Branch. He's also the cofounder and co-director of the HepFree Hawaii Coalition, a community-based program focused on increasing awareness and access to hepatitis services in Hawaii.

Julie Hook: In 2018, he was recognized by the National Minority Quality Forum as a 40 under 40 leader in minority health. He poses public health from a social justice perspective and seeks to leverage community partnerships and systems level policy changes to address health disparities regardless of disease state. I'd like to turn it over to Marissa.

Marissa Tonelli: Great. Thank you so much, Julie. We're really happy to be able to participate today and be able to kind of kick off the webinar with our colleague from Hawaii. Good afternoon to everyone on the webinar today and good morning to those in Hawaii, Guam, and the Marianna islands.

Marissa Tonelli: As Julie mentioned, my name is Marissa Tonelli, and I serve as the director of health systems capacity building at HealthHIV, working on the IHAP TAC as a partner and also doing technical assistance for health departments, healthcare organizations, CBOs and a variety of other HIV prevention partners across the country.

Marissa Tonelli: My goal here is really to provide an introduction to this collaborative webinar and really set the stage for our discussion around strategies and models for incorporating Hepatitis C services into state and local integrated HIV prevention and care plans and into the health departments and services they provide themselves.

Marissa Tonelli: So really what we're talking about when we're talking about incorporating Hepatitis C services, there's a variety of ways that this can happen. Health departments across the country are integrating their programs or services for a variety of reasons, and a number of them are beginning first and foremost with maximizing resources.

Marissa Tonelli: So with limited federal and state resources, one important rationale for integrating hepatitis C services is to lower cost by addressing both Hep-C and other concurring conditions simultaneously. Another reason is that we really have the ability to respond to syndemics with similar risks for acquisition.

Marissa Tonelli: So HIV, STIs, and hepatitis C, and that allows us to eliminate duplication of services and also enhance the capacity to address multiple goals, ao across a

number of different planning goals, federal and state initiatives as well. And lastly, really thinking about maximizing the opportunities for the clients themselves to receive the best care and treatment.

Marissa Tonelli: So ensuring that we don't have any missed opportunities. We know there's overlapping risk factors among risk populations, whether it be those living with HIV, people who inject drugs or men who have sex with men and really thinking about focusing on the patient needs rather than service areas, which often are siloed by funding. Organizational structure is really important.

Marissa Tonelli: And then I also want to point out kind of this renewed and a new focus at least by the federal level on the opioid epidemic. And certainly kind of keeping in mind that as we address the opioid epidemic, we also have to address the growing rates of infectious diseases as a result.

Marissa Tonelli: So that includes HIV and Hep-C and perinatal infections. And also of course, kind of bringing new partners together, bringing different partners internally and externally to our health department together to address Hep-C can be really beneficial. As I mentioned, really kind of the biggest rationale for this integration is it's client focus.

Marissa Tonelli: Thinking about the client needs not as separate disease-based program funding and reporting is really important. We can give clients access to comprehensive services. So across HIV, STD, viral hepatitis. Again, that's tailored to their needs, their risks, rather than the program outcomes or outputs.

Marissa Tonelli: And again, reduce missed opportunities. We also recognize there really is kind of an already shared skillsets across health department staff and positions. Many health departments that we've talked to and interacted with, they're already thinking about this.

Marissa Tonelli: This is kind of a really obvious integration and expansion of their staff roles and staff positions to start thinking about Hep-C because it's what the clients are requesting and needing. So again, we have the skillsets there to make this a very client-focused process there.

Marissa Tonelli: There really are a variety of opportunities to do this at a health department level and at a planning level, and we're going to go into that a little bit more. Kind of the obvious is the service level integration. So integrating hepatitis C screening, navigation or linkage to care, whether it's at an STI clinic, an HIV program or a HIV case management services for people living with HIV.

