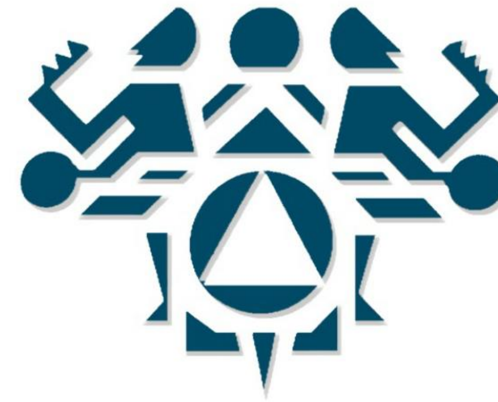
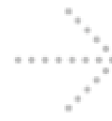
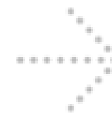
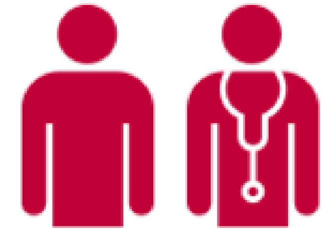
Welcome to the Northwest Portland Area Indian Health Board's HCV TeleECHO



Indian Leadership for Indian Health

Clinic will start at 12PM PST



People need access to specialty care for their complex health conditions.

There aren't enough specialists to treat everyone who needs care, especially in rural and underserved communities.

ECHO trains primary care clinicians to provide specialty care services. This means more people can get the care they need.

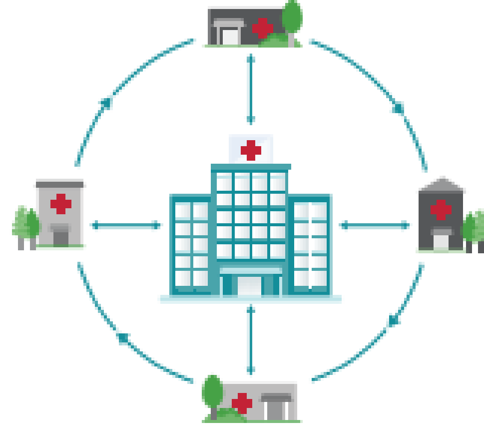
Patients get the right care, in the right place, at the right time. This improves outcomes and reduces costs.

UNM HEALTH SCIENCES CENTER | Project ECHO

In the U.S. and around the world, people are not getting the care they need, when they need it, for complex but treatable conditions.

Moving Knowledge, Not Patients

Through telementoring, ECHO creates access to high-quality specialty care serving local communities.



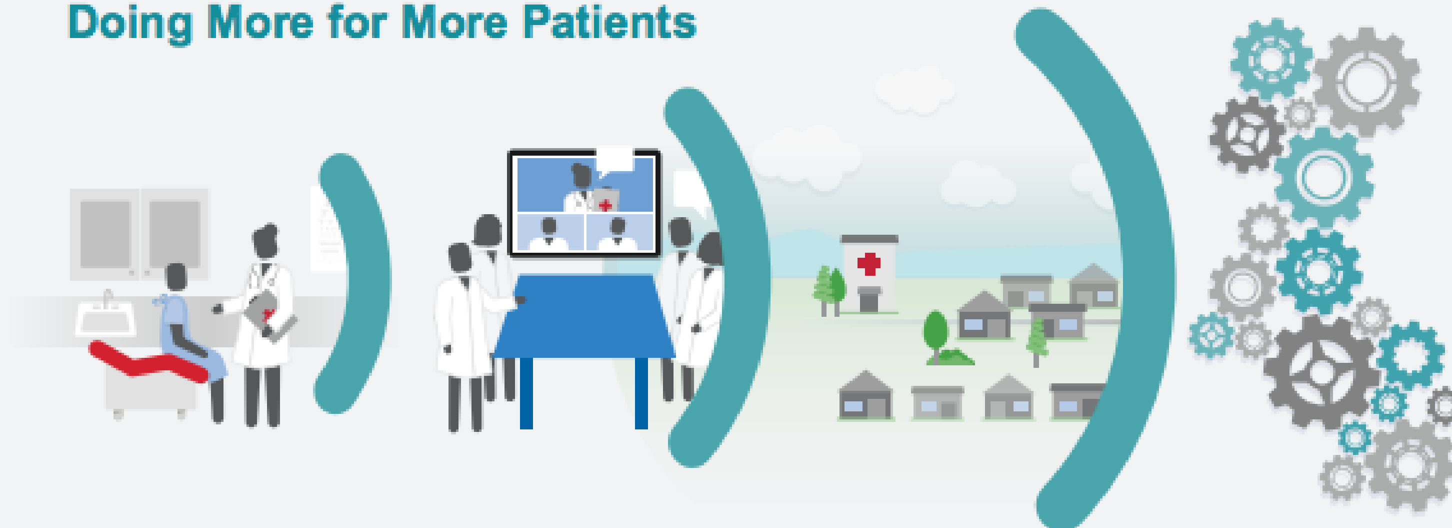
Hub and spoke knowledge-sharing networks create a learning loop:

Community providers learn from specialists.

Community providers learn from each other.

Specialists learn from community providers as best practices emerge.

Doing More for More Patients



PATIENT
- Right Care
- Right Place
- Right Time

PROVIDER
- Acquire New Knowledge
- Treat More Patients
- Build Community of Practice

COMMUNITY
- Reduce Disparities
- Retain Providers
- Keep Patients Local

SYSTEM
- Increase Access
- Improve Quality
- Reduce Cost

Changing the World, Fast

NEW MEXICO
- Operating more than 25+ teleECHO clinics
- More than 300 community clinic sites

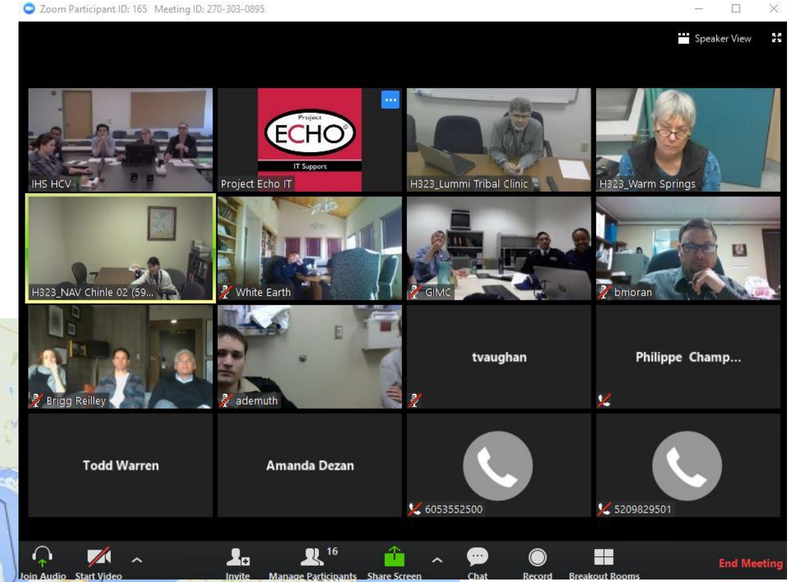
NATIONAL
- Operating in more than 30 states and growing
- More than 55 complex conditions

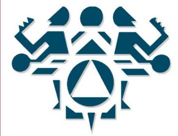
GLOBAL
- Operating in more than 18 countries and growing
- Goal of touching 1 billion lives by 2025

Project ECHO
Northwest Portland Area Indian Health Board (NPAIHB)

Indian Leadership for Indian Health

IHS HCV TeleECHO Clinic Sites





IHS HCV TeleECHO Clinic Sites

What it means to be part of the NPAIHB ECHO Community

- The 1 hour long clinic includes an opportunity to present patient cases and receive recommendations from a specialist
- Engage in a monthly didactic session
  - 10-15 minute presentation that focuses on:
    - The epidemiology of HCV in Indian Country (Brigg Reilley-Epidemiologist, IHS)
    - Assessment tools for clinicians (CAPT Stephen “Miles” Rudd-Medical Director POR Area IHS)
    - Demonstration of focused efforts (e.g. Cherokee elimination program)
    - Standard practice and evidence based interventions (e.g. AASLD HCV tx guidelines)
    - Access to medications (e.g. Medicaid overview in your state, etc.)
- Become part of a learning community and network
- Together, manage patient cases so that every patient gets the care they need

