Reducing barriers to access and engagement in hepatitis C care through integration

Amanda Giacomazzo, Moderator
Dr. Shruti Mehta
Rachael Edwards
Matthew Bonn

December 5th, 2019
Webinar Agenda (1.5 hours)

• Welcome and speaker introductions
  *Amanda Giacomazzo, 5 minutes*

• Identifying and overcoming barriers to hepatitis C care for people who use drugs; integrating/co-locating services
  *Dr. Shruti Mehta, 30 minutes*

• Canadian front line program experience with hepatitis C testing and treatment integration
  *Rachael Edwards, 15 minutes*
  *Matthew Bonn, 15 minutes*

• Questions
  *All, approximately 30 minutes*
Shruti Mehta is a Professor and the Deputy Chair of the Department of Epidemiology at the Johns Hopkins Bloomberg School of Public Health.

Her research focuses on HIV and hepatitis C virus (HCV) infection among people who inject drugs (PWID) in the US and in India with a particular interest and focus on identifying and overcoming barriers to access care and treatment for HIV and HCV.
Reducing barriers to access and engagement in hepatitis C care through integration

Shruti H. Mehta
Department of Epidemiology
Johns Hopkins Bloomberg School of Public Health

December 5, 2019
There are numerous, layered barriers to optimal engagement in HCV care/treatment...

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...and Service integration / co-location addresses many of these barriers

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Integrating / co-locating services will be critical to optimal engagement in HCV care

- **Advantages**
  - Minimal direct expense to patient
  - Treatment can be paired with daily delivery of OAT
  - Demonstrated high SVR rates among persons receiving OAT
  - Other services often offered

- **Challenges**
  - OTP providers may not see HCV treatment as part of their core business
Integrated, co-located telemedicine-based HCV treatment for patients on methadone (New York)

62 patients evaluated, 45 initiated treatment, 93% SVR

Talal AH et al Clin Infect Dise 2018
Integrating / co-locating services will be critical to optimal engagement in HCV care

- **Advantages**
  - Limited barriers to engagement
  - Supports continuity of care (particularly post-treatment)
  - Often have wrap around services (mental health, social services)

- **Challenges**
  - More effective with provision of MOUD but not the norm
Co-located HIV and HCV care (Baltimore, MD)

- **Comprehensive care** including testing, evaluation, treatment, pharmacy prior authorization, support for patient assistance
- Care delivered through **multidisciplinary team**: clinicians, nurses, social workers

  - Stop light protocol for adherence support
    - **Green**: minimal
    - **Yellow**: moderate
    - **Red**: intensive support with mandatory nursing visit and follow-up calls/visit with nurse

Falade-Nwulia O et al *Open Forum Infect Dis* 2019
Integration with community HIV programs (Ukraine)

- HCV treatment scaled up in 16 locations primarily through **NGOs delivering HIV care/treatment**
- **Community-based** approach
- **Multidisciplinary team** delivering care: physicians, nurses, social workers
- Program **did not** reach many **active injectors**

Mazhnaya et al *Int J Drug Policy* 2017
Integrating / co-locating services will be critical to optimal engagement in HCV care

**Advantages**
- Lowers threshold for entry into care
- Enhances continuity of care
- PCPs can obtain waiver for buprenorphine/naloxone prescription
- Potential for facilitated linkage with other services
- Particularly relevant for rural areas

**Challenges**
- Heavy burden on PCPs already
Task shifting to primary care providers is effective

- Phase 4, prospective observational study in federally qualified health centers in Washington DC
- Task-shifting of DAA-based HCV therapy to non-specialist providers
- Comparable SVR among non-specialist providers

Kattakuzhy S et al Ann Intern Med 2017
Support for HCV treatment in primary care through telemedicine (Punjab, India)

- 94 PCPs trained, 4-hour workshop
- Telehealth consultation every 2 weeks
- WhatsApp group to solve case-based discussions in real time (hub and spoke model)

50,242 started on treatment, SVR = 92%

Fig. 1. Disease burden and cure rates across the 25 treatment sites in Punjab (This figure appears in colour on the web.)

