

Provider Feedback Forum on HCV Diagnosis, Treatment, and Care

February 28, 2008

Fiesta Resort Conference Center

Tempe, Arizona

Department of Veterans Affairs, Veterans Health Administration

Public Health Strategic Health Care Group

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Overview and Summary

On February 28, 2008, the Public Health Strategic Health Care Group (PHSHG) convened the Provider Feedback Forum on HCV Diagnosis, Treatment, and Care. The primary purpose of the forum was to obtain feedback from frontline providers about their experiences in diagnosing and treating hepatitis C virus (HCV) in patients receiving care from the Veterans Health Administration (VHA). PHSHG sought this input in order to help determine priority areas for ongoing and future program and policy efforts.

VHA health care providers were invited to submit applications to participate in the forum. In selecting participants, PHSHG sought a representative cross section of frontline providers involved in diagnosing and treating HCV, including: HCV Lead Clinicians, HCV and liver transplant coordinators, physicians (primary care, infectious disease, gastroenterology, and psychiatry), nurses, nurse practitioners, psychologists, pharmacists, researchers, laboratorians, and directors of Hepatitis C Resource Centers (HCRCs) (see Appendix A). Participants came from facilities across the country in both urban and rural settings, reflecting the diversity of VHA sites.

The forum addressed five major topic areas:

- Staffing and models of care for HCV-infected veterans;
- Diagnosis of HCV infection and linkage to care;
- Treatment and care of HCV-infected veterans;
- End Stage Liver Disease (ESL) and Hepatocellular Carcinoma (HCC); and
- Informational resources for providers and patients.

For each topic area, participants were asked to identify: 1) what is working well; 2) areas that might require improvement or increased attention; and 3) how the VA Central Office could better support efforts to improve hepatitis C care (see Appendix B).

Cross-Cutting Themes

As participants discussed the identified topics, four cross-cutting themes emerged.

Increasing Caseloads. According to published studies, almost 4 million people in the United States have hepatitis C. It is estimated that the HCV seroprevalence rate in veterans who use VHA for their health care is three times that of the general U.S. population; the majority of these veterans have chronic infection. A substantial number of veterans with HCV are co-infected with HIV. Although it is likely an underestimate, at least 4% of veterans with HCV are also HIV(+). Co-infection increases their risk of developing life-threatening complications from HCV infection. As of 2006, approximately 14 percent of the VHA's 210,000 HCV-infected patients had been treated with antiviral therapy. Returning Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans who engage in high risk behaviors may increase the number of HCV patients served by the VHA. The number of HCV-infected patients who require treatment and related support services could place enormous strains on the existing system. Also noted

was the fact that patients are not always diagnosed in a timely manner and may be more likely to have liver damage at the time of diagnosis.

Lack of Staff and Resources. Many of the participants serve as HCV coordinators within their facilities (although there was little commonality in terms of specific responsibilities assigned to that title). These participants reported various barriers to providing comprehensive services to veterans with HCV infection. In particular, the lack of staff to focus on HCV was noted. Many participants reported that when key staff (e.g., nurses, nurse practitioners, and physician assistants) leave the departments in which HCV services reside, they are often not replaced. This seriously impacts the provision of services, especially key aspects such as timeliness of services, completion of confirmatory testing, receipt of necessary screenings over time, and receipt of treatment when indicated. In addition, necessary services are often not available in all facilities, necessitating a significant amount of travel on the part of patients. Some participants reported insufficient staff time to conduct necessary patient education and support groups, especially since these responsibilities often fall upon the HCV coordinator. Some participants reported linking to services within their community (e.g., support groups conducted by outside organizations) to address these gaps.

Treatment Coordination and Linkage to Care. Participants reported that HCV services are, for the most part, provided by Infectious Disease (ID), Gastroenterology (GI), or Primary Care. Patient education is often coordinated and/or provided by the HCV coordinator. Participants related that the level of communication across these various departments is often insufficient to manage a complex chronic disease such as HCV infection. Because of the breakdown in communication, necessary referrals and

follow up may not take place. In addition, the disconnect between departments can impact patient adherence to treatment due to the fragmented nature of care.

Participants also identified a need to coordinate with substance use disorder services and mental health services. Patients with histories of mental illness and/or substance abuse, who also present with hepatitis C risk factors, need HCV screening. Providers of these services must be able to assess risk factors associated with HCV infection and provide or arrange for prevention, screening, and treatment.

Provider Education and Training. HCV infection is a complex condition and providers need education and training on the management of HCV infection. However, given that the model of care differs from facility to facility, providers also need to receive information on coordination of services within their facility. Participants noted that even with notes in the medical record, follow up services may not always be provided. Training opportunities and better use of notes in medical records can help to address these issues. Participants noted that trainings must be tailored to the needs of providers and that there are many competing training needs and topics, as well as other time commitments.

The following report describes the many issues raised during the forum. As is apparent after reading the report, there are a number of challenges facing VA providers as they strive to deliver the highest quality of HCV care to America's veterans. Some of these challenges can be addressed through the implementation of improved policies and practices; other issues will require longer term solutions. However, in addition to the identification of challenges, participants also shared a number of innovative approaches

to the delivery of HCV care in VA as well as various best practices for the diagnosis, treatment and management of chronic hepatitis C infection.

1. Staffing and Models of Care for HCV-infected Veterans

Participants shared with the group how services are provided within their facilities. Experiences varied widely. While some participants reported that a comprehensive array of services was generally available and easily accessible within their facility, other participants described a system that lacked both coordination and sufficient staff and resources.

