



Virtual State Policy Briefing

October 1, 2020

“Hepatitis C Treatment and Elimination in Washington State”

Featuring:

Washington State Representative Cindy Ryu, Vice Chair, Women In Government Board of Directors
Michael Ninburg, Executive Director, Hepatitis Education Project
Sue Birch, Director, Washington State Health Care Authority

Representative Ryu: Welcome Washington State colleagues to Women In Government’s first virtual state policy briefing: *Hepatitis C treatment and Elimination in Washington State*.

For those listening in, I am Representative Cindy Ryu, representing Washington’s 32nd legislative district. I also serve as Vice Chair of Women In Government’s [Board of Directors](#), all of whom are sitting women state legislators from across the country. WIG is a [nonpartisan, nonprofit organization](#) that serves women state legislators nationwide with educational programming and resources to address complex policy issues.

Before we get started with today’s presentation, we have a few housekeeping items to mention. First, all participants are muted through the system. We will have time for Q & A with the panelists at the end of the program, and attendees may write questions in the chat box located in the Zoom toolbar. Please be sure to select “To: Everyone”. Finally, this briefing is being recorded and it will be made available on the [WIG website](#) following the [event](#).

Now, please join me in welcoming our two panelists for today’s briefing on *Hepatitis C Treatment and Elimination in Washington State*.

We are honored to have with us Michael Ninburg, Executive Director of [The Hepatitis Education Project](#) or HEP, and Sue Birch, director at the [Washington State Health Care Authority](#). Welcome Michael and Sue!

Michael Ninburg: Thank you very much Representative Ryu.

Representative Cindy Ryu: Welcome. First up will be [Michael Ninburg](#) and in addition to his role as HEP Executive Director in Seattle, Michael also serves on the steering committees of the HPV forum and the forum for collaborative HIV research. And has previously served as a WHA Regional Board Member. Michael is also President of the [World Hepatitis Alliance](#), and so he has a lot of experience working with local and global partners on this issue. Thank you for joining us, Michael, and I am turning the floor over to you.

Michael Ninburg: Thank you so much for the kind introduction. And thank you also to Women In Government for the invitation to speak about this topic that is very important, and near and dear to my heart. Next slide, please.

So, I’m going to set the stage about why this is a problem that needs to be addressed now. It’s a problem that demands attention now, and there really is urgency. Sue Birch will be talking about the



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amazing work that we’ve been doing, and that she has led in Washington State in the last two years since Governor Inslee issued [his directive](#) that we create a state [plan](#) to eliminate Hepatitis C.

First, I want to talk a little bit about HEP, which is an organization that I’ve been running for about twenty years. It was started in the early ‘90s by Hepatitis C patients when almost nothing was known about Hepatitis C. Hep C was only cloned and named in 1989, and it was almost ten years before there was a real understanding of the national history of Hepatitis C. And, the picture here I put up because this is where you work. Some of you will recognize the steps of the Capitol in Olympia and this predates me. This was in the late ‘90s, and these were some of the first people who were involved with HEP who knew, even then, that this was a much bigger problem than anyone really appreciated. And so here we are, 20 years later. We have made amazing leaps in treatment, we have curative therapy now that didn’t exist then, but we still have a lot of work to do, and about half of those living with Hepatitis C still remain undiagnosed. Next slide, please.

So HEP is based here in Seattle but I did want to mention that we do run a couple of programs. The direct services piece and we work very closely with the State Department of Health, with the Healthcare Authority, Medicaid, local health jurisdictions; that is the Hepatitis Education Project.

We also manage a group based in the other Washington, D.C., the [National Viral Hepatitis RoundTable](#), that is really the de facto policy and advocacy group around Hepatitis B and Hepatitis C in the U.S. It grew out of a [CDC program](#) and is almost twenty years old.

About ten years old is the [National Hepatitis Corrections Network](#), and that is a network of clinicians, correctional administrators, community groups, and people who have a lived experience of being incarcerated, addressing Hepatitis in the correctional setting. And, for Hepatitis C in particular, about a quarter of those in the U.S. living with Hepatitis C in any given year have some connection to the correctional system. Either they’re living behind bars or in some form of correctional custody (probation or parole). So very important piece to address if we’re talking about eliminating Hepatitis C. Next slide, please.

