Integrating Hepatitis C Care Into Your MAT clinic

Yavar Moghimi, MD
Chief Psychiatric Medical Officer, Amerihealth Caritas DC

November 10th, 2020
12:00-1:00 PM
Webinar Housekeeping

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Meet Our Speaker

Yavar Moghimi, MD

- Chief Psychiatric Medical Officer, Amerihealth Caritas DC (Medicaid Manage Care)
- So Others May Eat MAT program director (FQHC)
I have no relevant financial relationships to disclose
Learning Objectives

By the end of this presentation, attendees will be able to:

1. Understand the Chronic Hepatic C (HCV) care continuum.

2. Apply evidence-based interventions throughout the HCV continuum of care.

3. Use medication-assisted treatment as a linkage to HCV continuum of care.
The following people are at increased risk for hepatitis C:

1. **People with HIV infection**
2. **Current or former people who use injection drugs (PWID), including those who injected only once many years ago**
3. People with selected medical conditions, including those who ever received maintenance hemodialysis
4. Prior recipients of transfusions or organ transplants, including people who received clotting factor concentrates produced before 1987, people who received a transfusion of blood or blood components before July 1992, people who received an organ transplant before July 1992, and people who were notified that they received blood from a donor who later tested positive for HCV infection
5. Health care, emergency medical, and public safety personnel after needle sticks, sharps, or mucosal exposures to HCV-positive blood
6. Children born to mothers with HCV infection

(CDC, 2020)
Chronic Hepatitis C Epidemiology

- An estimated 2.4 million people in the United States were living with hepatitis C during 2013–2016
- More than half the people who become infected with HCV will become chronically infected
- 5-25% will develop cirrhosis over within 10-20 years and of those 1-4% have an annual risk of hepatocellular carcinoma
- Estimated prevalence of about 53% among PWID
- Estimated prevalence of about 12-35% within correctional settings

(CDC, 2020)
The Age of Direct Acting Antivirals (DAA) Treatment

- Paradigm shift in the course of treatment
- Simplification of treatment regimen-8-12 week course of oral treatment with 95% cure rate
- Minimal side effects
- No longer reliant on interferon-based treatment with severe adverse effects that complicate treatment adherence along with lower cure rates
- No longer dependent on liver biopsy as a necessary diagnostic step, Fibrosis Scores and non-invasive approaches to liver staging
- Have potential to reduce cases of chronic HCV by 90% by 2030

(Meyer et al., 2015)
HCV Continuum of care

In order to ultimately achieve sustained virologic response (SVR), individuals must:

1. Be tested for, diagnosed with, and made aware of their HCV infection
2. Engage with a healthcare provider with treatment knowledge and capacity
3. Evaluated for treatment
4. Initiated on treatment
5. Adhere to and complete treatment
6. Prevent re-infection

(Meyer et al., 2015)
From Diagnosis to Cure!

Figure 2. Treatment Cascade for People with Chronic Hepatitis C Virus (HCV) Infection, Prevalence Estimates with 95% Confidence Intervals.

(Yehai et al., 2014)
HIV Continuum of Care

The U.S. HIV Care Continuum

Number of Individuals

- 100% HIV-Infected
- 87% HIV-Diagnosed
- 75% Linked to HIV Care
- 57% Retained in HIV Care
- 55% Undetectable Viral Load

40,000 new infections per year

(HHS, 2020)
Similarities and Differences Between HIV and HCV

- HIV mainly infects immune cells
- 40 million infected with HIV worldwide
- Most common way HIV is transmitted is through anal and vaginal sex
- HIV inserts material into host DNA and uses host genetic material to replicate
- HIV treatment is aimed at lowering HIV viral load, increasing or stabilizing CD4 cell counts and preventing long-term consequences of infection, not curing, because it is integrated into the host DNA
- Treatment as Prevention

- HCV mainly infects liver cells
- 170 million infected with HCV worldwide
- Most common way HCV is transmitted is through sharing needles, drug preparation and tools
- HCV virus is about 10 times more concentrated in blood than HIV, more easily transmitted
- HCV uses the host’s cell to replicate, but does not insert itself into the host DNA.
- Hepatitis C can be cured—this is because the hepatitis C virus does not integrate into the host’s DNA when it is replicating
- Treatment as Prevention may have to be more targeted

(CDC, 2020)
Evidence-Based Interventions to Enhance the HCV Continuum of Care

(Meyer et al., 2015)
Intervention Strategies: Diagnosis and Case Finding

High rates of uptake and case-finding are found when HCV screening is targeting high-risk individual in specific settings:

- Needle and syringe programs
- Opioid Treatment Programs
- Specialty Addiction Treatment Clinics
- Correctional Settings
- Mobile Medical Clinics
- Individual with co-occurring disorders in a community mental health clinic

(Meyer et al., 2015)
## Recommendations for Screening and Treatment of HCV Infection in People Who Inject Drugs (PWID)

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
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<tbody>
<tr>
<td>Annual HCV testing is recommended for PWID with no prior testing, or past negative testing and subsequent injection drug use. Depending on the level of risk, more frequent testing may be indicated.</td>
<td>IIa, C</td>
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<tr>
<td>Substance use disorder treatment programs and needle/syringe exchange programs should offer routine, opt-out HCV-antibody testing with reflexive or immediate confirmatory HCV-RNA testing and linkage to care for those who are infected.</td>
<td>IIa, C</td>
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<tr>
<td>PWID should be counseled about measures to reduce the risk of HCV transmission to others.</td>
<td>I, C</td>
</tr>
<tr>
<td>PWID should be offered linkage to harm reduction services including intranasal naloxone, needle/syringe service programs, medications for opioid use disorder, and other substance use disorder treatment programs.</td>
<td>I, B</td>
</tr>
<tr>
<td>Active or recent drug use or a concern for reinfection is not a contraindication to HCV treatment.</td>
<td>IIa, B</td>
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Intervention Strategies: Linkage to Care

Addiction Treatment Centers:
- A multidisciplinary approach that combines medical and addiction treatment with intensive social support that can be introduced at any stage of treatment

Primary Care:
- An interdisciplinary care team to optimize patient experience around HCV care and treatment, using on-site primary care behavioral health consultants, an HCV treatment coordinator, especially within clinics that have prolonged engagement with homeless, substance using populations, or PWIDs.

Peer-Driven Interventions:
- Peer-driven interventions have demonstrated high uptake of HCV treatment and SVR rates among PWIDs, but data is generally limited and primarily descriptive with few randomized or controlled studies

(Meyer et al., 2015)
Regardless of the treatment setting, recent and active IDU are not absolute contraindications to HCV therapy. There is strong evidence from various settings in which PWID have demonstrated adherence to treatment and low rates of reinfection, countering arguments that have been commonly used to limit HCV therapy access in this patient population.
Intervention Strategies: Pre-therapeutic Evaluation/Treatment Initiation

HCV treatment is often deferred or not recommended for active PWIDs, even though they might benefit most from HCV treatment, especially since they have the highest risk of transmission to others, and can achieve SVR if adequately supported through the treatment initiation process.

- Surveying PWID on their knowledge of HCV and barriers to treatment initiation if they perceive themselves to be at-risk, younger, or had more knowledge about HCV
- Peer-Driven approach paired with buprenorphine maintenance treatment (OASIS program)
- Care Coordination program linked with methadone maintenance treatment
- Educating on directly-acting antivirals (DAA) as gold-standard of treatment currently, dispel notions of intolerability associated with interferon-based treatments

(Meyer et al., 2015)
There are no data to support the utility of pretreatment screening for illicit drug or alcohol use in identifying a population more likely to successfully complete HCV therapy. These requirements should be abandoned because they create barriers to treatment, add unnecessary cost and effort, miss an opportunity to decrease HCV transmission, and potentially exclude populations that are likely to obtain substantial benefit from therapy. Instead, scaling up HCV treatment in PWID is necessary to positively impact the HCV epidemic in the US and globally.
Intervention Strategies: Treatment Adherence

Most of the studies around treatment adherence are from interferon-based age of treatment, but small studies of current DAA treatments show:

• Most patients achieve Sustained Virology Response (SVR)
• HCV providers favorable perceptions of DAA were strong motivators for adherence
• Care Manager check-in between appointments/lab draws
• Minimal side effects becomes a motivator to complete treatment
• Patients who utilize external reminder system (i.e. alarm, timer, or family member/friend) have better adherence
• Daily-Observed Therapy a potential option if treatment delivered in a methadone-maintenance clinic
• Regardless of active drug or MAT use, patients who received direct-acting antiviral (DAA) therapy achieve high HCV cure rates (SVR ≥95%)

(Meyer et al., 2015)
Qualitative Barriers to Care from PWIDs

Despite the efficiency and minimal side effects of current DAA treatments, PWID may still perceive barriers to care that reduce treatment uptake and adherence:

- Deservingness of HCV treatment and stigma
- Dissatisfaction with provider interactions
- Perceived lack of referral to treatment and care continuity
- Disincentives around HCV treatment for PWID
- Perceived need for treatment
Colocation of HCV Care Continuum with MAT

(Narayanan et al, 2019)
Integration of HCV Care Continuum in an FQHC

(Bartholomew et al., 2019)
Concrete Work Plan to Integrate HCV Care into your MAT program

<table>
<thead>
<tr>
<th>Objective(s)</th>
<th>Actions/Activities</th>
<th>Results</th>
<th>Person(s) Responsible</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1: Create infrastructure to integrate MAT, HCV and HIV Treatment</strong></td>
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<tr>
<td><strong>Objective 1: Create Registry</strong></td>
<td>Identify items to include in the registry. Build Excel spread sheet while CRM is being completed. Protocol for data entry modules is: emr verifications, cross check, follow up, auditing</td>
<td>Will have an Excel based registry Will have a protocol and process for Data Entry Will be in the process of building a CRM registry</td>
<td>Care Coordinator RN Front Desk IT for CRM</td>
<td>Should take several weeks</td>
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<td><strong>Objective 2: Training Staff</strong></td>
<td>Training both program and direct care staff on HCV/HIV and MAT</td>
<td>Initiative and the program and their role in the project. Direct providers will have the knowledge to identify, track and refer HCV, HIV and MAT</td>
<td>Clinic Staff, recorded trainings</td>
<td>1 month</td>
</tr>
<tr>
<td><strong>Objective 3: Referral process for needed services</strong></td>
<td>RN Clinical care training related to SOME services and external partnerships.</td>
<td>100% connection to care for referred clients as based upon callback and registry data entry</td>
<td>Care Coordinator RN</td>
<td>ongoing</td>
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<td><strong>Objective 4: Outreach</strong></td>
<td>Education to outreach staff. Medical staff participation in SUD/MAT treatment meetings for outreach. Partnering with Assessment and</td>
<td>1 partnership in first month.</td>
<td>MAT Providers, Chief Clinical Officer, Sr. Dir of Health Services, Sr Dir of Addictions</td>
<td>ongoing</td>
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# Concrete Work Plan to Integrate HCV Care into your MAT program

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<tr>
<td><strong>Goal 2: 80% Successful enrollment of HCV/HIV/MAT Clients in appropriate services</strong></td>
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<tr>
<td><strong>Objective 1:</strong> 100% self sufficiency screening for barriers</td>
<td>Finish self sufficiency screening for intake. Review current intake packet, update as needed. Identify where to data enter score in</td>
<td>Completed Self Sufficiency Intake form, and process to follow.</td>
<td>Office Manager, CQI Staff, Sr Dir Mental Health, Sr Dir Health Services</td>
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<td><strong>Objective 2:</strong> 75% Treatment compliance across service lines</td>
<td>EMR weekly reports. Care Coordinator RN weekly contact w clients. Weekly Treatment Center contact for clients who have been connected to care. Barriers to care ID'd and documented and discussed at weekly meetings.</td>
<td>Training on reports. Weekly meetings as identified. Data entry on registry.</td>
<td>Billing representative for reports training, Care Coordinator RN, Psychiatrist,</td>
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<td><strong>Objective #3:</strong> 80% compliance on referral for all needed client services</td>
<td>Maintenance of client registry to incorporate multidisciplinary and linkage to care. Weekly reports from referral partners regarding client participation and compliance. Warm handover training to Care Coordinator RN regarding linkage to care referrals.</td>
<td>Creation of client registry to include differentials and results in diagnoses. Ongoing communication with referral partners.</td>
<td>Care Coordinator RN, RN Clinic manager, BHS outpatient clinic manager</td>
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References

References


• Burton, M.J. In DAA We Trust: Key Factors Essential to HCV Elimination. Dig Dis Sci 64, 2701–2702 (2019).

• Margie R. Skeer, Keren Ladin, Lindsay E. Wilkins, David M. Landy, Thomas J. Stopka (2018). ‘Hep C’s like the common cold’: understanding barriers along the HCV care continuum among young people who inject drugs. Drug and Alcohol Dependence 190,246-254.


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Clinical and Public Health Approaches to the Overdose Crisis

Dr. Alexander Walley, MD, MSc
Associate Professor of Medicine, Boston University School of Medicine; Director, Addiction Medicine Fellowship Program

Tuesday, January 12th, 2021
12:00 – 1:00 PM ET
PCSS is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

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