Marissa Tonelli: Those are things that can happen sometimes relatively easily in leveraging those existing programs that are all already reaching those risk populations. Of course, provider outreach, especially among those who are already providing HIV care. Many of them are already seeing coinfected or mono infected hepatitis C patients.

Marissa Tonelli: And then as I mentioned, this opportunity to expand public health staff roles. Cross-training can happen via AETCs. I know there's a variety of training programs out there. But thinking about training staff, not just in HIV as a silo, but STDs and hepatitis C.

Marissa Tonelli: And one way to do this is also thinking about updating the position expectations and responsibilities and I believe Thaddeus is going to mention this as well when it comes to some of their HIV staff and harm reduction staff. We also mentioned kind of thinking about people who inject drugs, so those at-risk populations.

Marissa Tonelli: Opportunities for Hep-C service integration can happen at syringe services programs. This may already be happening, but HIV funded syringe services programs. Thinking about drug user health initiatives and other opioid response efforts that are happening. Hepatitis C disease prevention should certainly be a part of this.

Marissa Tonelli: And then lastly, thinking about partnerships across programs and externally even looping in behavioral health services and settings as a part of this integrated partnership to identify people with hepatitis C and really leverage existing services because we know the funding for Hep-C is quite limited federally on a state level.

Marissa Tonelli: There are a number of barriers. We recognize this, and I'm sure there's many more than are on this slide here. We know they're very siloed systems of prevention and care in HIV already, and there's also siloed systems across disease states in hepatitis C, viral hepatitis and also STDs.

Marissa Tonelli: And sometimes that makes these systems incompatible, whether it comes to services, data and funding. Of course, there often is a lack of flexibility in the use of federal HIV funding, especially for those mono infected with Hep-C. And of course, kind of a limited surveillance data at a local level and a federal level around people living with chronic hepatitis C.

Marissa Tonelli: There also may be a lack of resources to cross-train staff or staff just might have limited time. They're already maxed out, burning out with the variety of tasks that they've already taken on. And then we're also faced structurally with some barriers in Hep-C treatment, access challenges and eligibility challenges.

Marissa Tonelli: And I won't go into that now, but there's a variety of resources and providers really looking into, how do we address treatment access and eligibility for treatment? So one of the things that we did as we were thinking about this webinar was we really wanted to think about how health departments are already incorporating hepatitis C services into planning.

Marissa Tonelli: So we wanted to see what hepatitis C activities look like currently in the integrated HIV prevention and care plans. Now, I'll provide a little caveat that I

know some health departments do not always make their updated plans on an annual basis publicly available, so this is really based on publicly available data.

Marissa Tonelli: But I think it still shows kind of on a higher level where health departments are really focused in integrating Hep-C. So over half have included Hep-C in their work plan activities, and there were very few that had no mention of hepatitis C. This is across 74 state and local integrated HIV prevention and care plans.

Marissa Tonelli: About a third mentioned hepatitis C as part of their needs assessment, but did not specifically mention hepatitis C as part of their work plan activities. And most health departments are thinking about hepatitis C even in their integrated HIV prevention and care planning.

Marissa Tonelli: But I think what we're trying to do here is really encourage it to be something in a work plan that has meaningful metrics and outcomes over the course of your year to year activities. So the primary ways that health departments seem to be incorporating Hep-C is screening. That was kind of the largest category.

Marissa Tonelli: We also noted that there was activities or tactics around identifying risk populations and engaging them, training providers in Hep-C, some surveillance and data sharing, collaboration, linkage to care, and if you were to plan program planning, harm reduction services related to both HIV and Hep-C, and then also behavioral health awareness and support related to HIV and Hep-C together.

Marissa Tonelli: Other mentions that were not listed here include some health departments which are already co-locating services for HIV and Hep-C, whether that's through kind of a local health department clinic or encouraging their funded providers to do so. Outbreak response and also some health departments mentioned doing some social media and marketing work around Hep-C prevention and screening, which is great.

