WASHINGTON STATE
HEPATITIS C ELIMINATION COORDINATING COMMITTEE
Kickoff Meeting
October 26, 2018
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00-10:30</td>
<td>Welcome &amp; Introductions</td>
</tr>
<tr>
<td>10:30-10:40</td>
<td>Background on the Governor’s Directive and Purpose of Coordinating Committee (presentation)</td>
</tr>
<tr>
<td>10:40-10:50</td>
<td>Hepatitis C in Washington State</td>
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<tr>
<td>10:50-11:00</td>
<td>Defining “Hepatitis C Elimination” (presentation)</td>
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<tr>
<td>11:00-12:00</td>
<td>Building on What We Already Have: Various approaches to Hepatitis C Elimination from Other Jurisdictions and the Existing DOH Hepatitis C Strategic Plan (presentation and discussion)</td>
</tr>
<tr>
<td>12:00-12:45</td>
<td>LUNCH BREAK</td>
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<tr>
<td>12:45-1:30</td>
<td>How to Make a Collective Impact: Developing a Multisector Commitment to Elimination (presentation, discussion)</td>
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<tr>
<td></td>
<td>• Who is at the table? Who is missing?</td>
</tr>
<tr>
<td></td>
<td>• How do we ensure commitment from various actors?</td>
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<tr>
<td>1:30-2:15</td>
<td>Administrative Questions (discussion)</td>
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<tr>
<td></td>
<td>• Structure of this group — do we want to elect co-chairs?</td>
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<tr>
<td></td>
<td>• Do we need work groups on specific sub-topics and report back to the Coordinating Committee?</td>
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<tr>
<td></td>
<td>• What’s in a name? What should we call this initiative?</td>
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<tr>
<td></td>
<td>• How should we define our mission and vision?</td>
</tr>
<tr>
<td></td>
<td>• How often should we meet in person vs. Go To Meeting?</td>
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<tr>
<td></td>
<td>• Where would you like in-person meetings held?</td>
</tr>
<tr>
<td>2:15-2:30</td>
<td>Next Steps and Closure</td>
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</table>
Welcome & Introductions

- Please share a little bit about yourself:
  
  - *Your name*
  
  - *Your affiliation / where you work*
  
  - *How do you see yourself and/or your organization playing a role in eliminating hepatitis C in Washington State?*
Background on the Governor’s Directive & the Purpose of the Coordinating Committee
History of How We Got Here

1998 – Advocates press for a state response to hepatitis C
2003 – Bill passed requiring DOH to develop a hepatitis C strategic plan
2004 – DOH develops first Washington State hepatitis C strategic plan
2006 – Funding for hepatitis C response is included in state budget for the first time
2014 – DOH develops a second Washington State hepatitis C strategic plan
2018 – Internal state cross-agency work group starts discussing elimination in spring, meeting regularly from June through September

- Department of Corrections
- Department of Health
- Department of Labor & Industries
- Department of Social & Health Services
- Health Care Authority
- Office of Financial Management
- Office of the Governor
- Office of the Insurance Commissioner
Governor Inslee Issued Directive on September 28, 2018 to Eliminate Hepatitis C in Washington by 2030
DOH, in collaboration with any other relevant state agencies that it identifies, shall convene and facilitate an hepatitis C virus (HCV) elimination coordinating committee comprised of stakeholders from various sectors, including individuals personally affected by HCV.

- The committee shall draw on existing efforts, best practices, and community knowledge to develop, by July 2019, a comprehensive strategy to eliminate the public health threat of HCV in Washington by 2030.

- The strategy will address needed improvements to the public health systems to help ensure that all people living in Washington who have or are at risk for contracting HCV, have access to preventive services, know their status, and connect to care and ultimately the cure.

- The elimination strategy shall include a major public health communications plan financed, to the extent possible, by the funds saved through the purchasing strategy described in the next two slides.
Innovative Drug Procurement Strategy

• Innovative drug procurement strategy being led and coordinating by Health Care Authority.