What has happened with HEP, and also with general practitioners and specialists who deal with Hepatitis C, is that there has been a shift in the demographic that has been affected by Hepatitis C in the last ten years, really. When I started in the early aughts, Hepatitis C was really seen as a baby boomer disease and more than 75% of those Americans living with Hepatitis C, were born in that 1945-1965 cohort. Treatments were not great. They consisted of a year of weekly shots of a drug called [interferon](#), which was equivalent (side effects wise) to a low-grade chemotherapy. Response rates were very low, and a lot of people opted to not do the treatment because the treatment was often worse than living with the disease.

About seven years ago, the first interferon-free drug regimens became available, approved by FDA, and today, treatment for Hepatitis C is: pill once a day for eight or twelve weeks, cure rates almost 100%. This is really an unappreciated revolution in medicine. It is the first ever cure for a chronic viral infection, and what happened with that initial cohort of baby boomers, most of them were white collar, they had



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insurance through their employers. When these new drugs were approved, seven years ago, those who had not done treatment and were still alive, started getting treated and cured, and there was an echo epidemic as a result of the opioid epidemic.

So, about ten years ago--and we'll see this in a moment--Hepatitis C cases in the U.S., after having dropped every year since 1990, started ticking up again as people were moving from pharmaceutical opiates to injecting other opiates (heroin). And so, if you look at the epidemiology of infections in the U.S., you see one hump of baby boomers and then you see a new cohort of people who have been infected in the last year, and those are people generally between 20 and 40 years of age. And so, our population at HEP moved from primarily white collar baby boomers to now the people who just don't have access to these drugs because they don't have jobs, they don't have insurance through their employers, and we have moved in the last ten, really beginning fifteen years ago, to serving primarily underserved and marginalized populations: people who use drugs, people who inject drugs, people who are living homeless, people who are in and out of prisons and jails. And that has brought our organization to a place where [we do lot more](#) than Hepatitis now.

We provide medication for opioid use disorder. We have a low-barrier buprenorphine clinic. We do a lot of work with re-entry for people coming out of prisons and jails. We do vaccination. We do HIV. But again, a shift in our population, which has mirrored, somewhat, a shift in the American population affected by Hepatitis C. Next slide, please.

So why is this important? Well, about ten years ago, the [mortality for Hepatitis C](#), which had been climbing steadily for twenty years, surpassed that of all of the other 60 notifiable infectious disease conditions in the U.S. So, I'll just say that one more time. There are 61 notifiable infectious disease conditions in the U.S., and that includes HIV, that includes TB, that includes dengue. In 2011, mortality for Hepatitis alone surpassed that of all the other infectious disease notifiable conditions combined. So, this was before these new drugs became available, and, in the last seven or eight years, we have seen a slight decrease in mortality related to Hepatitis C, but this is why it's a problem and this is likely a serious underestimate of the actual numbers of people who die every year related to Hepatitis C. Next slide, please.

And this is what I talked about earlier, with this new cohort of people acquiring Hepatitis C in the U.S. after twenty years of consecutive decreases. In 1990, blood banks began to screen and so, that was the primary driver of a precipitous decrease in new infections. But, as I said earlier, about ten years ago we began to see this uptick, and that continues to this day. This goes through 2016, but the most recent data we have are through 2018 and those new infections are up to about 50,000 a year. Next slide, please.

I know that the Democratic caucus is really looking at COVID and health care in general through the lens of health equity and social determinants of health, and I really want to emphasize that Hepatitis C and Hepatitis B (which we'll touch on briefly) are both conditions that disproportionately impact both people of color and underserved and marginalized populations. You can see here, these are for new Hepatitis C cases in the last almost twenty years and by far, the population that has the highest incidence per capita



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are American Indian and Alaskan Native groups. And that, sadly, should not come as a surprise because American Indian and Alaskan Natives have poor outcomes when it comes to many healthcare indicators. But you can see this here how stark the difference is. Black, non-Hispanic as well would be the next and Hispanic after that.

When it comes to Hepatitis B, I will say that the populations that are disproportionately impacted are Asian and African populations, and those are primarily people who immigrate from those countries where Hepatitis B is endemic. In the U.S., fortunately, we have a very good Hepatitis B vaccination system where even if a person is living with Hepatitis B, and is pregnant--and my wife is in that category, she's from China--if the newborn is vaccinated, given that birth dose within the first 24 hours and continues the series (two more shots in the next six months) they will almost always be protected. So, I have two young boys--they're wonderful, they drive me crazy--but they were protected from the potential of contracting Hepatitis B from my wife, who is still living with Hepatitis B. And now they do not have to worry about monitoring their liver for liver cancer and other potential complications. Next slide, please.