Models of Care. In some facilities, HCV-related services are provided by the GI department, in others, by the ID department. Some participants reported a “tug of war” between these two departments, which have different approaches to addressing HCV infection. Participants also reported that a significant amount of care is provided by Primary Care (PC) physicians, especially in the Community-Based Outpatient Clinics (CBOCs). However, participants noted that PC physicians sometimes lack the expertise and often lack the time necessary to treat a complex condition like HCV infection.

Participants reported that use of telemedicine can assist PC physicians, especially those in remote locations, in meeting the needs of HCV-infected patients. For example, providers with expertise in the care of HCV infection can provide consultation by phone during primary care appointments with patients. Participants stated that including standardized notes in the computerized patient record system (CPRS) can also help PC physicians in managing these complex patients. In addition, standardized notes in CPRS (Remote Data) can help to track care that the patient has received at other facilities.

Participants discussed the possibility of mandating a specific model of care for HCV infection and specifying staffing levels. This would help to address the patchwork approach to care in many facilities and provide more support to the HCV coordinator, who often constitutes the entire program. One participant suggested that an approach similar to the one being used for traumatic brain injury (TBI) might work well with HCV infection. However, other participants believed that a single model could not be developed that would fit all facilities, given the diversity across sites. Instead, they suggested that facilities look at the resources within their region and work to improve access, especially through the use of technology and telemedicine.

It was also suggested that programs employ creative approaches for more effectively using their existing resources. For example, one participant reported working with pharmacy staff to provide patient education. A pharmacist conducts a 45-minute session with patients prior to initiating treatment and provides treatment and injection education. Performing laboratory tests in CBOCs rather than referring patients to larger facilities was also suggested, thus reducing the amount of travel required by patients and helping to ensure that monitoring labs are being performed.

Linkage to Other Services. Participants related varied experiences in terms of establishing and maintaining effective linkages to mental health and substance use disorder services. These linkages are important at two levels: 1) to identify patients with undiagnosed HCV infection; and 2) to provide mental health and substance use disorder services to patients receiving treatment for HCV infection. Participants noted that it is essential for mental health and substance use disorder service providers to receive training about HCV infection in order to provide appropriate care and patient education.

Participants also noted that case management services are very important in the management of HCV infection, as with any other chronic disease. However, sufficient resources to provide these services are not always available.

Barriers to Care. Participants identified several challenges to the provision of comprehensive care for HCV infection. It was noted that community advisory boards can be a valuable resource in raising issues related to inadequate services as well as identifying potential solutions.

- **Appointments within 30 Days**

Participants reported that it can be difficult to meet the requirement of scheduling the first appointment within 30 days of diagnosis. Several participants reported that their program addresses this by holding group appointments for new patients each month. At the appointment, education is provided to the group. Some also conduct substance abuse and mental health screenings during the group appointment. Following the group appointment, patients are referred to GI clinic for initial consult and then to treatment. One provider questioned the validity of this performance measure—if a patient has had HCV infection for 30 years, is it really critical that they have an appointment within 30 days?

- **Need for Dedicated Staff**

Participants reported that in many facilities there are not enough staff to provide comprehensive services to HCV-infected patients in a timely manner. A frequently cited deficit was insufficient staff to carry out the time consuming tasks of identifying infected patients and conducting

patient follow up for those already identified. Many participants reported a lack of support staff to carry out these types of services, either because there are insufficient resources or because staff are not replaced when they leave. Support services, such as case management, are also difficult to provide due to insufficient staff. In addition, participants stated that while the Clinical Case Registry (CCR) for HCV provides tools that are helpful in managing hepatitis C care, responsibility for maintaining the Hepatitis C Registry places additional demands on staff whose primary responsibility is providing clinical care to patients with HCV.

- **Lack of Access to Specialty Care**

Participants reported that some facilities, especially in rural areas, have very limited access to specialty care. To obtain this care, patients must often travel for hours. Fee basis referral to local providers for specialty care was suggested as a strategy for addressing this challenge.

Residents and Fellows. Participants reported some challenges related to care provided by residents and fellows. Because residents and fellows rotate through the department, patient follow-up can be problematic in the absence of effective case management and patient tracking. These providers also require additional oversight, which can be a burden for staff. It was noted that it is up to the facility to determine how to utilize residents and fellows effectively. Residents and fellows want to gain experience in this area and can be a valuable resource within a facility.

2. Diagnosis of HCV Infection and Linkage to Care

Participants discussed a variety of issues related to the diagnosis of HCV infection and linking patients to care.

Role of HCV Lead Clinician. Questions arose relating to the role of the HCV lead clinician, which can be filled by any member of the clinical staff and does not have to be a physician. Participants expressed the need to more clearly define the role and responsibilities of the HCV lead clinician and identify a process for addressing turnover in the position.

Participants related that it is important to make sure that HCV lead clinicians have sufficient time to carry out their responsibilities and that busy clinicians may not be the best persons for these positions. Also, it was suggested by a participant that if the position is not filled by a physician, a physician should be assigned to work with the HCV lead clinician as physicians may be more effective in building bridges with other departments. Participants also suggested that specific FTEs be allotted for the HCV lead clinician position.

Routine Screening. Participants suggested that routine screening for certain populations could be beneficial. For example, patients receiving mental health services should be screened for HCV. Pilot grants for point-of-care testing could help implement routine HCV screening in various settings.