• First-in-nation comprehensive procurement of hepatitis C medications purchased by state agencies to get the best prices possible from manufacturers and make sure curative treatment is more readily available to all.
Hepatitis C Drug & Price Distribution

Manufacturer

- HCA-contracted guaranteed net unit price, rebates through PBM MedImpact, 100% pass through to programs
- Medicaid, federal & supplemental rebates contract
- Distributor- HCA contracted guaranteed net unit price

Uniform Medical Plan (UMP)

Labor & Industry (LNI)

Department of Corrections (DOC)

Department of Social & Health Services (DSHS)

Retail pharmacy

Members
Hepatitis C in Washington State
• Hepatitis C is the most common bloodborne infection in the United States.

• In the US, it kills more people every year than all other 59 reportable infectious diseases combined.

• Hospitalization costs related to hepatitis C in Washington were $114 million from 2010 through 2014.
Hepatitis C Surveillance in Washington State

• Hepatitis labs and cases reportable to each of the 35 local health jurisdictions (LHJs) in WA
  ▪ Hepatitis C reporting became mandated in Dec 2000
• Labs and healthcare providers required to report positive test results for HCV (antibody/RNA)
  ▪ Negatives are not currently mandated
  ▪ Majority of reports come from labs; provider reporting rare
• WA DOH operates the state’s electronic lab reporting system, so state hepatitis staff have access to ELR data (but not hard copy lab reports)
  ▪ Approximately 10,000 electronic laboratory reports (ELR) each month
  ▪ ELRs account for 30-40% of total lab volume
Limitations of Hepatitis C Surveillance in Washington State

• General lack of resources at both the state and local level:
  ▪ Most LHJ staff work on all communicable diseases; dedicated hepatitis staff at just 3 largest LHJs

• Unable to accurately track patients in the registry who have:
  ▪ Moved out of state
  ▪ Died
  ▪ Cleared their infections
  ▪ Been cured

• Other limitations include:
  ▪ ~75% of risk (and race/ethnicity) data among known chronic cases are missing
  ▪ Diagnoses missed due to asymptomatic nature of disease
  ▪ Some Baby Boomers not being appropriately screened
  ▪ Limited in ability to conduct partner/contact investigations
Estimated proportion of unreported HCV cases by local health jurisdiction
Washington State, January – June 2017

Source: WA DOH Hepatitis Surveillance Records
Hepatitis C Surveillance in Washington State

- In 2017:
  - 8,839 new reports of chronic infection
  - 543 deaths attributed to chronic HCV
  - 73 new reports of acute infection
- There are an estimated 65,000 who are currently living with chronic HCV

<table>
<thead>
<tr>
<th>Year</th>
<th>Acute</th>
<th>Chronic</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>2012</td>
<td>54</td>
<td>4,865</td>
<td>4,919</td>
</tr>
<tr>
<td>2013</td>
<td>63</td>
<td>4,438</td>
<td>4,501</td>
</tr>
<tr>
<td>2014</td>
<td>83</td>
<td>5,995</td>
<td>6,078</td>
</tr>
<tr>
<td>2015</td>
<td>63</td>
<td>7,085</td>
<td>7,148</td>
</tr>
<tr>
<td>2016</td>
<td>95</td>
<td>8,118</td>
<td>8,213</td>
</tr>
<tr>
<td>2017</td>
<td>73</td>
<td>8,839</td>
<td>8,912</td>
</tr>
</tbody>
</table>

Source: WA DOH Hepatitis Surveillance Records

- 333% increase statewide 2009-2016
- ~75% of those for whom risk factors were collected report injection drug use

Source: WA DOH Hepatitis Surveillance Records

- Risk/exposure data for chronic cases is sparse (~80% missing), but when present, injection drug use is often reported

Source: WA DOH Hepatitis Surveillance Records
### Age shift among chronic cases

<table>
<thead>
<tr>
<th>Age range</th>
<th>#</th>
<th>%</th>
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<tbody>
<tr>
<td>0-9</td>
<td>18</td>
<td>0.3</td>
</tr>
<tr>
<td>10-19</td>
<td>53</td>
<td>1.0</td>
</tr>
<tr>
<td>20-29</td>
<td>378</td>
<td>6.9</td>
</tr>
<tr>
<td>30-39</td>
<td>752</td>
<td>13.7</td>
</tr>
<tr>
<td>40-49</td>
<td>1701</td>
<td>31.1</td>
</tr>
<tr>
<td>50-59</td>
<td>2050</td>
<td>37.5</td>
</tr>
<tr>
<td>60-69</td>
<td>392</td>
<td>7.2</td>
</tr>
<tr>
<td>70-79</td>
<td>94</td>
<td>1.7</td>
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<tr>
<td>80+</td>
<td>36</td>
<td>0.7</td>
</tr>
<tr>
<td>unknown</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5496</td>
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### 2017