And just another reminder, the previous [slide] was new cases, [and] this [slide] is death. And again, American Indian and Alaskan native have the highest mortality rate of Hepatitis C, Black, non-Hispanic after that, and then Hispanic. Next slide, please.

So, something that's happened in the last really five years, although it predates that, is this understanding and appreciation that viral Hepatitis, which included Hepatitis A, Hepatitis B, and Hepatitis C--all completely different viruses, by the way, different families of viruses, unrelated--they all happen to affect the liver. Hepatitis means inflammation of the liver, so that is the connection there. There was an appreciation, especially after these new amazing cures for Hepatitis C began to be approved, and there are several, that viral Hepatitis is something like smallpox or polio that we can eliminate. Hepatitis A and Hepatitis B are vaccine preventable. Very simple; you get vaccinated at an early age, you're not at risk for Hepatitis A or B. Hepatitis C is curable. You get tested, if you're positive, you get treated, and you're done.

So, understanding that viral Hepatitis as a whole is a winnable battle, the World Health Organization came up with targets for the [elimination of viral Hepatitis by 2030](#). And, those targets were ratified at the World Health Assembly in [2016](#) by 193 member states, of which the U.S. is still a member. And we saw in the wake of that, and even before that in some cases, jurisdictions. States, counties, [and] cities, coming up with their [own elimination plans for Hepatitis C](#) mostly, but some were Hepatitis B, and some were a combination of both Hepatitis B and Hepatitis C, and in the case of [Hawaii](#), very recently, just in the last month, Hepatitis A, B, and C. So, this is on the [HHS website](#). It gives you a pretty good snapshot of where some of these initiatives are. Next slide, please.

And as I mentioned, you know, this is happening all over the country, and it is at every jurisdictional level. And, I'll just reemphasize that [HEP-free Hawaii](#), which created a plan in the model similar to ours in Washington state, really was very ambitious in their plan and included both Hepatitis A and Hepatitis B. Next slide, please.



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So, I’m almost finished here, but I want to bring to your attention a project that we have been working on with the [Center for Health Law and Policy Innovation at Harvard Law School](#) for the last three years. It’s looking specifically at access to Hepatitis C treatment at the [state Medicaid level](#). And, unfortunately, what happened when these new drugs started being approved, six [or] seven years ago, payers started putting up roadblocks to get access to these drugs.

The treatment at the time, the standard of care, was about \$75,000, not cheap, but cost effective, and it prevented all of the downstream consequences of long-term infection of Hepatitis C, including liver cancer, end-stage liver disease, and death. The new drugs were not that much more expensive--about \$80,000, still not cheap--but there was much more demand because now, the treatment was shorter, and the side effects were not an issue. And payers foresaw this tsunami of Hepatitis C patients that had been waiting for these new treatments and decided to put up barriers to access, which was unethical at best. And, those restrictions at the Medicaid level include primarily three major restrictions.

One, many Medicaid’s required their patients to be sober, drug-free. There is no evidence that that is a condition that makes treatment any more effective. In fact, we have a lot of evidence today showing that people who use drugs, people who are using alcohol, if they are psychosocially ready, if they’re in care, they respond equally well to people who aren’t using drugs.

The second exclusion criterion was [that] people had to have a certain degree of liver disease. So, if you did not have advanced liver disease--state Medic aids, and private payers put these in place as well but lawsuits put those to an end relatively quickly--you had to wait until you had cirrhosis or had, you know, very advanced liver disease before you were even eligible, which did not make sense at all. You were basically telling someone we will treat you when perhaps some of the damage that this disease has done is irreversible.

The third restriction had to do with who can prescribe these drugs. Before the interferon-free regimens, just managing side effects was a full-time job, and so it made sense that it belonged in the specialist realm. But, with these new treatments, a pill a day for eight to twelve weeks with almost no side effects, this is moving, as it should, to the primary care settings. So, there is no reason that a specialist should be required to write the prescription for Hepatitis C drugs.