Reflex Confirmatory Testing. The primary purpose of reflex confirmatory testing is to link patients to care by promoting prompt diagnosis. Participants reported various experiences with reflex confirmatory HCV testing. For example, some facilities use a plasma preparation tube, which allows several tests to be conducted without

separate blood draws. This saves a significant amount of laboratory time and removes the need for patients to make a second visit for additional specimen collection. Some participants reported that reflex confirmatory testing can result in a delay in obtaining results but that it is worth the wait given that it cuts down on unnecessary follow up and is more convenient for patients.

Some participants stated that their laboratories lack the capacity and funding to conduct reflex confirmatory testing. It was stressed that when considering the implementation of reflex confirmatory testing that it is essential to include laboratory staff in all stages of the discussion.

Participants stated that if reflex confirmatory testing is not available, PC physicians should be educated about the need to do confirmatory tests. Even when ordered, confirmatory testing does not always get done. Participants related that physicians do not always read notes in the patient record. Requiring a confirmatory signature that the notes have been read could help to address this. The use of templates for screenings and referrals was also suggested as a way to increase efficiency. It was cautioned that PC providers have numerous demands on their time and that processes related to confirmatory HCV testing should not be too onerous.

Notification of Patients. When patients do test positive, the question arises of how best to notify them. In most cases, it is preferred that patients be notified in person; some facilities notify patients by mail, with the letter containing comprehensive information on their condition. It was noted that the letter must be carefully worded because receiving a diagnosis by mail can be traumatic and patients may not understand the significance of the test result or the importance of obtaining treatment. In addition, if

only the initial screening antibody test is available, patients must be advised to obtain confirmatory testing.

One participant stated that he used data from the Hepatitis C CCR to demonstrate to primary care physicians the lack of confirmation of positive antibody test results in his facility. Once the physicians recognized the extent of the problem, some wanted to notify patients themselves, others preferred that the HCV program notify patients. This example demonstrates the importance of working with PC providers to identify patients and link them to care.

Linkage to Care. It was also reported by participants that in some facilities there are specific requirements that must be completed before patients can receive HCV-antiviral treatment. Because of the many steps involved in the process of accessing care, patients can sometimes “fall through the cracks.” In other facilities, the referral process is streamlined. While participants noted that CPRS can be a useful tool in coordinating care, they opined that it is necessary to determine how to use it most effectively and then to train physicians in its use. Use of standardized consult templates can facilitate efficient care delivery, for example, by prompting the referring provider to obtain necessary lab work prior to referring the patient.

3. Treatment and Care of HCV-infected Veterans

Patients with chronic HCV infection require various levels of care. Treatment of HCV infection is complex and the decision to receive antiviral treatment should be based on many factors. Those patients who are not receiving antiviral therapy still require ongoing care.

Antiviral Therapy. Participants discussed the issues related to providing antiviral therapy to patients. Regardless of the size of the facility, participants agreed that treatment is resource intensive and many participants reported that the necessary resources are not always available. For example, a participant from a small clinic said that limited resources forced them to focus on the best candidates for treatment since it is not possible to safely manage all the patients who might otherwise be candidates for treatment. Some participants reported that the necessary mental health services to provide support during antiviral treatment are often not available.

As of 2006, 14 percent of the VHA’s HCV-infected patients had been treated with antiviral therapy. Participants discussed the need to identify appropriate benchmarks for

<p>Barriers to HCV Care Identified by Participants</p> <ul style="list-style-type: none"> • Patients do not know they have HCV infection. • Substance use disorder treatment is not available on an outpatient basis. • Facility has requirements regarding length of patients’ sobriety (e.g., 6 months). • Patients fear side effects. • Distance patients must travel to access care. • CBOCs may not be allowed to refer patients for care and do not have the resources to provide treatment in their facility. • Restrictions on fee base care (e.g., many facilities will not treat a transplant patient). • Some providers (e.g., physicians, mental health providers) may recommend against treatment.

patients entering treatment and suggested comparing VHA’s treatment rate to the private sector. Current guidelines recommend that in most cases treatment should be offered to patients with more than portal fibrosis (Stage 1). Participants stated that there are many factors impacting whether patients enter treatment (e.g., alcohol and/or substance use). Some patients may elect to forego treatment for various reasons (e.g., fear, required travel, prefer alternative therapy). There are also special considerations related to VHA’s

patient population when it comes to the success of treatment (i.e., sustained virological response (SVR) rates). For example, patient weight can affect the success of treatment and many VHA patients are overweight. Given that treatment is not indicated for all HCV-infected patients and VHA's patient population can be difficult to treat (because of co-morbidities and other factors), these issues should be considered when determining benchmarks.

Participants also identified strategies for supporting patients during antiviral treatment. For example, pharmacists can work with patients during the course of treatment and help to monitor side effects. Peer support and "treatment mentors" were two methods suggested to support patients undergoing treatment. Peers and mentors can provide ongoing support and tell patients what to expect from treatment. Support groups were also suggested, although travel can be a barrier to participation in such groups. Mental health services (e.g., clinical psychologist) can also help support patients through the treatment process.

Participants stressed that it is necessary to continue working to get patients into treatment. Patients who are not ready for treatment at present may be ready at some point in the future. With appropriate mental health and substance use disorder treatment, patients may achieve sobriety and enter treatment. Some participants reported treating patients who are still consuming alcohol and drugs, as long as they are making active efforts to cut down on use and they are receiving treatment for their substance use disorder. However, one participant cautioned that patients can have very violent reactions if they use drugs and alcohol during antiviral treatment.