Marissa Tonelli: So we wanted to just quickly ask a poll about how your health department is integrating Hep-C services. You can select as many of you want. The options are hepatitis C screening, risk population identification and engagement, education and training of providers, data sharing, linkage to care, strategic program planning, harm reduction or behavioral health or others. You can feel free to chat in.

Marissa Tonelli: And I also see a question from [Rajiv 00:00:15:23]. I don't know if the facilitators want us to... We could answer that at the end. It is a complex question around Ryan White grants, which is certainly challenging and siloing services. So we can save that for the end or address it now. But I am seeing a number of results come in. We're just going to wait. Okay, great. So this looks a lot like what we saw in the plans.

Marissa Tonelli: Certainly the majority of health departments are already integrating the screening piece around Hep-C. It looks like next highest is linkage to care and

access to care, which is great. So linking to Hep-C care after screening, and then education and training of providers. So that's an important opportunity.

Marissa Tonelli: I see harm reduction and then I also see risk population identification. So there's a number here. I saw people selected chat-in, but I didn't see any chat-ins or feel free to share some other strategies you're using or opportunities for integrating Hep-C services. But it's great to see that a number of these are being implemented across the board.

Marissa Tonelli: So we kind of looked at this in a level of integration and created a number of tiers to try to think about how these strategies might work. Acknowledging that every health department, whether you're a state health department, a local health department or even a community-based organization or a health center, there's a number of ways Hep-C integration can happen.

Marissa Tonelli: Some are very easily feasible in the short term and require minimal resources. Others require a number of resources. We know screening and education one time annually for adults as well and more for high risk populations is something that is relatively feasible to work into an HIV program.

Marissa Tonelli: Certainly combining the education with people who inject drugs or use drugs. Education across kind of your health department. So whether that's an inservice or providing that training and education for staff that might be seeing these co-occurring conditions in their populations they're working with.

Marissa Tonelli: Coordinating screening specifically for target populations like MSM as we are seeing more evidence and more epidemiological data showing that MSM, both living with HIV and not living with HIV, becoming infected with viral hepatitis C, and B I should say, but primarily C.

Marissa Tonelli: And then of course kind of the expanded relationships across programs. That might not mean integration of programs. It might not mean removing those silos. But it could mean just regular meetings, regular communication methods or mechanisms so that you're continuing to talk about these shared kind of populations that are at risk across HIV, STI and Hep-C programs.

Marissa Tonelli: I also wanted to mention, that's not on the slide here, that one of the first steps that's again, short term feasible, is really thinking about where Hep-C belongs in your planning efforts. I'll mention an example of that and Thaddeus might mention that as well. But just inviting your hepatitis C staff to planning discussions is a great way.

Marissa Tonelli: It does not require resources. It simply requires engagement and communication to start thinking about this on a larger level, beyond kind of these short term feasible options. The second tier we're thinking longer term implementation. It might require a foundation level training of staff. It might

also require some additional funding, which may or may not exist or it might require political buy-in.

Marissa Tonelli: So we call these kind of tier two in there. Just some examples here. One of the ways to really enforce kind of the integration is by cross-training staff and by creating cross-training protocols. So that might mean kind of education and protocols for your HIV case managers. It might also be ensuring that there's a comprehensive ADAP formulary that includes access to HCV treatment.

Marissa Tonelli: And I think most health departments have already done this or most states have already done this, so I think that's really great. But again, at the time, it does require some political buy-in. So we do think that's feasible across all states. Also, working with external partners might be difficult.

Marissa Tonelli: It might require some political buy-in or engagement or additional funding to work with corrections, behavioral health and offering both Hep-C, HIV screening, and then also implementing harm reduction models. In some cases this might require political buy-in versus syringe services program or a safe injection site.

Marissa Tonelli: It might require training of staff around harm reduction and how to work with people who inject drugs. So those are all kind of what we considered tier two. And then lastly, some of the longer term implementation would be some design of specialized outreach programs, co-location of services and training HIV providers and medical case managers.