<table>
<thead>
<tr>
<th>Age range</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>30</td>
<td>0.3</td>
</tr>
<tr>
<td>10-19</td>
<td>106</td>
<td>1.2</td>
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<tr>
<td>20-29</td>
<td>1255</td>
<td>14.2</td>
</tr>
<tr>
<td>30-39</td>
<td>1349</td>
<td>15.3</td>
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<tr>
<td>40-49</td>
<td>1097</td>
<td>12.5</td>
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<td>50-59</td>
<td>2270</td>
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<td>26.0</td>
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<tr>
<td>70-79</td>
<td>353</td>
<td>4.0</td>
</tr>
<tr>
<td>80+</td>
<td>59</td>
<td>0.7</td>
</tr>
<tr>
<td>unknown</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>8839</td>
<td></td>
</tr>
</tbody>
</table>

Source: WA DOH Hepatitis Surveillance Records

*Baby Boomer cohort*
HCV by Year of Birth
The Tale of 2 Epidemics

Figure 33. Persons affected by hepatitis C infection by year of birth—Washington State, 2000–2014

Source: Washington State death records

1945–1965 birth cohort
second wave, ages 37 and younger in 2014
Gender Breakdown of Chronic HCV Cases
Washington State, 2008-2017

Source: WA DOH Hepatitis Surveillance Records
Race/Ethnicity Breakdown of Chronic HCV Cases
Washington State, 2008-2017*

*on average, ~75% of records are missing race/ethnicity data

Source: WA DOH Hepatitis Surveillance Records
Five-year rate of chronic hepatitis C infections per 100,000 persons among non-incarcerated residents—Washington State, 2010-2014

Source: WA DOH Hepatitis Surveillance Records
In Washington in 2016, there were 65k viremic infections and 50k already diagnosed. Annually there were 2.2k treated and 2.0k cured.*

*one of several attempts to estimate the prevalence through modeling

- The viremic prevalence of HCV in Washington is 0.9% with more than 75% of infections already diagnosed.
- In 2016, an estimated 2,160 patients (or 3.3% of total infected) were treated.
Defining Hepatitis C Elimination
Defining HCV elimination*

A state where HCV is no longer a public health threat and where those few who become infected with HCV learn their status quickly and access curative treatment without delay, preventing the forward spread of the virus.

*Elimination is distinct from eradication. Eradication is reduction of the worldwide incidence of a disease to zero as a result of deliberate efforts, obviating the necessity for further control measures. True eradication usually entails eliminating the microorganism itself or removing it completely from nature.
How to reach HCV elimination

The World Health Organization has set goal of HCV elimination by 2030:

- Increase syringe supply coverage from 20 sets per year per PWID at baseline (2015) to 300 sets per year per person who injects drugs
- 90% of those with HCV diagnosed
- 80% of those eligible treated for HCV by 2030
- 90% reduction in HCV incidence
- 65% reduction in HCV mortality

As this group develops the state elimination plan, we will need to define process and outcome objectives for reaching hepatitis C elimination.
Building on What We Already Have: Various Approaches to Hepatitis C Elimination from Other Jurisdictions and the Existing DOH Hepatitis C Strategic Plan
US Department of Health & Human Services, National Viral Hepatitis Action Plan, 2017-2020

Recommendations relevant to hepatitis C:

• The highest level of the federal government should oversee a coordinated effort to manage elimination.

• Centers for Disease Control & Prevention (CDC), in partnership w/ state and local health departments, should support standard hepatitis case finding measures and the follow-up and monitoring of all viral hepatitis cases reported through public health surveillance. CDC should work with the National Cancer Institute to attach viral etiology to reports of liver cancer in its periodic national reports on cancer.