It was also stated that evidence suggests that patients who are diagnosed early (i.e., less liver damage) had a better response to treatment; therefore, treatment of patients prior to Stage 2 disease should be considered. In addition, participants suggested that treatment should be considered for patients with more advanced liver disease as a means of reducing symptom burden, even though SVR may not be a realistic goal.

Care for Patients not Receiving Antiviral Therapy. Participants discussed the need to provide care to HCV-infected patients who are not receiving antiviral therapy. This is important for two reasons: 1) ongoing monitoring of the health of the liver; and 2) educating patients on reducing risk factors and promoting healthier behaviors. Engaging patients at this level can serve to reduce the number of patients who are lost to follow-up.

Care of Co-morbid Conditions. Participants reported various experiences in treating patients who are co-infected with HCV and HIV. Treatment guidelines are available for HIV/HCV co-infection and participants reported that patients with HIV are often very compliant with their treatment regimens. Some participants stressed that it is important to control HIV infection prior to initiating antiviral treatment for HCV. Co-infected patients who do not want to receive treatment for their HCV infection need to be educated by their providers about the risks and benefits of HCV treatment so they can make informed decisions.

Special Populations. Participants discussed the needs of female patients with HCV infection. In particular, participants noted the importance of making sure that female patients receiving antiviral treatment are using birth control as there is a risk of birth defects. For male patients, their female sexual partners should also be using birth control. Condoms are available through VHA, but the female partner of a male VHA

patient may not receive birth control medications or contraceptive devices through VHA, sometimes representing a financial challenge. Participants encouraged that data relating to pregnancies while on antiviral therapy be made available.

Clinical Research. Participants noted that clinical research can represent an opportunity for increasing access to care for VHA patients. Discussions between VHA and the pharmaceutical industry in relation to Cooperative Research and Development Agreements (CRADA) should be encouraged. In addition, VHA providers need information on the availability of clinical trials and how to enroll patients; www.clinicaltrials.gov is a good resource for informing providers about available trials.

5. End Stage Liver Disease and Hepatocellular Carcinoma

Overall, participants reported that their facilities are unprepared to meet the needs of the anticipated number of hepatitis C patients who may progress to end stage liver disease (ESL) and hepatocellular carcinoma (HCC). Participants reported that providers need training on how to provide treatment to these patients. Also, many facilities lack the necessary staff to provide the significant level of care required. It was suggested that

Key Issues in Detection and Treatment of ESL and HCC Identified by Participants

- Early detection
- Emotional support (for patient, family and significant others)
- Need to educate HCV-infected patients that they are at risk of ESL and HCC
- Follow up with patients who have successfully completed antiviral therapy

advanced practice nurses and physician assistants could help to fill gaps, but these staff require training. Given the level of care required by these patients, participants identified provider burnout as a possible risk.

Participants reported screening for HCC with ultrasound, CT scans and alpha-fetoprotein (AFP) tests. A participant from a CBOC

reported that their facility lacked an advanced level hepatologist to do the evaluations and that communication across facilities via the CPRS was not effective. Other participants stated that it was much more likely that HCC would be detected if the patient was receiving care from the GI department and that other physicians who do not routinely deal with ESL may not be aware of HCC risk factors. A challenge that was identified was the best way to determine when a patient develops cirrhosis (biopsy, CT scan, etc., or other methods that may not yet be widely available in the U.S.). One participant reported that their facility is developing a liver disease database that will help them track patients at risk of developing HCC.

Once HCC is identified, participants related various experiences in accessing treatment. Treatment for HCC encompasses a variety of modalities, including: surgical resection; liver transplantation; radiofrequency ablation (RFA), percutaneous ethanol injection (PEI) and transarterial chemoembolization (TACE). There are limited chemotherapy options for patients with unresectable HCC. A participant from a rural site stated that there is a significant delay in accessing care as the larger facilities already have an overwhelming caseload. Other participants reported experiencing resistance from the Interventional Radiology (IR) department to treating HCC and relying on obtaining care on a fee basis.

Liver Transplants. The VHA provides about 100 liver transplants each year at a cost of approximately \$250,000 per transplant. VHA patients also receive transplants from non-VA facilities and very often return to the VA for aftercare.

Participants discussed the challenges of the transplant evaluation process, which must be completed within 90 days. In particular, participants noted the difficulty of

screening patients on the psychosocial criteria. It was suggested that there may not be sufficient numbers of clinical psychologists to conduct the necessary 1- to 2-hour screening and physicians do not have the training to perform the psychological assessment. It was suggested that other qualified clinicians (e.g., psychiatric nurses, physician assistants) should be provided training and allowed to conduct the evaluations. Participants also suggested that a standard process for evaluations is necessary. Another participant suggested that transplant centers develop a pre-evaluation screening process so the likelihood of the patient's acceptance is determined prior to the completion of the entire evaluation package.

Participants related challenges pertaining to substance use disorder treatment. Participants from smaller facilities reported having transplant candidates turned down because they lacked a history of substance use disorder treatment, and in many instances, these services were unavailable in their facilities. Another participant stated that by the time some patients can access substance use disorder treatment, they are too sick to undergo transplantation.

Support for patients undergoing transplants was identified as an important issue. Support groups and peer support can help patients through the transplant and provide comprehensive support post-transplant. One participant reported having two excellent candidates for transplantation who were rejected because they lacked social support networks. This challenge could become more common as the number of liver transplant requests increases.