Dhiman RK et al j Hepatology 2019
Optimizing HCV treatment within primary care (US Veterans Affairs)

- **Multidisciplinary Hepatitis Innovation Team (HIT):** physicians, nurse practitioners, nurses, pharmacists, physician assistants, social workers, mental health and substance use providers, peer support specialists, administrators, information technology experts and systems redesign professionals
- Also created a Veterans Integrated Service Network (VISN) to **facilitate communication** and process improvement
- **Lean process improvement framework** focused on eliminating waste and maximizing value

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**TABLE Increases in Birth Cohort Testing and SVR12 by HIT**

<table>
<thead>
<tr>
<th>Year</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
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<tr>
<td>Goals</td>
<td>Baseline</td>
<td>Goal</td>
<td>Achieved</td>
<td>Goal</td>
</tr>
<tr>
<td>Birth cohort tested, %</td>
<td>65.8</td>
<td>69.0</td>
<td>68.8</td>
<td>73.0</td>
</tr>
<tr>
<td>Tested for SVR12, %</td>
<td>n/a</td>
<td>n/a</td>
<td>55.4</td>
<td>80.0</td>
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Abbreviations: FY, fiscal year; HIT, Hepatitis Innovation Team; SVR12, sustained virologic response 12 weeks after treatment.

*Data are provided by Veteran Health Administration Population Health Services.

Park A et al *Federal Practitioner* 2018
Integrating / co-locating services will be critical to optimal engagement in HCV care

**Advantages**
- SSPs reach those that may not be accessing care in the formal health care system
- Can serve as a ‘one-stop shop’ for health services including HCV and HIV care
- Provide linkage to MOUD

**Challenges**
- Most programs do not provide wrap around services
HCV treatment integrated into community-based harm reduction center (Washington, DC)

- Patients with opioid use disorder who had injected in the prior 3 months
- Offered simultaneous buprenorphine, PrEP as needed
- Treated with 12 weeks of SOF/VEL
- Adherence assessments every 4 weeks

Kattakuzhy S et al AASLD 2018
HCV treatment integrated into community-based harm reduction center (Washington, DC)

**Results: Sustained Virologic Response**

SVR – Intention to Treat

- SVR: 78%
- Virologic Failure: 9%
- Lost to Follow-up: 3%
- Dead: 10%

N = 93

**SVR: Baseline Factors**

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<th>Baseline factor (n = 93)</th>
<th>Impact SVR</th>
<th>P-value</th>
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<tr>
<td>Injecting daily or more</td>
<td>No</td>
<td>PP = 0.73</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ITT = 1.00</td>
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<tr>
<td>Not being on MAT at baseline</td>
<td>No</td>
<td>PP = 0.48</td>
</tr>
<tr>
<td></td>
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<td>ITT = 0.43</td>
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<tr>
<td></td>
<td></td>
<td>ITT = 0.21</td>
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<tr>
<td>Hazardous drinking</td>
<td>No</td>
<td>PP = 0.47</td>
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Kattakuzhy S et al AASLD 2018
HCV treatment integrated into community-based harm reduction center (Washington, DC)

Kattakuzhy S et al AASLD 2018
Integration of HCV testing with community-based OTP and other HIV prevention/treatment services (India)

**TB Testing & Treatment**
Symptom screen and sputum collection on-site; Testing and treatment from DMC/DOTS centers

**Syringe services**
Field-based & on-site

**STI syndromic management**
Government sponsored

**General medical care:** Glucose screening, blood pressure monitoring, doctor available for general health problems

**HCT:** rapid testing performed on-site; positive results confirmed at govt center

**ART:** delivered through a link model (ARVs provided by government but peer health worker picks up meds so clients can receive directly from ICC)