So, what we’ve done is, taking these three criteria, abstinence, liver disease, and specialist prescriber, and we’ve created a [report card](#) of all of the states in the union, and I’m proud to say that Washington State is one of a few that has an A. And it was a process. There was a lawsuit involved but the folks at the Health Care Authority, certainly Sue and Dan Lessler before her, they wanted to do the right thing and we got there. So, next slide please.

And you can see, and it’s an interactive website, I’ll just, I didn’t mention it is [stateofhepc.org](#), I encourage you all to go there and you can brag to your fellow representatives in other states about the great job that we’re doing [here](#). But if you do click on the state, you will get some details about how the policies are playing out in that specific state. Next slide, please.



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And so, this is the progress that we’ve made in the last six years. The [National Viral Hepatitis RoundTable](#), again, one of the programs that we run at HEP, has been instrumental in working with state Medicaid, working with advocates at the state level, working with legislators, to really address the barriers, and a novel argument that just came out in a paper this summer. Perhaps the illegality of denying treatment to someone who is using drugs and that came from our [colleagues at Harvard Law](#) looking at the ADA and determining that by denying someone who might have a substance abuse or alcohol use disorder treatment, Medicaid can be in breach of the ADA. Next slide, please.

Sobriety restrictions. We still have a fair amount of work to do, but you can see that we’ve made some progress. Not as much as the [fibrosis](#). And the next slide, please.

And then the prescriber restrictions. And I mentioned that, again, this is something that 90% of Hepatitis C patients can and should be seen in the primary care setting because this is a pill a day, eight to twelve weeks [with] very few side effects, and I’ll say, importantly, the cost or the price of these drugs, I should say, has dropped precipitously in the last several years. So, what was a treatment that cost \$80,000 plus six years ago, payers (including Medicaid) are getting a full course of therapy for \$10,000 plus or minus a few thousand dollars. And so, that’s less than a year of treatment for HIV. And at that price, we are well beyond cost effectiveness for Hepatitis C treatments. We are into cost savings and so it actually is saving payers, saving state governments money, to go out, test, identify, treat, and cure their citizens living with Hepatitis C because the downstream consequences of that infection are going to be far more than the cost of intervening with testing, and treating, and curing. Next slide, please.

And I’m going to pass it off to Director Birch here in just a moment, but two years ago and three days, September 28, 2018, Governor Inslee, after much deliberation with his policy staffs [and] Chief of Staff, made a commitment to eliminate Hepatitis C in Washington State, in alignment with the WHO goals, by 2030. He issued a [directive](#) to his department heads to come up with a plan and the plan was to have several components. I think the most exciting for a lot of people was this kind of innovative drug procurement model, which we’ll hear about in a moment, but, next slide please.

What I think was one of the most impactful parts of this whole process was bringing in every possible stakeholder to help with the drafting of this plan. The [folks at DOH](#) did an amazing job. Emalie Huriaux, who oversees the viral Hepatitis work, is a master at this collective impact model where one brings in multiple stakeholders to really discuss every possible permutation of what might be effective in a plan. In this case, to eliminate Hepatitis C and that is our mission: to eliminate Hepatitis C as a public health threat by 2030. And with that, I will hand it off to my friend, Sue Birch.

Representative Cindy Ryu: Thank you so very much, Michael. Sue, let me introduce first. Thank you so very much for your group’s work to eliminate Hep C in our communities here in Washington State. So, now I’d like to welcome [Sue Birch](#), Director of the Washington Health Care Authority.

In her role as Director, Sue focuses on transforming the health care delivery system to better serve those for whom the [Health Care Authority](#) purchases care while simultaneously keeping health care costs in check.



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Prior to assuming her role at the HCA, Sue served as the Executive Director of the Colorado Department of Health Care Policy and Financing.

She is also a nurse and holds both an M.B.A. and a Bachelor of Science in Nursing from The University of Colorado at Denver.

So here, welcome, Sue, and I turn the floor over to you now!

Sue Birch: Thank you Rep. Ryu and Michael, it’s just always such a pleasure. Leadership matters more than ever these days, and to work with leaders like Michael truly is just a delight. So, I’m going to just do a quick sound check. Are we ok, Rep. Ryu? I know earlier was a little hard. Okay, good. So, thank you for that first slide. Let’s go ahead and move on to the next.