6. Informational Resources for Providers and Patients

Educational Resources for Providers

Participants were in agreement that providers, especially PC physicians, need training on how to diagnose and treat patients with HCV infection. While participants reported that VHA does a good job in educating specialty providers focusing on HCV-related care, more training is necessary for those providers who see HCV-infected patients but are not focused exclusively on HCV (e.g., PC, mental health and substance use disorder providers). The following were training needs identified by the participants: the diagnostic testing algorithm for hepatitis C; how to tell a patient they have hepatitis C and what they need to know; brief alcohol interventions; diagnosis and treatment of HCC; and models for follow-up treatment and care.

Participants emphasized the need to ask clinicians about the best ways to provide training. Educational session with a call-in option, satellite conferences that address “Hot Topics,” and lunch and learn sessions were suggested by participants. Participants noted that there may be issues in terms of covering the cost of training for PC providers and that local approaches that do not require providers to interrupt their clinics are good options.

Educational Resources for Patients

Participants reported using a variety of educational materials in their work with patients and make these materials available in various formats and settings. Participants emphasized the importance of listening to patients in determining their educational needs. Participants also identified the need to tailor materials to specific populations (e.g., OEF/OIF veterans, women, etc.).

Sources of educational materials include: VHA’s National Hepatitis C Program (www.hepatitis.va.gov), HCRCs, non-governmental organizations such as the American Liver Foundation, International Hepatitis Foundation, the O.A.S.I.S. Clinic, and pharmaceutical companies. Some participants reported developing their own materials by making print outs from websites. These can be printed on different colors of paper so that the topics are easy to distinguish.

Materials are used during educational sessions and support groups and are also made available through displays on desks, posted in clinics, and placed in waiting rooms (e.g., GI department or lab). Some participants reported packaging these materials in resource folders for patients. DVDs, either from VHA or other sources, can also be used for patient education. One participant reported developing a DVD that is used in CBOCs and remote facilities to provide essential information to patients without their having to

<p style="text-align: center;">Specific Educational Needs of Patients <i>Identified by Participants</i></p> <ul style="list-style-type: none">• Healthy and unhealthy liver models• Pictorial handouts that show the impact of drugs, alcohol, and smoking on the liver• Materials that walk patients through the treatment process• Materials that show “fibrosis score”• Materials on HCC• Materials on fatty liver disease

travel to another facility. Participants report that PowerPoint presentations, such as the one on the www.hepatitis.va.gov website, are very effective educational tools.

Challenges to making materials available that were identified by participants include the lack of storage space and insufficient time to identify new materials.

Participants noted that it is sometimes difficult getting materials from the Employee

Education Services (EES). For example, some participants stated that it has been difficult to obtain the booklet on cirrhosis developed by the HCRC.

Participants reported that many patients also use the Internet and it could be an effective vehicle for reaching some patients. Posting materials, developing podcasts, or facilitating a chatrooms on My HealtheVet were suggested. Participants suggested that some of the materials that are currently available online should be made available in hardcopy. In particular, it was noted that materials on My HealtheVet cannot always be printed.

Support groups were identified as an important resource for patients. Many participants stated that their facilities lacked the resources to conduct these groups. Other participants reported that they conducted groups “on their own time.” One participant stated that volunteer services provided dinner for support groups, which serves as an incentive for patients to attend. Participants also reported linking patients to support groups in their communities. It was noted that in rural areas, travel time can be a barrier to patient participation.

Participants stated that peer educators can be an effective approach for providing information. Peers can participate in educational activities and can also provide one-on-one support to patients during antiviral therapy and the transplantation process.

Appendix A: Participant List

JENNIFER BAILEY, NP

Lead HCV Coordinator
VA Central Iowa HCS – Des Moines Campus
3600 30th Street
Des Moines, IA 50310
Phone: 515-699-5999 x4568
Email: jennifer.bailey@va.gov

PHYLLIS BAKER, MSN, APRN, BC

Psychiatric Clinical Nurse Specialist
Richard L. Roudebush VAMC
1481 West Tenth Street
Indianapolis, IN 46202
Phone: 317-988-2649
Email: phyllis.baker@med.va.gov

SUSAN BERTILACCHI-GREEN, RN

Hepatitis C Coordinator
VA Northern California HCS - East Bay Division
150 Muir Road
Martinez, CA 94553
Phone: 925-370-4135
Email: susan.bertilacchi@med.va.gov

CHRISTINE BIALKO

HCV & Liver Transplant Coordinator
North Chicago VAMC
3001 Green Bay Road
North Chicago, IL 60064
Phone: 847-688-1900 x85595
Email: christine.bialko@va.gov

NORBERT BRAU, MD

Staff Physician, Infectious Diseases
James J. Peters VAMC
130 West Kingsbridge Road
Bronx, NY 10468
Phone: 718-584-9000 x6672
Email: norbert.brau@va.gov

JANE BURGESS, A.C.R.N., M.S.