Marissa Tonelli: And also again, expanding services to possibly include distribution of home HIV and Hep-C test kits. And we mention a lot of these because these are being done currently. They're practical examples from across health departments. So these are things to consider of course.

Marissa Tonelli: And certainly the most important piece is to think about planning and where your health department is at so that you can start to think about what is feasible longterm, short term and include that in your planning process. So just to ask you all, what do you think is your jurisdictions current level of integrating hepatitis C services?

Marissa Tonelli: So I mentioned kind of tier one, tier two, tier three. So certainly thinking about very basic, easy, feasible, low cost. And then tier three would be those that require more cost, more buy-in, more staff and resources. We'll wait a minute for you guys to respond here. All right. So it looks like about a third are in tier one or tier two and less than 10% in tier three and a number are unsure.

Marissa Tonelli: Again, maybe this is a little plug to certainly start to think about engaging individuals that are working in viral hepatitis at your health department and talk about what services are being provided, what level of engagement they have with your HIV section, et cetera, so that you're aware of kind of where you're at

in this integration process because we do truly think this is important in order to address a lot of the epidemic right now.

Marissa Tonelli: I just quickly want to provide just a couple of brief examples. We know integration is really defined differently across jurisdictions, and as I mentioned, there's often a lack of funds, a lack of model practices and lack of staffing. As much as we encourage health departments to integrate wherever possible, whenever possible, we know that systemic integration is not always possible.

Marissa Tonelli: It might not always be necessary, and it might not always be appropriate. So again, these are just a couple of examples. I think an important piece as I mentioned is really engagement around planning. We know from some conversations with the state of Wisconsin that they made an effort to engage Hep-C staff on each of their four planning work groups for their integrated HIV prevention and care plan.

Marissa Tonelli: And they also invite Hep-C staff to attend their statewide action planning group to talk to the planning members about Hep-C services, epidemiology and drug user health. They did identify staff turnover is a challenge, but I think again, this is kind of a tier one to start that engagement process and discussion and make it a point to be a part of the planning process and meetings.

Marissa Tonelli: Virginia has made an effort to combine their HIV and hepatitis testing programs and one way they've been effective in doing this and improving their collaboration and efficiencies is by developing common data collection and quality assurance methods. One of these is their Hep-C quality assurance manual.

Marissa Tonelli: They've also integrated their contract administration so that Hep-C testing can be included in existing HIV testing contracts. And then they have combined site visits again to kind of reduce that duplication and maximize resources. They also did internally some structural changes by incorporating their viral hepatitis program with the HIV testing team, and just overall made an effort to create better knowledge sharing mechanisms across staff.

Marissa Tonelli: So again, this might be something that health departments can start to think of. I know administratively it can be a challenge to merge and integrate programs. But with the correct buy-in and leadership, I think this is possible. So that's the end of what we wanted to share. We're going to go ahead and turn it over to our colleague Thaddeus Pham at the Hawaii Department of Health and he's going to share his practical experience with his health department.

Thaddeus Pham: Great. Thanks, Marissa. Can everyone hear me?

Marissa Tonelli: Yes.

Thaddeus Pham: Great. So hi everyone. Aloha from Hawaii. This is Thaddeus. I'm the viral hepatitis prevention coordinator from the Hawaii State Department of Health and I'm just going to share a little bit of what we do in Hawaii and hopefully it can stimulate some ideas or generate some opportunities for you folks in your health departments.

Thaddeus Pham: I really appreciated Marissa going first because I think she really set the stage for a lot of the things that we're trying to do in Hawaii, and I loved the polls and surveys because it made us feel that we were doing stuff that's pretty much what other folks are trying to do too.

Thaddeus Pham: So what we'll talk about today is what we're trying to do locally. I'm just calling this intersect to integrate and this is how we approach hepatitis and HIV co-programming within the department of health, and also in our community-based settings. So I want to start with this intersectional framework.