To get the latest HCV news and updates delivered to your inbox

text

HCV

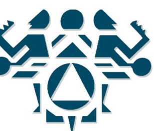
to

97779

Some helpful tips:

- Mute microphone when not speaking
- Position webcam effectively
- Test both audio & video
- Communicate clearly during clinic:
  1) Speak clearly
  2) Use chat function

IT Issues? Call 503-416-3281



Indian Leadership for Indian Health

To protect patient privacy, please only display or say information that doesn’t identify a patient or that cannot be linked to a patient.

References:

For a complete list of protected information under HIPAA, please visit www.hipaa.com

Indian Leadership for Indian Health

Common Patient Identifier Slip-Ups

1st – **Names**: Please do not refer to a patient's *first/middle/last name* or use any *initials*, etc. Instead please use the *ECHO ID*.

2nd – **Locations**: Please do not identify a patient's *county, city or town.* Instead please use only the patient's *state* if you must or the *ECHO ID*.

3rd – **Dates**: Please do not use any dates (like *birthdates*, etc) that are linked to a patient. Instead please use only the patient's *age* (unless > 89)

4th – **Employment**: Please do not identify a patient's *employer*, work *location* or *occupation.* Instead please use the *ECHO ID*.

5th – **Other Common Identifiers:** Do not identify patient's *family* members, *friends*, *co-workers*, *numbers*, *e-mails*, etc.

Project ECHO®
Northwest Portland Area Indian Health Board (NPAIHB)

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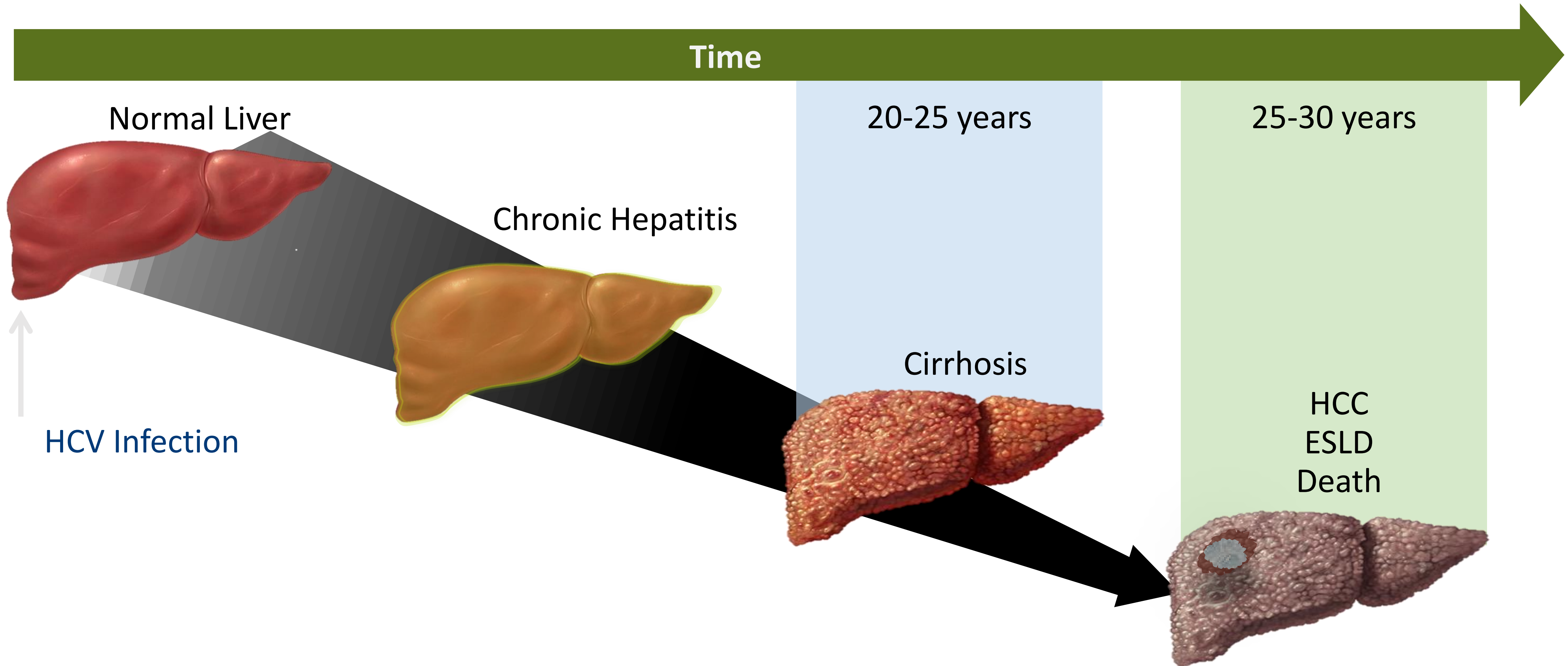
Liver Fibrosis Staging