National Program Manager, QUERI-HIV/HCV
VA West Los Angeles Healthcare Center
11301 Wilshire Boulevard (111G)
Building 500, Office 3249
Los Angeles, CA 90073
Phone: 310-478-3711 x40921
Email: jane.burgess@va.gov

MICHAEL CHAPKO, PHD

Associate Director, NW HCRC
VA Puget Sound HCS – Seattle Division
1660 South Columbian Way
Seattle, WA 98108
Phone: 206-764-2821
Email: michael.chapko@va.gov

RAMSEY CHEUNG, MD

Chief of Hepatology
VA Palo Alto HCS – Palo Alto Division
3801 Miranda Avenue
Palo Alto, CA 94304
Phone: 650-493-5000 x66482
Email: ramsey.cheung@med.va.gov

RADU CLINCEA, MD

Infectious Disease Staff Physician
Orlando VAMC
5201 Raymond Street
Orlando, FL 32803
Phone: 407-629-1599 x1088
Email: radu.clincea@va.gov

DENA CORWIN, RN, MN

Hepatitis C Nurse Coordinator
Spokane VAMC
4815 North Assembly
Spokane, WA 99205
Phone: 509-434-7607
Email: dena.corwin@va.gov

DONNA COX, PHARM D

Clinical Pharmacist
VA Southern Oregon Rehabilitation Ctr & Clinics
8495 Crater Lake Highway
White City, OR 97503
Phone: 541-826-2111 x3104
Email: donna.cox2@va.gov

MARY CRANCE, RN

Hepatitis Coordinator
White River Junction VAMROC
215 North Main Street
White River Junction, VT 05009
Phone: 802-291-6208
Email: mary.crance@va.gov

RAUL CUBILLAS, MD
Staff Physician, Gastroenterology & Liver Diseases
VA North Texas HCS – Dallas VAMC
4500 South Lancaster Road
Dallas, TX 75216
Phone: 214-857-1459
Email: raul.cubillas@va.gov

CHARLES DE COMARMOND, MD
Head of Section, Infectious Disease
W.G. (Bill) Hefner VAMC
1601 Brenner Avenue
Salisbury, NC 28144
Phone: 704-638-9000 x3570/5270
Email: charles.decomarmond2@va.gov

ERIC DIEPERINK, MD
Co-Director, Minneapolis HCRC
Minneapolis VAMC
One Veterans Drive
Minneapolis, MN 55417
Phone: 612-725-2000 x2037
Email: eric.dieperink@va.gov

KATHY DOWNEY, CRNP
HCV Lead Clinician for VAPHCS
VA Pittsburgh HCS – University Drive Division
Pittsburgh, PA 15240
Phone: 412-688-6000 x815738
Email: kathy.downey@med.va.gov

JOHN EDWARDS, MD
Staff Psychiatrist
Spokane VAMC
4815 North Assembly
Spokane, WA 99205
Phone: 509-434-7013
Email: john.edwards@med.va.gov

ERIC EGERT, PA
HIV/HCV Coordinator/Provider
Coatesville VAMC
1400 Black Horse Hill Road
Coatesville, PA 19320
Phone: 610-384-7711 x6206
Email: eric.egert@va.gov

JOSE FERNANDEZ, MD
Staff Physician
Marion VA Health Care System
2401 West Main Street
Marion, IL 62959
Phone: 618-997-5311
Email: jose.fernandez@med.va.gov

MARK HOLODNIY, MD, F.A.C.P.
Director, Office of Public Health Surveillance & Research
Department of Veterans Affairs
VA Palo Alto Health Care System
Palo Alto Division
3801 Miranda Avenue
Palo Alto, CA 94304
Phone: 650-852-3408
Email: mark.holodniy@va.gov

ANTOUN HOURANIEH, RPH, MS, PHD
Clinical Specialist
VA Boston HCS – Jamaica Plain Campus
150 South Huntington Avenue
Jamaica Plain, MA 02130
Phone: 857-364-4618
Email: antoun.houranieh@va.gov

BARBARA FIOTO, NP
Hepatitis C Lead Clinician
Ralph H. Johnson VAMC
109 Bee Street
Charleston, SC 29401
Phone: 843-789-7054
Email: barbara.fioto@va.gov

JANET FLAGG, APRN
Infection Control Nurse
VA Connecticut HCS – Newington Campus
555 Willard Avenue
Newington, CT 06111
Phone: 860-666-6951 x6409
Email: janet.flagg@va.gov

JAMES HALLORAN, R.N., M.S.N., C.N.S.
National Quality Manager
South Texas Veterans HCS – Audie L. Murphy
Memorial Veterans Hospital
7400 Merton Minter Boulevard
San Antonio, TX 78229
Phone: 210-617-5300 x 14791
Email: james.halloran@va.gov

ANNETTE HAMPTON, NP
Hepatitis C Clinical Coordinator
VA Loma Linda HCS
11201 Benton Street
Loma Linda, CA 92357
Phone: 1-800-741-8387 x1215
Email: annette.hampton@va.gov

KAREN KONE, RN
Liver Transplant Coordinator
VA Salt Lake City HCS
500 Foothill Drive
Salt Lake City, UT 84148
Phone: 801-582-1565 x1184
Email: karen.kone2@va.gov

JOSEPH LIM, MD

*Assistant Professor of Medicine
Director, Yale Viral Hepatitis Program
Section of Digestive Diseases
Yale University School of Medicine
333 Cedar Street, 1080 LMP
New Haven, CT 06520
Phone: 203-737-6063
Email: joseph.lim@yale.edu*

TZE SHIEN LO, MD

*Chief, Infectious Disease Service
Fargo VAMC
2101 Elm Street
Fargo, ND 58102
Phone: 701-232-3241 x93509
Email: tze.lo@med.va.gov*

CATHERINE MARTYN, NP

*Acting Hepatitis C Coordinator
James J. Peters VAMC
130 West Kingsbridge Road
Bronx, NY 10468
Phone: 718-584-9000 x5776
Email: catherine.martyn@va.gov*

DONALD MAYO, SCD

*Associate Director, VA CT Virology Reference Lab
VA Connecticut HCS – West Haven Campus
950 Campbell Avenue
West Haven, CT 06516
Phone: 203-932-5711 x3376
Email: donald.mayo@va.gov*