Thaddeus Pham: And this is just something that we've gleaned over the many years that we've been doing hepatitis integration in our health department and in our community agencies. It's a little bit smaller there, but under intersectional framework, I'm sure you folks can read that. It says things are related to the other things.

Thaddeus Pham: And this has become in a sense our motto in doing harm reduction and hepatitis work in relation to all the other diseases that we cover in our branch. So when we say things are related to other things, it's just really a simple reminder that as much as we can get siloed due to grant funding or due to contract obligations.

Thaddeus Pham: That when we are picking apart one piece of, for example, hepatitis, what we end up talking about really is not only HIV, but also homelessness, mental health issues, substance use issues, immigrant-migrant healthcare, LGBTQ health. All the different issues that are broader social justice priorities for us in our branch.

Thaddeus Pham: So this is where we're coming from, and this is the framework that we use to look at these issues. So I'll just go over them really quickly and then I'll mention them again at the end. But I figured this is a very helpful way if you're looking at planning to see how you're working forward in terms of implementation.

Thaddeus Pham: So for us in Hawaii, one of the things we do is... And these are very obvious, but I think it's very helpful to remember, is just to look broadly. So look beyond the silos. So, as I mentioned, when we talk about hepatitis, we use that as a jumping off point to address larger social justice issues.

Thaddeus Pham: And that not only allows us to address the health inequities in our communities, but also allows us to build great partnerships with folks who are not necessarily interested in hepatitis. Especially in Hawaii where we're an island state with

rural communities that are literally separated from each other by bodies of water, we really value relationship building.

Thaddeus Pham: And so we think about the two forms of capital that are really important. And it's not only financial capital, but that relationship capital and how do we maintain these partnerships and build on those? And we found that to be very important in moving our programs forward.

Thaddeus Pham: I would say also that every challenge is an opportunity. So as much and as difficult as it is to find these partners and to maintain those partnerships, we think of things in the long term. So sometimes it takes three or four years to kind of get into our primary care association or into our corrections work that see the longterm efforts as worthwhile.

Thaddeus Pham: So sometimes we're going to be trying for many years and we acknowledge that that's part of the process. And then finally determine impact. So I'm a viral hepatitis prevention coordinator. I am not an epidemiologist in any sense. But someone once told me don't get mad, get data.

Thaddeus Pham: And I think that's a very powerful motto that kind of echoes through all the work that I do, although now we could probably say get mad and get data. But really just showing that things we're trying work. And I think this also allows for innovation, right? So it allows us to try something new, and at least if we're collecting data, to show that it works.

Thaddeus Pham: We can move forward. If it's not working, then we can fail fast and move on to other innovations. So this is the four kind of tenants that we use in terms of hepatitis integration in Hawaii. So I'm going to share a little bit about our harm reduction services branch.

Thaddeus Pham: So I am housed now within... We actually have a branch called the harm reduction services branch within the department of health and it falls under communicable diseases and public health nursing. I wanted to show this mission because it really does not state disease-specific issues.

Thaddeus Pham: It really is looking broadly at the different communities that we serve, and we really are centering it on being client centered, which I love that Marissa mentioned in one of the slides. Being nonjudgmental and to really address that comprehensive care, which was the spirit of Aloha and respect.

Thaddeus Pham: So I kind of wanted to illustrate that philosophically we've embraced this as something we do in the branch. This is the picture of our lovely branch folks from two Christmases ago. I put this here just to kind of show the diversity of folks in terms of programming.

Thaddeus Pham: So here we have our STI folks, we have hepatitis, we have our harm reduction folks, HIV, and we also have folks working in medical cannabis. So looking at the

intersection of all the issues around sex, drugs, and social justice. So how do we actually do the integration in our health department?

Thaddeus Pham: Marissa stated this so well, but really looking at opportunities for planning. So even just inviting someone to be included in the planning process I think is a big step. Again, if we think about that relationship capital, it's an opportunity to cultivate longstanding relationships that might lead to other opportunities in the future.