I’ll just quickly highlight or just echo a few of Michael’s comments. I want to talk in a little bit deeper discussion about the directive that was ordered. I also want to highlight our partners at [the] Department of Health, their roles in this process. We’ll share with you a little bit more about that purchasing strategy that we have a national reputation for, and then I want to also just help you understand too another few features on why we think this is such a winnable, attainable goal. And, lastly, we’ll both, I’m sure, talk about the impact of COVID-19 on the elimination efforts. So, let’s go ahead to the next slide.

So, Michael was so eloquent taking you through the background about Hep C, but I do want to remind everybody, this is the most common blood-borne infection in the U.S., as he said, and it can be cured. And as he said, we’ve got nearly 60,000 living here in Washington, or we did in 2018, and we’ve got to find them, and we’ve got to get them cured and treated. He talked to you about the drugs, and they were outrageously expensive. I served under a different Governor in Colorado, and we were always watching what Washington was doing, and you all were groundbreaking in the country with your lawsuits and whatnot. But we clearly have helped move the pharmacy industry in getting this cost of the drug down and we’ll again dig deeper into that with the way we purchased these drugs. And then lastly, I just want to highlight that this is really a home run, almost 100% effective and we find, really, in these great programs that patients really have great compliance and in eight to twelve weeks, we can heal those livers and these sick folks, and boy, it just really gets them back to being productive and functioning and feeling so much better.

So, as Michael said, I do think it’s really important for you as legislative leaders to know that there really has been a noticeable shift in the age distribution of folks. So really, it did, it has been challenging in that first we were working with kind of the white baby boomers and that epidemic has now really shifted to younger persons who were really more likely introduced to this virus by sharing drug injection equipment. And so it just, it really keeps us on our toes to know that with kind of the opioid epidemic going on, that we’ve got to not only kind of control for older folks that likely have Hep C, but we also have to be hypervigilant about checking out younger populations. So, let’s move on to the next slide.



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You know, Michael kind of understates his role, but he will be someday, in decades to come, the one that is credited for eradicating this disease in the world. Eradication means it's a global squashing of this bug. Here in Washington, we aim to eliminate Hep C, and we really mean it where we say we want to be the first state where HCV is no longer a public health threat, and where those few people [that] become infected with HCV learn their status quickly and access curative treatment without delay, and that we then prevent the spread of this virus. This is so achievable, and we need all of your help doing this. And I know many of you have been champions so I know Michael and I are kind of preaching to the choir, but we will hear why it's so important now more than ever for us to stay on our game about eliminating Hep C. Next slide.

Governor Inslee: imagine when I came to the State from Colorado, I was delighted as a public health nurse to know had I have a Governor in Governor Inslee who said Sue, we really want to get this done. And so, he issued that [directive](#) and he said, Healthcare Authority and Department of Health who work together, develop strategies to eliminate it expediently from Washington by 2030. And my team here at Healthcare Authority and our partners at Department of Health in that public private partnership with Michael's group, were elated. And initially it was Doctor Lessler. He handed off that work to Dr. Zerzan, and there are a [whole slew of champions here at Health Care Authority](#) that keep Hep C top of mine.

And I know some of the team, Stella Chang and others here at the Health Care Authority, who have worked tirelessly on this and are listening in as well, so I want to call them out because again, leadership on this issue really matters. That directive said, “hey healthcare authority, you do the procurement strategy to get the cost of this drug down so we can better pay for and cover all state-covered lives and finance the public health efforts. And Department of Health, you work with all those other stakeholder groups, like Michael's, to develop this [comprehensive strategy](#) to eliminate public health threat of the virus here in Washington.” And I have to say, that sounds easy but getting that alignment and getting everybody rowing in the right direction, all the while Louisiana kind of claiming “we're going to be first,” and Washington was saying “we're going to be first,” and we all just moved, it doesn't matter who's going to be first, but let's spring into action, save money, and do this in a much more efficient way.

So, if Doctor Lofy was here, she would be reporting out about this next slide, which is about the [Department of Health public health strategy](#). They brought together that range of partners to develop this Hep C free Washington initiative, and Michael already gave a huge shoutout to the team over there, but they truly have been just striding along with everybody in this work. The participants included state agencies, our Tribal Health Partners and the Tribal health centers, the local health jurisdictions, the federally qualified health centers, community based organizations, the syringe service programs, the opioid treatment programs, the University of Washington, Washington State University, all the health plans, professional organizations, and people affected by Hepatitis C.