HEATHER MCCURDY, RN

*Clinical Coordinator, Liver Program
VA Ann Arbor HCS
2215 Fuller Road
Ann Arbor, MI 48105
Phone: 734-845-3756
Email: heather.mccurdy@va.gov*

LARRY MOLE, PHARM D

*Director, Center for Quality Management in Public Health
Department of Veterans Affairs
VA Palo Alto Health Care System
Palo Alto Division
3801 Miranda Avenue
Palo Alto, CA 94304
Phone: 650-849-0273
Email: larry.mole@va.gov*

ALEXANDER MONTO, MD

*Director, San Francisco HCRC
San Francisco VAMC
4150 Clement Street
San Francisco, CA 94121
Phone: 415-221-4810 x2958
Email: alexander.monto@med.va.gov*

KIMBERLY MOORE, MSN, CRNP, LNC

*Nurse Practitioner
Cincinnati VAMC
3200 Vine Street
Cincinnati, OH 45220
Phone: 513-861-3100 x4435
Email: kimberly.moore@va.gov*

FERNANDO ONA, MD

*Chief, Ctr for Digestive & Liver Diseases & Nutrition
VA Pacific Islands HCS
459 Paterson Road
Honolulu, HI 96819
Phone: 808-433-0078
Email: fernando.ona@med.va.gov*

SANDRA PAEZ, PA

*Hepatitis C Coordinator
VA New Jersey HCS – East Orange
385 Tremont Avenue
East Orange, NJ 07018
Phone: 973-676-1000 x1828
Email: sandra.paez@va.gov*

MARGUERITE PETRUCCI

*Nat'l Clinical Public Health Program Coordinator
Public Health Strategic Health Care Group-13B
VA Connecticut Health Care System
950 Campbell Ave.
West Haven, CT 06516
Phone: 203-932-5711 x5758
Email: marguerite.petrucci@va.gov*

CHRISTINE POCHA, MD

*Hepatitis C Lead Physician
Samuel S. Stratton VAMC
113 Holland Avenue
Albany, NY 12208
Phone: 518-626-6156
Email: christine.pocha@med.va.gov*

ALBY QUINLAN, RN

*Clinical Nurse Specialist
VA San Diego HCS
3350 La Jolla Village Drive
San Diego, CA 92161
Phone: 858-642-3157
Email: alby.quinlan@va.gov*

CAROLYN REA, PA

*Physician Assistant
Durham VAMC
508 Fulton Street
Durham, NC 27705
Phone: 919-286-6945
Email: carolyn.rea@med.va.gov*

LINDA REED, NP

Hepatitis C Coordinator
Central Texas VA HCS – Olin E. Teague Veterans' Ctr
1901 Veterans Memorial Drive
Temple, TX 76504
Phone: 254-534-4275
Email: linda.reed3@med.va.gov

DAVID ROSS, MD, PHD

Director, Clinical Public Health Programs
Department of Veterans Affairs – Central Office
Veterans Health Administration
Public Health Strategic Health Care Group (13B)
810 Vermont Avenue, NW
Washington, DC 20420
Phone: 202-461-7249
Email: david.ross4@va.gov

AZRA SHAHIDI, PHD

Chief Microbiology & Molecular Diagnostics
James J. Peters VAMC
130 West Kingsbridge Road
Bronx, NY 10468
Phone: 718-584-9000 x6319
Email: azra.shahidi@va.gov

SANDRA SMITH, NP

Nurse Practitioner – Hepatology/Gastroenterology
VA Gulf Coast Veterans HCS
400 Veterans Avenue
Biloxi, MS 39531
Phone: 228-523-4955 x4013
Email: sandra.smith24404@med.va.gov

LAURIE STEVENSON, ANP

Staff Nurse
Alaska VA HCS & Regional Office
2925 DeBarr Road
Anchorage, AK 99508
Phone: 907-283-2231
Email: laurie.stevenson2@va.gov

ERMA STORAY, MSN, APN

Hepatitis C Coordinator
Central Arkansas Veterans HCS – John L. McClellan
Memorial Veterans Hospital
4300 West 7th Street
Little Rock, AR 72205
Phone: 501-257-5764
Email: erma.storay@med.va.gov

ROBERT STRIKER, MD, PHD

Infectious Diseases Staff
William S. Middleton Memorial Veterans Hospital
2500 Overlook Terrace
Madison, WI 53705
Phone: 608-263-2994
Email: rtstriker@wisc.edu

RONALD O. VALDISERRI, MD, MPH

Chief Consultant, Public Health SHG
Department of Veterans Affairs – Central Office
Veterans Health Administration (13B)
810 Vermont Avenue, NW
Washington, DC 20420
Phone: 202-461-7240
Email: r.valdiserri@va.gov

EDWINA WATSON, NP

HCV Coordinator
Birmingham VAMC
700 South 19th Street
Birmingham, AL 35233
Phone: 205-933-8101
Email: edwina.watson@va.gov

SUSAN ZICKMUND, PHD

Director, Qualitative Research Core
VA Pittsburgh HCS – University Drive Division
Pittsburgh, PA 15240
Phone: 412-365-4967
Email: susan.zickmund@va.gov

Appendix B: Agenda and Discussion Questions

Provider Feedback Forum on HCV Diagnosis, Treatment, and Care Thursday, February 28, 2008 Fiesta Resort Conference Center