Thaddeus Pham: So when we talk about hepatitis, you can see a little bit of our icon for HepFree Hawaii. It's a local coalition. We'll talk about that more later. We work with our HIV planning folks. We always try to go to those meetings and represent and we are also actively involved in our statewide opioid initiative.

Thaddeus Pham: So really ensuring that the voice of hepatitis and HIV is included in all these different planning processes. When we talk about the implementation part of it, if we're considering just health department, we really look and see how we can integrate into existing contracts because a lot of the work that is done is not provided by us directly, but by the community agencies and the AIDS service organizations and the Ryan White clinics.

Thaddeus Pham: So how can we ensure that hepatitis is included in the contract? So this is really a great opportunity I think for folks who aren't already doing it. But ensuring that the language in the contract reflects these integrated services. So for a lot of our HIV prevention and care contracts, Hep-C screening and testing is actually required and there are metrics that they report back to the health department.

Thaddeus Pham: There's referrals for hepatitis A and hepatitis B vaccinations that they can report on. And then also we have a custom contract with [inaudible 00:34:29] consulting for evaluation web or a firm, I think it's now called, so that all the data that's collected for HIV testing also includes hepatitis and STI data if those tests were also done.

Thaddeus Pham: So it allows us to again get mad or don't get mad and get data and really show that the communities need this. That it is an issue for them, and that it's something that can be addressed. And because of that funding is tied with the contracts, we're able to kind of use some of the funding, whether it's state general funding or other funding to pay for some of these services, or at least have staff there who are cross-trained. I think that will be what we'll talk about next.

Thaddeus Pham: So we do a lot of cross-training and workforce development at different levels. So within the department of health, all new staff, at least in the harm reduction services branch, are required to kind of learn about hepatitis.

Thaddeus Pham: And if they're providing direct service, especially for our epidemiologist or epispecialists, our DIS, they usually will attend the OTL, which is Outreach

Testing and Linkage training, which is a state certification program that includes myself, one of the HIV testing coordinators and one of our community-based agencies. Just certified folks who do rapid HIV and hepatitis C testing statewide.

Thaddeus Pham: So that's a great opportunity to integrate and to ensure that people are aware of the issue. And then finally we work closely with a lot of our different partner agencies and our physician organizations to hold conferences and create summits around hepatitis and liver health to ensure that we can get the providers on board as well.

Thaddeus Pham: And we really make an intentional effort to include pharmacists, nurses, social workers and certified substance abuse and counselors to ensure that the breadth of the education will be addressed in the entire care team. I really want to highlight, and it's not because I'm involved with them so deeply.

Thaddeus Pham: But one of the great opportunities for us in the health department has been leveraging our community allies. And so as we know, I think many folks on the call do work in health departments and we acknowledge that there's a lot of bureaucratic challenges in terms of just getting things approved or even getting things funded for certain things.

Thaddeus Pham: So really having a robust community coalition has been very helpful. For example, sometimes what we'll do if we want to do more integrated services is help write grants for the community-based agencies or the coalitions so that they can implement the services, and then we don't have to have it pass through the department of health.

Thaddeus Pham: So how can we provide technical assistance and support to these community coalition sand then build up their voices so that they can also do things like advocate within their legislature for more resources and funding. So really supporting that community coalition and also being part of that discussion in a very active way has been very helpful.

Thaddeus Pham: I would also just say something very easy to do, but it's sometimes challenging with all the obligations we have is just to be present. We should try to show up at the meetings and just be there so that the community can build trust with us and know that the health department is there to listen and to take back what they share with us.

Thaddeus Pham: So some of the lessons learned in terms of moving forward. Well, first I would want to acknowledge some of the challenges that were already mentioned, but a big one of them is the silos between the different I guess branches or the different programs, especially when funding is very specific and dedicated in certain ways.