**HCV testing:** Rapid on-site HCV testing

**Counseling:** Individual & group/substance use, alcohol, adherence, couples, family etc

**Condoms**

**Government sponsored Condoms**
Integrated care centers (ICCs) in India

OAT nurse (Imphal)

General nurse (Imphal)

OAT clients (Ludhiana)

Counselor (Imphal)

Clinical exam (Imphal)

OAT Nurse (Ludhiana)
Integration of HCV testing improves 1st step of the care continuum (awareness)

- Significant impact on community HCV testing and awareness
- Modest impact on linkage to HCV care, treatment uptake, cure
- Need on-site HCV treatment, other strategies (peers, incentives) for linkage

Solomon SS et al *J Hepatology* 2019
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**HCV testing and treatment:**
Rapid on-site HCV testing with immediate HCV RNA confirmation and treatment with tailored adherence support (2020)
Integrating / co-locating services will be critical to optimal engagement in HCV care

Common themes
- Benefits of a **multidisciplinary team** with **task shifting** to improve efficiencies
- Important role for **telemedicine**
- **Integration** of multiple services desired

Future directions
- **Other venues** that need to be considered?
- How much **infrastructure** is really needed?
If you build it, will they come? *Is integration alone enough??*

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Should additional support be provided?

**ELIGIBILITY**
- Drug injection in prior 3 months
- DAA-treatment naïve
- Genotype 1-6
- With and without HIV

**A: mDOT**
- Tx Initiation
- EOT
- SVR 12
- Arm A: 1) OTP = 150; 2) CHC = 150
- Arm B: 1) OTP = 150; 2) CHC = 150

**B: Patient Navigation**
- Tx Initiation
- EOT
- SVR 12
- Consent
- Baseline
- Up to 12 weeks to initiate treatment
- 12 weeks sof/vel
- Week 0
- Week 12
- Week 24
- Quarterly follow up
- Monthly follow up
- Week 120

1890 screened, 961 eligible, 754 enrolled and randomized, 622 initiated treatment
Can we tailor support to individual need?

Maximize impact, promote efficiency

Screen persons for eligibility

Enroll eligible persons (n~3000)

Administer Electronic survey to determine propensity for non adherence

MINIMAL RISK

ARM 1: Low intensity intervention

ARM 2: Medium intensity intervention

ARM 3: High intensity intervention

MINIMAL

ELEVATED

Randomization to HCV treatment + tailored treatment support (1:2:3)

HCV testing and treatment: Rapid on-site HCV testing with immediate HCV RNA confirmation and treatment with tailored adherence support (2020)

ART: delivered through a link model (ARM), provided by government but peer health worker picks up meds so clients can receive directly from site

General medical care: Glucose screening, blood pressure monitoring, doctor available for general health problems

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Symptom screen and sputum collection on-site, Testing and treatment from DMC/DOTS centers

Syringe services
Field-based & on-site

Condoms

Counseling: Individual & group/ substance use, alcohol, adherence, couples, family etc

STI syndromic management
Government sponsored
Will integrated care approaches reach the populations we need to reach?

- Network-based referral strategy (♦□) with modest compensation more efficient at identifying PWID unaware of status than integrated care strategy (♦□).

- Highest risk, disengaged PWID more often reached by network-based strategy.

McFall AM et al IAS 2018
Combination approaches will be needed

Integration / co-location is an important first step!

- Opioid treatment programs
- HIV programs
- Primary care
- Community-based harm reduction
- Mobile services
- Mental health support
- Adherence support (tailored to need)

Approaches to engage and identify individuals living with HCV
Acknowledgements

- Johns Hopkins University
  - Sunil Solomon, Greg Lucas, David Celentano, Mark Sulkowski, David Thomas, Allison McFall, Seun Falade-Nwulia
- YR Gaitonde Centre for AIDS Research and Education
  - Aylur K Srir Krishnan, S Anand, CK Vasudevan, Pradeep Amrose
- HERO Study team
- National AIDS Control Organisation, India
- Funding sources:
  - NIDA, NIAID (National Institutes of Health)
  - Elton Johns AIDS Foundation
- Study staff and participants
Rachael Edwards

Rachael Edwards has spent the last 13 years working exclusively with vulnerable and marginalized populations through the Harm Reduction lens. She has extensive experience in program development, clinical teaching, and community engagement. She was integral in the development and implementation of end-of-life care programming for vulnerable populations through the Calgary Allied Mobile Palliative Program (CAMPP).