Jorge Mera, MD, FACP

ECHO

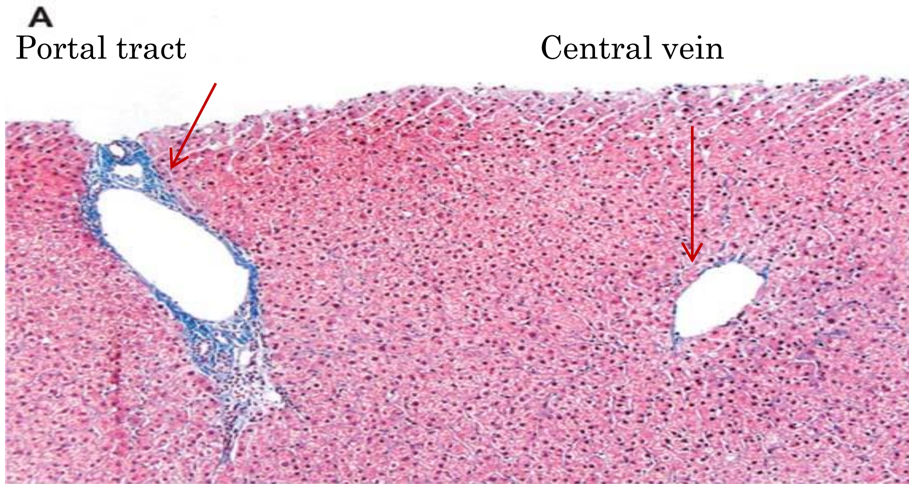
Figure 2

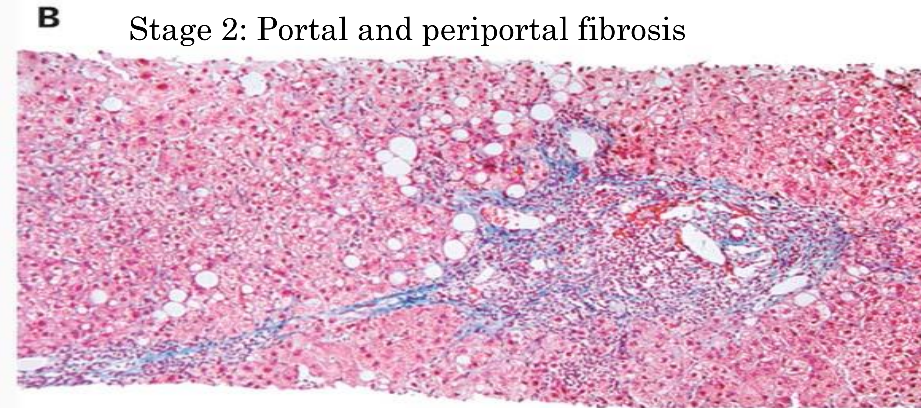
Hepatitis C: Progression of Disease



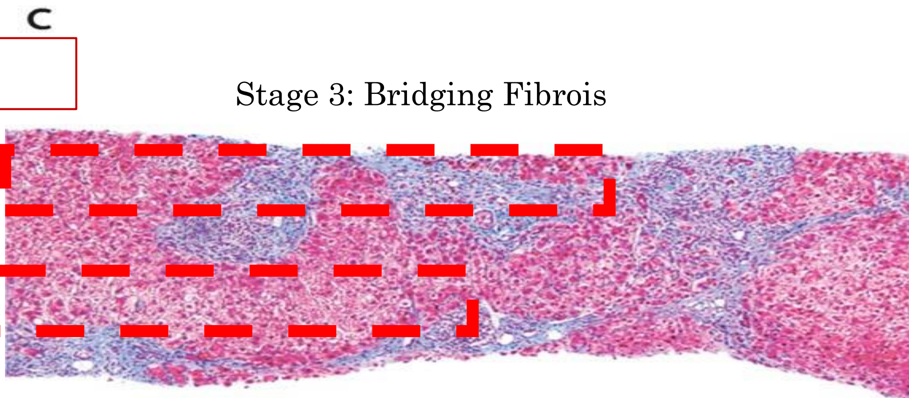
workflow

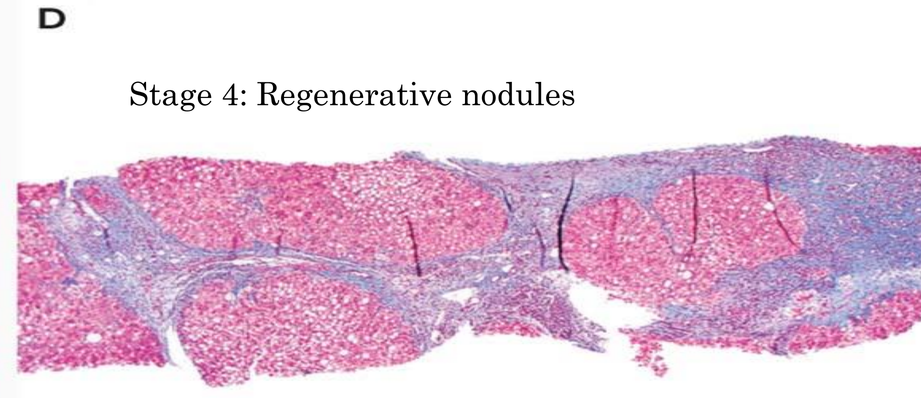
Histologic Features of HCV Infection According to Different Scoring Systems