• CDC should support cross-sectional and cohort studies to measure HBV and HCV infection incidence and prevalence in high-risk populations.

• States and federal agencies should expand access to syringe exchange and opioid agonist therapy in accessible venues.

• CDC should work with states to identify settings appropriate for enhanced viral hepatitis testing based on expected prevalence.

• Public and private health plans should remove restrictions that are not medically indicated and offer direct-acting antivirals to all chronic hepatitis C patients.
• The National Committee for Quality Assurance should establish measures to monitor compliance with viral hepatitis screening guidelines and include the new measures in the Healthcare Effectiveness Data and Information Set.

• The criminal justice system should screen, vaccinate, and treat hepatitis B and C in correctional facilities according to national clinical practice guidelines.

• The federal government, on behalf of the Department of Health & Human Services, should purchase the rights to a direct-acting antiviral for use in neglected market segments, such as Medicaid, the Indian Health Service, and prisons. This could be done through the licensing or assigning of a patent in a voluntary transaction with an innovator pharmaceutical company.

• American Association for the Study of Liver Diseases and the Infectious Diseases Society of America should partner with primary care providers and their professional organizations to build capacity to treat hepatitis B and C in primary care. The program should set up referral systems for medically complex patients.

• The Department of Health & Human Services should work with states to build a comprehensive system of care and support for special populations with hepatitis B and C on the scale of the Ryan White system.

Full report at www.nationalacademies.org/hepatitiselimination
Hepatitis C Elimination Efforts in Two Tribal Nations

Cherokee Nation HCV Elimination Initiative:
• In 2015, became first tribe in country to launch HCV elimination initiative.
• As of October 2017, over 40,000 tribal citizens tested, 200 new patients tested positive, and more than 680 patients treated for HCV. Some elements of success: Universal testing for 20-69 year olds; care managed by pharmacists; contact tracing to ID new infections.

Lummi Tribal Health Center Elimination Initiative:
• Rates of new HCV infection found to be 40x higher than in neighboring non-native community.
• Early 2016, began developing a program to treat HCV in primary care. Over 50% of patients known to have HCV now treated!
• Case managers, opioid tx program, syringe services program, UW Project ECHO consults, etc.
Hepatitis C Elimination in San Francisco, California

- End Hep C SF launched in 2016 and developed Strategic Plan for 2017-2019
  - Vision: A San Francisco where HCV is no longer a public health threat, and HCV-related health inequities have been eliminated
  - Coordinating Committee, Executive Advisory Committee, Consumer Advisory Committee, and Topic-Specific Work Groups
  - More info at [www.endhepcsf.org](http://www.endhepcsf.org)
Hepatitis C Elimination in New York State

  - Establishes an Elimination Task Force That Will Advise NYS on its Plan to End this 'Silent Epidemic'
  - Allocates initial $5 Million to Advance Plan to Eliminate Hepatitis C, Significantly Expands Treatment Capacity, Removes Insurance Barriers to Treatment
  - Establishes First-in-Nation Authorization of Medicaid Reimbursement for Harm Reduction Services
  - Creates Regulations Expanding Syringe Exchange Access

Hepatitis C Elimination in New Mexico

- May 2016, first meeting of NM Hepatitis C Elimination Collaborative, including:
  - NM Department of Health
  - University of New Mexico Health Sciences Center, including Project ECHO, and Division of Epidemiology, Biostatistics, and Preventive Medicine
  - NM Department of Corrections
  - Indian Health Service
  - Tri-Core Laboratories

- Agreed to an “incremental approach” with a targeted population: Medicaid population was prioritized. Other groups identified to focus on: the baby-boomer cohort, children, PWID, American Indians, homeless, and incarcerated populations to inform the “whole.”

- Steering Committee and topic-specific work groups

Three primary areas around which recommended actions are grouped:

1. **Identify people with HCV, link them to care, and get them to a cure.**
   - Build a health care workforce prepared to diagnose, care for, treat and cure persons with HCV.
   - Educate communities about risk factors for HCV, how to reduce risk, and availability of prevention, testing, and treatment services.
   - Improve testing, care, and treatment and raise the bars along the care continuum.