Rachael is a tireless advocate for low-threshold service provision, in the hopes of eliminating barriers for people who traditionally experience difficulty accessing health and social care. Through her six-year employment at the CUPS Liver Clinic, Rachael specialized in advocacy, education, screening, counselling and treatment of hepatitis C—this experience culminated in Rachael developing a strategic model for onsite and outreach liver clinics.
Reducing barriers to access and engagement through integration Calgary AB

Rachael Edwards, RN BN
Hailey Mawer, RN BScN
What's Happening in Calgary?
Check for prior screening/testing (within 6 mos)¹

If none: Order HepC serology (antibody and HCV viral load/PCR reflexive testing)²
If HCV Ab positive: Order current HCV RNA levels

HCV Ab POSITIVE

Viral Load POSITIVE (detected)³,⁴

Cirrhosis? Calculate APRI and FIB-4 scores (Current BW⁵)
   Fib-4: 0=mild, 1-4 moderate, 5-6 severe/cirrhosis
   APRI: ≤1 fibrosis unlikely, >1.5 sg. fibrosis, >2 probable cirrhosis

   YES
   NO

   Previous Treatment? — NO

   Compensated
   — YES
   — NO

   Decompensated

Refer to Hepatologist or Hep C experienced practitioner for treatment and screening for other causes of cirrhosis

Send for U/S and HCC screening

Viral Load NEGATIVE (below cutoff)

Fibroscan if APRI/Fib scores incongruent

Treat with one of:
1. Gile/gib x 8 wks
2. Sof/vel x 12 wks
3. Eli/gra x 12 wks (if renal failure)
4. Led/sof x 8 wks (if genotype 1)

Determine: Genotype, previous treatment, Sustained virologic response vs. Treatment failure Consult w/ specialist or experienced clinician

Use Ongoing Screening Protocol

Further Considerations:
1. Review drug interactions (PI, anti-convulsant, atypical antipsychotic)
2. Review vaccination status, offer: Hep A, Hep B, Pneumovax, Influenza, Tetanus/diphtheria

End of treatment labs:
CBC, AST, ALT

12 week End of Treatment labs: HCV RNA

Annual HCV RNA if high risk of transmission

¹ Required screening labs: bloodwork - HIV, syphilis, HCV Ab, HBsAg, HbsAb, HA1gG, AST, ALT, CBC. Urine - GC/CT, Beta hCG.
² Reflexive testing via ProvLab: complete requisition for both HCV Ab and HCV RNA, draw two vials
3. If viral load <1000 IU/ml discuss with client treatment now vs. retest in 6 mos for spontaneous clearance (consider risk of transmission to others)
4. If HIV+ and/or HBV Ag + refer to specialty clinic
5. Current (within one year): CBC, INR, Cr, electrolytes, Alb, ALT, AST, bill T/D.
Who does what?

**MD/NP**
- physical exam
- review labs
- Review treatment history
- treatment plan
- prescribe
- Drug interactions
- special authorization
- form completion

**Nursing**
- Check netcare and note recent labs: STBBI testing,
  HCV PCR, LFTs
- Drug coverage
- Follow up special authorization
- Vaccinate
- Patient support program enrollment
- Medication teaching
- Medication administration
- Teaching re: disease transmission/prevention
- Monitor HCV AB NEGATIVE clients q3months with POC tests