Liver Biopsy

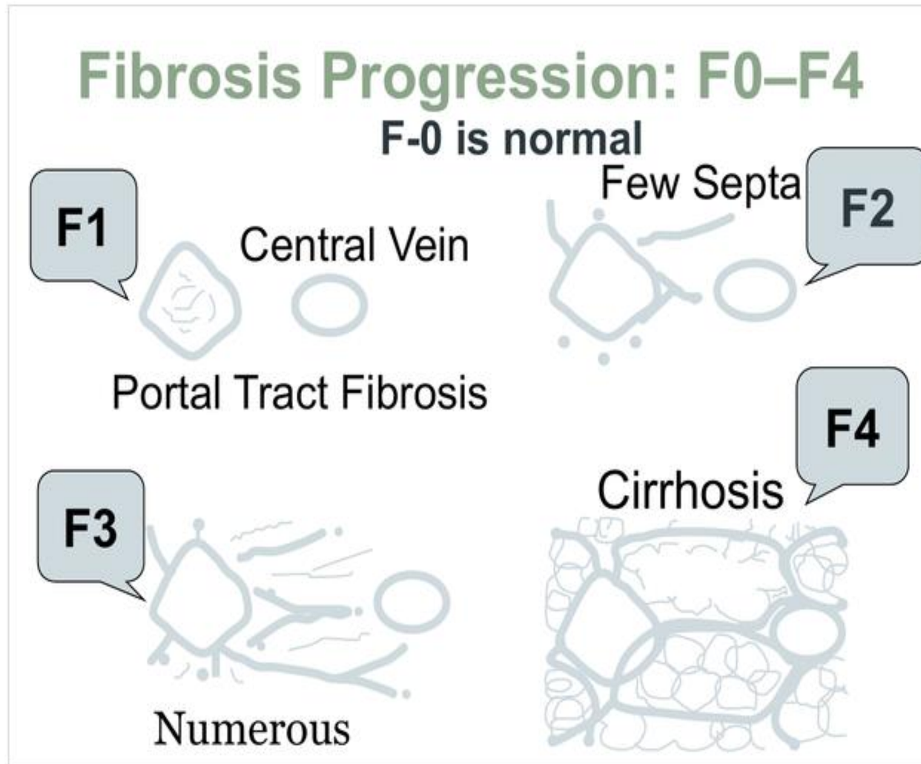




Rosen HR. N Engl J Med 2011;364:2429-2438

The NEW ENGLAND JOURNAL of MEDICINE

Liver Fibrosis Staging



Fibrosis Stage

- F0: No fibrosis
- F1: Portal fibrosis without septa
- F2: Few septa
- F3: Numerous septa without cirrhosis
- F4: Cirrhosis

Non Invasive Liver Fibrosis Testing

- Blood Tests
  - AstPlateletRatioIndex
  - FIB-4 – index
  - Fibrosure
  - Forns Index
  - Fibrometer
  - Hepascore
  - Fibrospect
- Liver Imaging
  - Transient elastography
  - MRI elastography
  - Acoustic radiation force impulse imaging (ARFI)

APRI: AST to Platelet ratio index

AST Level (IU/L)

126

AST (Upper Limit of Normal) (IU/L)

39

APRI = x 100 = 2.084

Platelet Count (10^9/L)

155

An APRI score > 0.7 had a sensitivity of 77% and specificity of 72% for predicting significant hepatic fibrosis .

APRI <=0.3:	Unlikely cirrhosis or significant fibrosis
APRI >0.3 and <=0.5:	Unlikely cirrhosis, significant fibrosis possible
APRI >0.5 and <=1.5:	Significant fibrosis or cirrhosis possible
APRI >1.5 and <=2:	Likely significant fibrosis, cirrhosis possible
APRI >2:	Likely cirrhosis

UpToDate

Lin ZH, Xin YN, Dong QJ, et al. Hepatology. 2011;53:726-36
University of Washington: Hepatitis C Online www.hepatitisc.uw.edu/