So, with this shared mission of eliminating Hep C, the partners developed a set of these recommended goals and actions to achieve this mission, broken up into three different work streams. Really importantly, data, data, data, and science and strategic information. Clinical strategies was the second and the third was community-based responses and intervention. For example, encouraging the public to



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get screened and linkage to care through these various strategies, just one of the ways we really tackled this. Go ahead to the next slide.

HCA really took on the role of the [purchasing strategy](#) and we put out, and why this was important was our agency currently covers about 1.9 million [Apple Health](#) --or Medicaid clients--you also buy health services and promote health services for all our public employees, benefit state enrollees. We knew we wanted to buy for [the] Department of Corrections, Department of Labor and Industries, and Department of Social and Health Services for those state hospitals. And so, it was very important for us to align this purchasing power, and we sent out a request for proposals, hard to believe, back in January of 2019. We requested those discounted drug costs for all [of] those state covered lives that I just mentioned, as well as the outreach services. So, we put that onus onto the pharma partners that were coming to the table and said “you have to be part of this aligned public health push”. And then we executed two contracts which became effective July 1, 2019.

[AbbVie](#), a pharmaceutical company, was [awarded the state contract](#) because they provided the best overall portfolio and they offered a product that treats about 97% of all patients with Hep C. And, really, if you can bear with me here, I’ll describe this as kind of a modified “Netflix subscription model”. And so I can’t take you too deep into all that procurement purchasing work--you could have a PhD course in it--but we worked with some very smart, brilliant Wall Street folks, and some pharmacy experts, and we, (and all of the partners) and we were able to craft this purchasing strategy that allowed us to bulk-buy and buy at an extraordinarily discounted rate off what Michael identified earlier, off that initial kind of \$80,000 per member cost. And Michael, you threw out a number, I can’t talk about that number as everybody knows, but he’s right. The cost of it, actually I think, was one of the reasons these drugs have moved in such different direction. Some other pharmaceutical companies came on the market as well, but it has been extraordinary to see the price of this drug move in the right direction.

I do want to say that it was really important to us in the contract that Medicaid had kind of that lower price threshold but still really included the patient outreach services. And then for the non-Medicaid part of the contract, we want the same net costs for all those non-Medicaid programs, and we wanted all those other non-Medicaid lives to get the benefits of all that great public health alignment and social media and marketing that we’re doing to try to find everybody. So, let’s just go on to the next slide, I’ll finish up here in just a minute.

(I already talked about the modified subscription model), the other piece I want to talk about when I talk about non-Medicaid, we have a traditional rebate for public and school employees now and injured workers covered by [L&I](#), and there’s an upfront discount and distribution for Department of Corrections in the state hospitals and there’s also an option to pursue [340B pricing for Department of Corrections](#). Go ahead to the next slide.

That purchasing strategy is called out as the benchmark in the country. [Louisiana](#) used a little different purchasing strategy, but everybody says our strategy was so much better. And we think because we hang out with Michael, our state did a better job at all this and that’s why we got that A grade. Anyways, go ahead to the next slide.



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So, you’ll see that with all of this, our state really is confident that we can pull this off. We’ve got good access to [syringe service programs](#), we’ve got increasing [access to medications for opioids](#), committed medical providers, academic institutions, we’ve got Medicaid expansion and aligned Medicaid policies that [create some efficiencies](#), the [AIDS Drug Assistance program](#), and we’ve really got improved [Hep C surveillance assessment](#) efforts. The [CDC](#) really is moved to in this progression with our work, again, thanks a lot to Michael’s leadership, and they recommend one-time Hepatitis C testing for all adults.

Just two years ago, it was more targeted to different age groups that have different symptoms as Michael talked about, and also, they recommend for all pregnant women during every pregnancy. CDC continues to [recommend people with certain risk factors](#), including people who inject drugs, to be tested regularly. Go ahead and move on to the next slide.

Here’s a little bit more about our Medicaid pharmacy policy. We’ve implemented these policy changes to clear the path for providers to treat Hep C patients, and as Michael already alluded to, we [eliminated a lot of the hurdles or challenges](#). And this policy alignment, along with that purchasing strategy and really just making things move more smoothly in the health care arena is no small effort and no small feat. So again, I just, huge kudos to the teams that have really implemented and made these, taken these obstacles out of the way.