2. **Prevent new infections.**
   - Ensure persons who inject drugs have access to screening, prevention, care, and treatment services.
   - Mobilize a coordinated response to drug user health.
   - Expand access to and delivery of hepatitis education and prevention services in correctional settings and beyond.

3. **Strengthen data systems and increase data use.**
   - Monitor HCV-associated transmission, disease, mortality, and health disparities.
   - Monitor provision and impact of HCV prevention, treatment and care, highlighting population-specific differences in access to services.
   - Develop and implement new regulations, technologies and lab procedures to improve surveillance.
Some recommended actions are achievable with existing resources in the public health system; some may be achieved by leveraging resources and technology in other systems, primarily the health care delivery system; and some recommended actions will require additional investments, primarily in the area of scaling-up promising practices.

The sooner we act:

- The more people with long-standing infection we will save from life-threatening disease and death;
- The sooner we see returns on our investments in public health;
- The more new infections we will avert so another generation is not impacted by disease; and
- **The sooner we can eliminate hepatitis C in Washington.**
WA DOH HCV Prevention Portfolio
Disease Detection & Provider Readiness

• Early adopters of rapid hepatitis C antibody screening technology
  • 2012, direct funding using General Fund State monies
  • Development of WA State Hepatitis C Rapid Screening Program
  • Community based organizations, local governmental health, and health care participants
• Current Funding:
  1. Rapid screening tests,
  2. Health education,
  3. UW Project ECHO,
  4. Local county jail projects, and
  5. CHC / FQHC screening interventions
WA DOH HCV Prevention Portfolio
Syringe Service Programs

• Started in response to the HIV epidemic and its impact on people who inject drugs (PWID) in United States.

• Washington State is home to the first publicly funded SSP in US:
  • 1988: Tacoma Needle Exchange/Point Defiance AIDS Project in partnership with Tacoma-Pierce County Health Department

• Washington State SSP Funding:
  • 1992: first direct funding using General Fund State monies
  • Current investments:
    • 11 programs receive a total of $1.3 million for FTE, screening, rent of space, etc.
    • ~30 programs receive injection equipment (e.g., needles, cottons, cookers)
WASHINGTON STATE SYRINGE SERVICE PROGRAMS

HCV Screening Sites

Sites currently providing HCV rapid screening

Sites that are building capacity
### Hepatitis C screening among Phase 1 & 2 Participants (November 1, 2016 - December 31, 2017)

<table>
<thead>
<tr>
<th>Agency (N = 14)</th>
<th>HCV Ab. Tests Conducted</th>
<th>Results Received (All Results)</th>
<th>HCV Ab. Reactive N (%)</th>
<th>Referred to Confirmatory Testing</th>
<th>Received PCR</th>
<th>Confirmed HCV+</th>
<th>Referred to Healthcare</th>
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<tr>
<td>Blue Mountain H2H</td>
<td>77</td>
<td>66</td>
<td>13 (17%)</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>8</td>
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<tr>
<td>Clallam County</td>
<td>67</td>
<td>38</td>
<td>33 (49%)</td>
<td>18</td>
<td>-</td>
<td>-</td>
<td>20</td>
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<tr>
<td>Clark County HD</td>
<td>44</td>
<td>44</td>
<td>4 (9%)</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>7</td>
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<tr>
<td>Gay City</td>
<td>32</td>
<td>32</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Hepatitis Education Project (HEP)</td>
<td>1610</td>
<td>1470</td>
<td>267 (17%)</td>
<td>222</td>
<td>47</td>
<td>35</td>
<td>29</td>
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<tr>
<td>Kitsap Public Health</td>
<td>29</td>
<td>29</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Kittitas County Health</td>
<td>12</td>
<td>12</td>
<td>1 (8%)</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Neighborhood House</td>
<td>180</td>
<td>173</td>
<td>7 (4%)</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>PHSKC – Mobile Unit</td>
<td>32</td>
<td>31</td>
<td>5 (16%)</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>5</td>
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<tr>
<td>PHSKC – NHBS</td>
<td>104</td>
<td>89</td>
<td>59 (57%)</td>
<td>57</td>
<td>-</td>
<td>-</td>
<td>57</td>
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<tr>
<td>Point Defiance AIDS Project (PDAP)&lt;sup&gt;2&lt;/sup&gt;</td>
<td>80</td>
<td>79</td>
<td>26 (32%)</td>
<td>26</td>
<td>-</td>
<td>0</td>
<td>26</td>
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<tr>
<td>Snohomish Health District</td>
<td>315</td>
<td>315</td>
<td>82 (26%)</td>
<td>82</td>
<td>-</td>
<td>0</td>
<td>82</td>
</tr>
<tr>
<td>Spokane Regional Health</td>
<td>19</td>
<td>16</td>
<td>6 (32%)</td>
<td>3</td>
<td>-</td>
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<tr>
<td>Whatcom County Health</td>
<td>41</td>
<td>29</td>
<td>6 (15%)</td>
<td>4</td>
<td>-</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td><strong>2642</strong></td>
<td><strong>2423</strong></td>
<td><strong>509 (19%)</strong></td>
<td><strong>437</strong></td>
<td><strong>59</strong></td>
<td><strong>47</strong></td>
<td><strong>243</strong></td>
</tr>
</tbody>
</table>
What else is happening to address HCV in Washington?