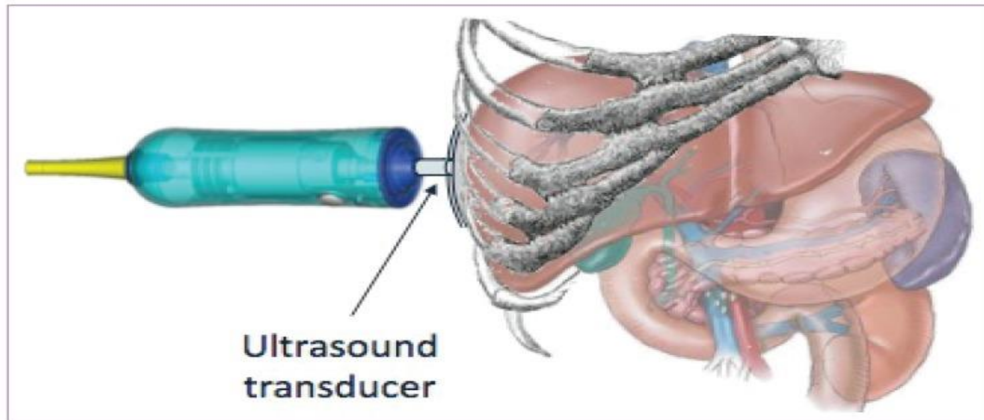
Fib-4 Index

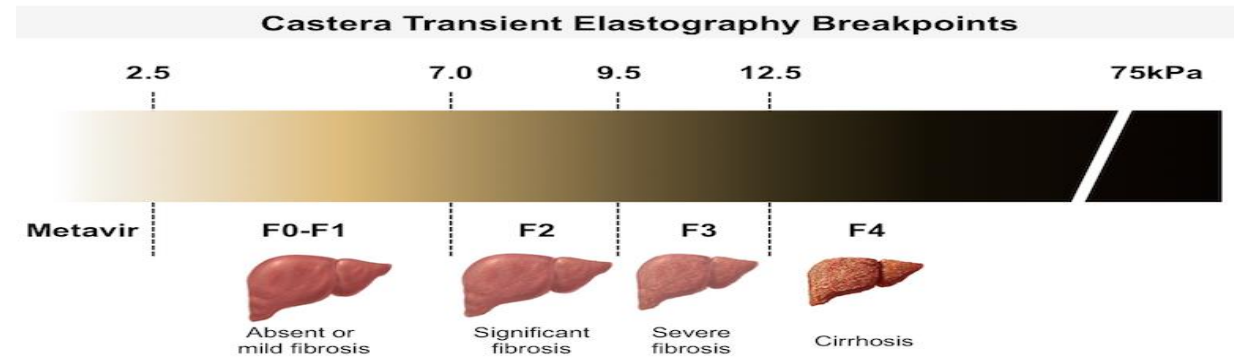
$$\text{FIB-4} = \frac{\text{Age (years) } 56 \times \text{AST Level (U/L) } 129}{\text{Platelet Count } (10^9/L) \text{ } 196 \times \sqrt{\text{ALT (U/L) } 96}} = 3.76$$

A FIB-4 score **<1.45** has a negative predictive value of 90% for advanced fibrosis A FIB-4 **>3.25** has a 97% specificity and a positive predictive value of 65% for advanced fibrosis.

Sterling RK, Lissen E, Clumeck N, et. al. Hepatology 2006;43:1317-1325
University of Washington: Hepatitis C Online www.hepatitisc.uw.edu/

Fibroscan





The probe of the Fibroscan device is positioned in an intercostal space near the right lobe of the liver, and a 50-MHz wave is passed into the liver from a small transducer on the end of the probe. The device then measures the velocity of the shear wave (in meters per second) as this wave passes through the liver, and this measurement is converted to a liver stiffness measurement.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3594956/