**Pharmacy**
- Who? Other Monitor
  - Compliance and number of missed doses
  - Reinfection rate after tx
  - Numbers lost to f/u
  - Co-infection rate (other STBBI)
  - Barriers to tx in IOAT (ie funding, pt not wanting tx, not committing to tx)

**Psychosocial**
- Support to obtain ongoing drug coverage

Resources:
Lab requisition for virology/serology: [https://www.albertahealthservices.ca/frm-10676.pdf](https://www.albertahealthservices.ca/frm-10676.pdf)
CUPS Liver Clinic
Supervised Consumption service (SCS)

Supervised consumption services are a place where people can use substances in a safe, hygienic environment to reduce harm from substance use while offering additional services such as STBBI testing including HIV and Hepatitis C from select RNs.
Treatment is more than just medication

“Management and care of a person [during] the combating of disease or disorder”

Dorland's Medical Dictionary
Opportunities for improving access

Engage with people where they are accessing care
Matthew Bonn is a Harm Reduction Advocate & Consultant. He is a member of the Halifax Area Network of Drug Using People (HANDUP) & Lead Peer with Peers Assisting & Lending Support (PALS). He is one of many of the co-Founders of the HaliFIX Overdose Prevention Society, which has implemented Atlantic Canada's first Overdose Prevention Site.

Matthew has lived experience with IV substance use, long term dependency on OAT, treatment for hepatitis C and being an ex-offender. He recently became a National Board member of the Canadian Students for Sensible Drug Policy.
PEER LED HCV ELIMINATION

By Matthew Bonn
Our services are located in Mi’kma’ki, the ancestral and unceded territory of the Mi’kmaq.
Local Context

In Nova Scotia there are approximately 60 Overdose related deaths each year, 300 new diagnoses of HCV & our HIV rates doubled from 2017-2018 reaching a confirmed 29 new diagnoses in 2018 up from 15 the year before.

In the Central Halifax Zone we have two Needle Exchange Services
Mainline Needle Exchange has two locations, one in Halifax (1992) & one in Dartmouth (2019). There is two Needle Exchanges in the rest of Nova Scotia, Northern Healthy Connections Society in Truro & The Ally Centre of Cape Breton in Sydney, Cape Breton.

There is one Overdose Prevention Site in all of Atlantic Canada, Halifix Overdose Prevention Society has a ‘Urgent Public Health Need Site’ in the North End of Halifax.
Reducing Barriers to Access and Engagement in Hepatitis C Care through Integration in Halifax Nova Scotia

Direction 180 is a community-based, opioid treatment program located in the North End of Halifax, Nova Scotia. This non-profit organization has been running since 2001 as a program of the Mi’kmaw Native Friendship Center...

Direction 180 is the home of the HANDUP, PALS & the OPS.
Peers Assisting & Lending Support

Mission

To reduce risky behaviors that could lead to HIV/HCV for 75-100 former or current substance users leaving CNSCF by up to 25%

By Providing:

Harm Reduction Supplies
Condoms/Lubrication
Naloxone
Hygiene Products

Additional Support includes Housing Referrals, Emergency Food Support, NS Government Identification, etc.
Peer Led POCT Events

Six Monthly Events starting in January

Led by HANDUP members

Engage 10 Guests at the OPS to be Tested

Focus Group with participants with Healthy Snacks

Creating a Concept Paper “For Users by Users” on HCV Elimination
Local Hepatitis C Services

The Hepatitis Outreach Society of NS

HepNS is a charitable organization that reduces the impact of hepatitis through support, information and education. They have a “Travel Program” that will help get you to appointments related to Hepatitis C.

Hep C Program w/Dr. Lisa Barrett

This program has a ‘Self-Referral’ Line which allows patients to call directly to set up an appointment. The number is (902) 473-5594.
Thank you!

Matthew Bonn

Twitter: @m_bonnxx
IG: @mb0nnxx
FB: Matt Bonn
Audience questions?

Please type your question or comment into the chat box.
Thank you

Please complete the webinar evaluation that will be provided following this webinar.