Thaddeus Pham: So we're always trying to find opportunities or learn from other jurisdictions in terms of how we can utilize funding in innovative ways or see what

opportunities there are to justify spending funds to cover hepatitis services. And so there's been a lot of interesting things.

Thaddeus Pham: I will point out that I was at the NASTAD meeting in DC in December and Heather Hawk from HERSA had mentioned that Hep-C elimination among people living with HIV/AIDS was a priority. So I think that's a great opportunity to start thinking about how Ryan White funds can be used in that direction, and I think that will build capacity and build infrastructure for hepatitis C care.

Thaddeus Pham: So we're acknowledging funding streams. I mentioned the grant requirements. And then staffing parity of course, turnover in staff, having staff champions on hepatitis are really important. Usually there's just only one or two folks within health departments, so really seeing how we can increase staffing for the hepatitis programs I think it would be really helpful as well.

Thaddeus Pham: For surveillance, there is no national surveillance of Hep-C in terms of funding, so I think it's typically piecemeal. And so sometimes what we'll try to do is identify other data resources to show what's happening in our local jurisdictions. And of course buy-in is really important.

Thaddeus Pham: So I'm going to just kind of remind us the four things that we used to look in terms of addressing hepatitis in Hawaii. We look broadly. We build the relationships. Every challenge is an opportunity and we don't get mad, but we do try to get data. And these are just some of the next steps in terms of what we're trying to do as we consider those frameworks.

Thaddeus Pham: So as I mentioned before, we're trying to look more into innovation projects on how to eliminate hepatitis C within people who are living with HIV/AIDS. Luckily, our H-step program does cover Hep-C medications. We're looking at micro elimination. So we're currently doing hepatitis elimination planning.

Thaddeus Pham: And as part of that, we're taking an approach where rather than be so specific about our guidance, we're trying to keep it a little bit more nimble and have broader goals and then have suggested micro elimination or innovation projects. And I think this will allow us to build partners to kind of try things and fail fast if needed and to ramp up if it's doing well.

Thaddeus Pham: We're doing a lot more around street-based medicine and care, and I think this allows us to engage with communities that are more at risk of hepatitis and HIV in a way that's meaningful for them. So we are really working a lot in providing street-based wound care because we found that as an issue among people who are injecting drugs in Hawaii.

Thaddeus Pham: And so the wound care aspect has been the entree point to start discussing more on HIV and hepatitis. So really looking beyond just the HIV and hepatitis silos and seeing what are the needs of the community and how we can use that

as an entry point. The intersections, I mentioned already, but we are very heavily involved in drug user health issues.

Thaddeus Pham: As I mentioned, in terms of data, we look beyond surveillance. And so we started looking a lot at the YRBS or Youth Risk Behavior Survey data to see what the issues are for our youth. And so for example, we found that 7.8% public middle school students in Hawaii have injected an illegal drug before they left middle school, which is very startling for us.

Thaddeus Pham: So how can we leverage that data to kind of raise awareness and build relationships with our education department? And we also use that data to look at sexuality and gender identity issues and see the intersections with injection and HIV education for kids who identify as asexual or gender minority.

Thaddeus Pham: And then we're also heavily involved with housing and homelessness. As we know, that's one of the major issues for a lot of our folks who are the hardest to reach in terms of providing care. And that's it. So I have my information here, and I'll turn it over for the Q&A section, I believe. Thank you.

Julie Hook: Great. Thanks so much, Thaddeus and Marissa. So if people have questions, please chat them into the chat box. I believe we do have a couple so far and we have a good chunk of time if people have additional questions. I believe that ECU did mostly ask this question.

Julie Hook: But just wanted to throw it out there for additional consideration in case Marissa that is an additional things to add around. That our Ryan White program grants are based on funding services, both medical and support for clients with HIV. This often causes siloing as well as narrowing the services that subrecipients are allowed to provide and get programmatic funds for. How do we move away from this if the system is set up with these challenges?

Marissa Tonelli: Go ahead, Thaddeus.