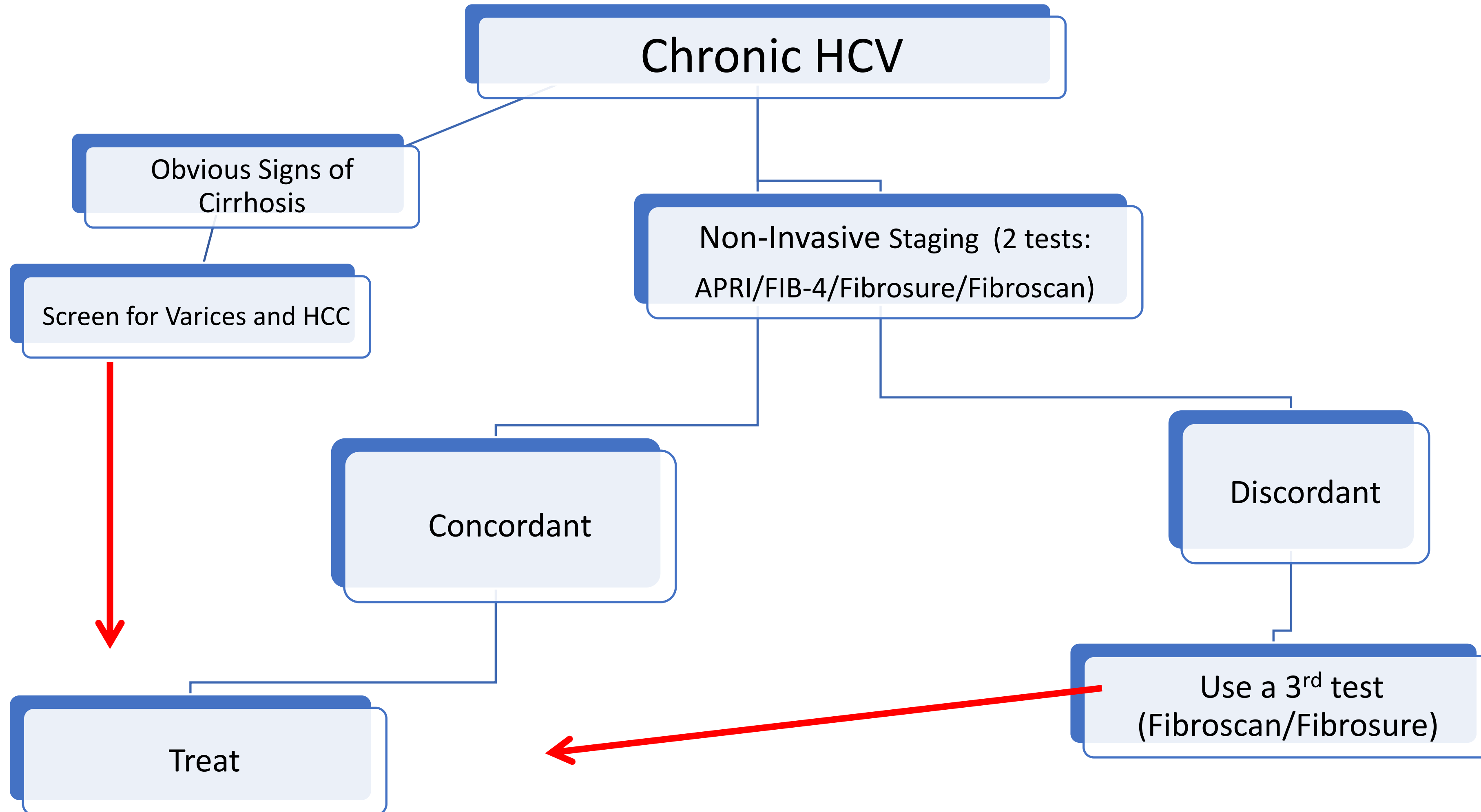
Non-Invasive Fibrosis Staging in HCV

Test	No Significant Fibrosis F0-F1	Significant Fibrosis F2-F4	Sens	Spec
APRI	≤ 0.7	> 0.7	77%	72%
APRI		> 2.0	46 %	91%
FIB-4	≤ 1.45	>3.25	73.4 % **(NPP 94.7%)**	98.2 % **(PPV 82.1%)**
Fibrosure	≤ 0.31	≥ 0.72	60-75 %	80% - 90%

Loaeza-del-Castillo et al. *Ann Hepatol*. 2008 Oct-Dec;7(4):350-7.
Lin ZH, Xin YN, Dong QJ, et. al.. *Hepatology*. 2011 Mar;53(3):726-36.
Udell JA, Wang CS, Tinmouth J, et. al. *JAMA*. 2012 Feb 22;307(8):832-42.
Vallet-Pichard A, Mallet V, Nalpas B, et. al. *Hepatology*. 2007 Jul;46(1):32-6.

workflow

Fibrosis Staging Algorithm



CNHS Workflow Algorithm
Adapted from Boghal H, Sterling RK, Infect Dis Clin N Am 26 (2012) 839-847

Why is it important to stage

- Treatment ***may be different between*** cirrhotic and non cirrhotic patients
- Treatment ***will be different*** between those patients with decompensated and NOT decompensated cirrhosis
- ***All patients*** with liver fibrosis (F3 or F4) will need screening for
  - hepatocarcinoma
  - Esophageal varices
  - Hepatic encephalopathy
- Patients with decompensated cirrhotic ***need*** to be referred to a liver transplant center
- STAGING IS NOT TO DECIDE IF YOU SHOULD TO TREAT HCV
  - BECAUSE **EVERYONE SHOULD BE OFFERED TREATMENT**