- What is your organization or organizations you know about doing to address hepatitis C in Washington?

- What would you like to be doing to address hepatitis C that you are not currently able to do?
Lunch Break

Please be back by 12:45pm
How to Make a Collective Impact: Developing a Multisector Commitment to Elimination
**Proposed Planning Approach - Collective Impact**

“Collective impact occurs when organizations from different sectors agree to solve a specific social problem using a common agenda, aligning their efforts, and using common measures of success.”

– FSG Consulting

- A framework to tackle deeply entrenched and complex social problems.
- An innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change.
- An approach to collaborative change, based on the foundation that large-scale social change comes from better cross-sector coordination, rather than the isolated intervention of individual organizations.
Collective impact involves a group of people getting together to work on a complex issue, under five conditions:

- DOH as Backbone Organization takes on the role of managing collaboration
- A ‘BACKBONE’ COORDINATING ORGANISATION/S
- A COMMON AGENDA FOR CHANGE
- Consistent and open communications allow a culture of collaboration
- Common understanding of the problem and shared vision for change
- Shared measurement for data & results
- Mutually Reinforcing Activities allow us to leverage individual expertise as part overall effort
- Common Progress Measures to evaluate progress in a consistent way over time and shared accountability
Three elements for successful collective impact

- Existing public health efforts to prevent and detect hepatitis C.
- Medications that cure hepatitis C in almost everyone affected in as little as 8 weeks.
- Significant morbidity and mortality related to hepatitis C.
- Medications and hospitalizations related to hepatitis C taxing public resources.

Urgency for change

- Multiple state agencies and public and private partners willing to devote staff time and resources to hepatitis C elimination.
- Seeking financing for this effort through various channels.

Resources

- Governor Inslee!
- Governor’s Health Sub-Cabinet
- Health & Human Service Agencies’ Leadership

Influential champion
Ensuring we are developing an elimination plan for all of Washington State

- Who is at the Coordinating Committee table?
- Who is missing from the Coordinating Committee?
- How do we meaningfully engage people most affected by hepatitis C to ensure the plan is informed by their wisdom?
- Who could benefit our planning effort, but may need to contribute in a different way?
- How do we ensure commitment from various actors (stakeholders)?
Administrative Questions
Structure, Organization, Communication Questions for Discussion

- What should be the organizational structure of this committee?
- How should agendas be developed?
- Who would you like to facilitate meetings?
- How would you like to receive communications (e.g., modality, frequency)?
- How do you envision external communications about this planning process?
- How frequently would you like to meet?
- How often should we meet in person (and where?) vs. Go To Meeting?
Questions for Consideration (not necessarily to be answered today)

- How should we define our vision and mission?
- What should we call this initiative?
- Do we need sub-committees / work groups? If so, on what topics?
- When should we have our next meeting? (look out for a Doodle poll!)
Next Steps & Closure