Thaddeus Pham: So I think that's a great question and this is something that we are always trying to figure out as well. So I think something that's really helpful is I know that in July of the past year, HRSA released a guidance called Eliminating Hep-C among People Living with HIV in the US and it's leveraging Ryan White programs to move forward. So I think that's a great starting point in terms of figuring out and seeing what other states and jurisdictions are doing. So I would throw that out there.

Marissa Tonelli: And I'll just add, I know that a lot of federal grants can be very siloed. And certainly they're allocated for specific target populations or focus populations and specific services. But I think one thing that health departments can think about is instead of... You might not always have the opportunity to remove the silos, but we do have the opportunity to create those linkages or those connections across services.

Marissa Tonelli: So if you're thinking of your subrecipient or even Ryan White recipients providing services in a silo, one thing to think about is, how can you facilitate those partnerships and linkages between these services, or at least facilitate linkages to viral hepatitis service providers in the area if those funded organizations can't provide, do not have the funding, or the service staff can provide those directly?

Marissa Tonelli: That would be kind of the low hanging fruit there. And the other thing just to think about, especially when it comes to our local funding and state funding, but even federal funding, is we really have the opportunity to kind of leverage our current buy-in around the opioid epidemic to really advocate for inclusion of hepatitis C in existing services.

Marissa Tonelli: I think that's become a focus along with a lot of the ending the HIV epidemic and of course some elimination for Hep-C planning. So how can we leverage the existing buy-in in certain areas to really advocate for Hep-C inclusion? I think those are all planning opportunities and education opportunities and that probably would be a good starting point if we can't overcome the funding silos.

Thaddeus Pham: And I think that's a great... This is Thaddeus again. So I just posted the link for the HRSA thing I had mentioned in the chat box for those who are looking for it. And also I would mention we've learned a lot from other jurisdictions in terms of what Ryan White has allowed them to do.

Thaddeus Pham: So for example, I was in discussion with Wyoming and with Washington in the past about funding hepatitis C care coordination in certain contexts for Ryan White. And I think something to keep in mind is sometimes building that infrastructure for these pieces, even if it's specific for Ryan White is still very helpful.

Thaddeus Pham: I will add that, for example, we learned from Tennessee in which we're able to do here is to get Ryan White funding to cover a mobile fiber scan machine to help people living with HIV who have liver issues. But at the same time, those clinics can also use them to address hepatitis C and provide treatment for people who are hard to reach otherwise. So think building that larger health infrastructure can really trickle down and help hepatitis C as well.

Julie Hook: Great. Thanks. Another question is around opportunity for HIV, hepatitis C providers outside of health departments to be funded for no cost STI testing.

Marissa Tonelli: Yeah. So I saw that question. This is Marissa. I don't know of a specific funding opportunity or way to leverage that necessarily in your jurisdiction or with HIV, Hep C providers assuming you might be a funded provider from a health department.

Marissa Tonelli: But I will say I think the point is very important that these services really need to be integrated and the funding silos are certainly a challenge. I would encourage

providers, especially if you're a clinical setting, but even if you're a nonclinical setting, exploring third party billing to start thinking about how you can leverage insurance reimbursement for services such as STI or STD testing.

Marissa Tonelli: I know those services aren't always covered under a certain funding opportunities, but they might be covered through the patient's insurance. So navigating them to insurance and billing the insurance can be one way to cover that at no direct cost, at least for the test to the provider.

Julie Hook: Great. Thanks Marissa. We still have some time, so if people have additional questions, please chat them in. But I will just let folks know that the slides for the webinar are already posted on our websites. You can access them here on this web address for our TA center and I will have the recording and the transcript up soon if you want to forward to colleagues who were unable to make the webinar.

Julie Hook: So please contact us if you want to obtain more information, request TA or share your experience with integrated planning or to join our mailing list. Rachel has just chatted out the evaluation link. If folks can fill that out, is it helps us to plan effective webinars. Thank you and have a great-