Lastly, I do want to call out something that I think is also unique to Washington. Washington has been very closely aligned with our primary care providers and a little known secret here in Washington is that we have an inordinate number of nurse practitioners and physician assistants and, because Michael was so successful in opening up that treatment, and because of Dr. Zerzan and myself and many others at Department of Health are so dedicated to workforce, we are doing some very interesting video outreach to try and really call on our prescribers, and our workforce professions and nurses make up the biggest number of the work force profession, to really be activists in helping us with eliminating this disease. So, I do think that that is a real credit to Washington and how we work so much more efficiently. And our public health partners who again, lots of nurses and doctors and health workers in that arena too, that are really engaged in this fight. So lastly, I’ll just touch on the impact of COVID-19 elimination efforts. If you want to move to the next slide.

And it, I have to say, we were really on a roll. Prior to the pandemic, HCA and [AbbVie](#) and all the partners deployed of this [elimination awareness bus](#), many of you might have seen the bus on the state capitol. It went out to areas of Washington with high risk Hep C population and did antibiotic testing, counseling, and linkage to care. Their goal was really to increase the elimination awareness, and the bus activities had to get postponed because of all the COVID-19 impacts and because of all the social distancing.

The bus went early in 2020. They went to the [9th Annual Spokane Homeless Connect](#). In February, they were at Seattle King County clinic, and even though the bus activities are on hold, currently, as many major events have been postponed, we’re working with the partners to figure out how to get this effort restarted in our new virtual kind of new normal way. And HCA Department Health are rebuilding the momentum around the elimination efforts, you’ll be seeing some great workforce videos coming out



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soon. And we’re starting this webinar series that’s really targeted to those workforce folks that I mentioned and to really engage them one on one as they keep pushing primary care and prevention, so Michael alluded, we feel strongly that this has to be just a normal part of one’s primary care that they receive as they go in for their overall health and wellness.

And I think I’m going to stop there. Oh, I do want to just say that my staff ran some numbers and said that on average our drug utilization is back to pre-pandemic utilization at the moment, but that’s not good enough. We want it to spike and we want to beat that 2030 goal. So, we know we’ve got a stiff campaign and work to do. But those are some of the impacts of COVID-19, that COVID-19 has had on our efforts and I think we’ll move on to the next slide and take your questions now.

Representative Cindy Ryu: Thank you so very much Sue. Actually, we are out of time and so we’ll wrap up here. We really appreciate HCA’s efforts to both strategically address Hep C in Washington State, of course before and during the COVID-19. So, I’d like to thank the panelists again for their time and expertise and ask each of them where we could find more information on Hep C treatment and elimination, and, specifically Sue, we had a question from Senator Darnielle as to what our strategy is for the incarcerated population, and Michael, where can folks find out more about your organization?

So, Sue, you can email me back, and then I’ll email everyone else. So, then Michael, where can we find out more about your organization?

Michael Ninburg: Sure. So, you can go to [Hepeducation.org](https://www.hepeducation.org) and all of my contact info, all of the work that we do. [NVHR.org](https://www.nvhr.org) as well, that’s for National Viral Hepatitis Roundtable. I will put those in the chat here, and I will say that we’ve actually done a pretty good job in our prison population, getting people screened at intake, and so Washington state is one of a handful of states that does opt out testing for all of the men and women who enter our prison system for Hepatitis B, Hepatitis C, and HIV, and if they test positive for Hepatitis C antibodies, they get a confirmatory test, and they are eligible for treatment so better than certainly most states.

Representative Cindy Ryu: Perfect, thank you so much again. And I’d also like to thank you my legislative colleagues and everyone else who joined us to learn about the Hepatitis C treatment landscape in Washington State and I encourage all of you to learn more about Women In Government’s work and events by following WIG on [Facebook](https://www.facebook.com/womeningovernment), [Instagram](https://www.instagram.com/womeningovernment), [Twitter](https://twitter.com/womeningovernment), [LinkedIn](https://www.linkedin.com/company/womeningovernment), and [SoundCloud](https://www.soundcloud.com/womeningovernment).

So, finally, would you please look out for a follow-up email from Women In Government with the resources referenced during the presentation that will also be posted to WIG’s website: www.womeningovernment.org.

Thank you again and please stay safe!

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