AGENDA

- 8:00 a.m. **Welcome** and Review of Meeting Goals
Dr. Ron Valdiserri, Chief Consultant PSHG
- What is working well?
 - What are areas for improvement?
 - How can VACO help?
- 8:10--8:30 **Introduction** of Participants
Group
- 8:30--10:00 **Session I:** Staffing and Models of Care for HCV-infected Veterans
Dr. Ron Valdiserri, Facilitator
- 10:00--10:15 Break
- 10:15--11:45 **Session II:** Diagnosis of HCV Infection and Linkage to Care
Ms. Jane Burgess, Facilitator
- 11:45--12:15 Break and Pick-up Boxed Lunch
- 12:15--1:30 **Session III:** Treatment and Care of HCV Infected Veterans/Caring
for Co-Morbid Conditions
Dr. Mark Holodniy, Facilitator
- 1:30--2:30 **Session IV:** End Stage Liver Disease and Hepatocellular
Carcinoma
Dr. David Ross, Facilitator
- 2:30--2:45 Break
- 2:45--3:45 **Session V:** Informational Products for Providers and Patients
Dr. Larry Mole, Facilitator
- 3:45--4:00 **Closing:** Final Thoughts and Adjourn
Group

SESSION I: STAFFING AND MODELS OF CARE FOR HCV-INFECTED PATIENTS

- How is HCV care structured at your facility?
- Describe the kind of relationship or support you have from mental health or substance use disorder treatment providers at your site.
- If you are a mental health professional, what services do you provide to liver clinics?
- Do you have any ideas about how we can identify and recruit additional providers into the domain of HCV care for veteran patients?
- Does your facility/VISN have any special programs or procedures to meet the health care needs of HCV infected veterans who live great distances from available sources of care? If so, what are they (e.g., telehealth)?
- Is your facility involved with the community/outside sources in providing diagnostic, clinical and other services to veterans who are not currently enrolled in HCV care (e.g., stand-downs, mobile vans, etc.)?

SESSION II: DIAGNOSIS OF HCV INFECTION AND LINKAGE TO CARE

- What is the role of the HCV Lead Clinician at your site?
- How is confirmatory testing handled at your site? If your site does not currently perform reflex confirmatory testing, what barriers prevent this from becoming standard operating procedure?
- In general, how well-informed about hepatitis C are primary care providers at your site?
- How well-informed are mental health, substance abuse, and social work providers? Do you encounter any barriers or problems regarding referrals for HCV evaluation or treatment from primary care?
- Are newly discharged OEF/OIF veterans being screened for HCV? Are they assessed for drug/alcohol use, mental health issues; if so, are they referred to other clinics for appropriate follow-up?
- What assistance or resources from PHSHG would you find helpful to promote HCV diagnosis and linkage to care?

**SESSION III: TREATMENT AND CARE OF HCV INFECTED
VETERANS/CARING FOR CO-MORBID CONDITIONS**

- As of 2006, approximately 14% of the VA's 210,000 hepatitis C patients had been treated with antiviral therapy. At your site, do you feel you are treating: (a) an appropriate percentage of patients? (b) fewer patients than you would like? (c) more patients than you think should be treated? What barriers exist to offering antiviral treatment to more HCV patients?
- What additional help from mental health providers is necessary to ensure comprehensive, integrated care and/or offer antiviral treatment to more patients with mental health or substance use disorders?
- How do you assess drug/alcohol use among your patients with HCV?
- How do you address the issue of alcohol use among heavy drinking patients with hepatitis C?
- What does your facility do to encourage patients with HCV to be tested for HIV?
- How are HIV/HCV co-infected patients followed at your site?
- In your experience, what is the most common barrier to HCV therapy? Drugs? Alcohol? Patient compliance?
- Are you aware of problems at your facility in obtaining or dispensing HCV treatment medications?
- What local and or national pharmacy resources would you find helpful in treating and caring for HCV infected patients? VACO?
- What is the single biggest challenge to providing optimal HCV care and treatment in your facility or VISN?
- In your opinion, what would be the most significant change/factor that would improve HCV treatment rates in your facility?
- Is reproductive healthcare discussed and available for HCV female patients?

SESSION IV: END STAGE LIVER DISEASE AND HEPATOCELLULAR CARCINOMA

- How do you handle patients presenting with HCC? What are the barriers at your site to offering them procedures or treatment options?
- The trend of HCC and advanced liver disease shows it will steadily increase over the next ten years. In light of this trend, within the next 5 years, what do you feel is the most important issue to focus our attention on in anticipating patient care and treatment?
- Do you feel your facility and/or VISN is prepared to meet the needs of these patients?
- How do you handle patients presenting with HCC? What are the barriers at your site to offering them procedures or treatment options?
- What are major issues or problems related to liver transplant referrals?

SESSION V: INFORMATIONAL PRODUCTS FOR PROVIDERS AND PATIENTS

- How is hepatitis C education provided to patients at your site?
- What educational resources (e.g., CDs, DVDs, Internet, brochures) do you feel are the most effective/beneficial to HCV patients? Providers?
- How much do you use the local Clinical Case Registry software for HCV patient management? What kinds of reports/queries are useful? What issues keep you from using the CCR software package more? What changes in the software would you like to see to make it more useful?
- What specific topics/products would you like the Hepatitis C Resource Centers (HCRC) to focus on in the next five years?
- What has been your experience with dissemination of products developed by the HCRC?
- Thinking about the broad array of technical information related to HCV diagnosis, treatment, management and preventing transmission of ongoing infection, in what 2 or 3 topic areas would continuing education be most beneficial for you?