The Impact of Psychosocial Factors on the Care Cascade for Hepatitis C Treatment at a Harm Reduction Program

Daniel Burack,1 Daniel Winetsky,1,2 Pantelis Antoniou,2 Bill Garcia,3 Peter Gordon,1,2 Matthew Scherer,1,2

1Department of Medicine, Columbia University Irving Medical Center, New York, NY 2Comprehensive Health Program, New York Presbyterian Hospital, New York, NY

The Comprehensive Hepatitis Care on the Corner (CHOC) program co-locates HCV screening, evaluation and treatment services within Washington Heights Corner Project (WHCP), a harm reduction organization based in northern Manhattan, New York.

METHODS

• The scope of this study is limited due to its observational nature, reliance on provider documentation and high rates of loss to follow up. No conclusions can be drawn about causality.

• Loss to follow-up is a challenge for PWID, but those who complete treatment achieve SVR at a high rate. Treatment of mental health comorbidities and substance use disorders may facilitate HCV cure.

• Supported by funding from the New York State Department of Health AIDS Institute [30567GG]

BACKGROUND

• Though direct-acting antiviral therapy (DAAT) is highly effective at achieving sustained virologic response (SVR) among patients with chronic hepatitis C virus (HCV), people who inject drugs (PWID) face significant barriers to DAAT access.

• Co-locating HCV treatment within a harm reduction organization has shown promise as a model for delivering DAAT to active PWID.

• Little is known about the care cascade among patients treated for HCV in such co-located HCV treatment programs.

RESULTS

• From 2015 to 2018, 92 patients completed intake. Fifty-one patients started DAAT. Seven patients discontinued treatment or were lost to follow-up before completion. Two patients are awaiting SVR confirmation. Of 42 patients completing therapy, 38 (90.5%) achieved SVR.

• At the time of intake, being in treatment/recovery from OUD (p < 0.01) and concurrent mental health treatment (p < 0.05) were associated with achieving SVR. Regular cocaine use was negatively associated with SVR (p < 0.05).

• The cascade of care was defined for HCV treatment within the CHOC program, and patients were categorized as having completed up to six steps: intake, initial provider visit, completion of the pre-treatment evaluation (consisting of basic laboratory assessment, HCV genotype, HCV viral load and fibrosis assessment), treatment initiation, treatment completion and SVR confirmation.

• Only patients having completed intake ≥9 months prior to the time of chart review were included to allow a “wash-out period,” during which patients could complete all necessary steps.

• Risk factors were assessed at the time of intake and included: housing status, opioid use disorder (OUD) treatment status (including methadone-, buprenorphine- and abstinence-based recovery), risky alcohol use/use disorder, use of cocaine, known mental health comorbidities, established mental health treatment and history of criminal justice involvement (CJI).

• Delays in initiating HCV treatment or interruptions of HCV treatment due to CJI were extracted.

• Rates of treatment completion and SVR were compared using Chi-square and Fisher’s exact tests.

• From 2015 to 2018, 92 patients completed intake. Fifty-one patients started DAAT. Seven patients discontinued treatment or were lost to follow-up before completion. Two patients are awaiting SVR confirmation. Of 42 patients completing therapy, 38 (90.5%) achieved SVR.

• At the time of intake, being in treatment/recovery from OUD (p < 0.01) and concurrent mental health treatment (p < 0.05) were associated with achieving SVR. Regular cocaine use was negatively associated with SVR (p < 0.05).

• The cascade of care was defined for HCV treatment within the CHOC program, and patients were categorized as having completed up to six steps: intake, initial provider visit, completion of the pre-treatment evaluation (consisting of basic laboratory assessment, HCV genotype, HCV viral load and fibrosis assessment), treatment initiation, treatment completion and SVR confirmation.

• Only patients having completed intake ≥9 months prior to the time of chart review were included to allow a “wash-out period,” during which patients could complete all necessary steps.

• Risk factors were assessed at the time of intake and included: housing status, opioid use disorder (OUD) treatment status (including methadone-, buprenorphine- and abstinence-based recovery), risky alcohol use/use disorder, use of cocaine, known mental health comorbidities, established mental health treatment and history of criminal justice involvement (CJI).

• Delays in initiating HCV treatment or interruptions of HCV treatment due to CJI were extracted.

• Rates of treatment completion and SVR were compared using Chi-square and Fisher’s exact tests.

DISCUSSION

• The cascade of care was defined for HCV treatment within the CHOC program, and patients were categorized as having completed up to six steps: intake, initial provider visit, completion of the pre-treatment evaluation (consisting of basic laboratory assessment, HCV genotype, HCV viral load and fibrosis assessment), treatment initiation, treatment completion and SVR confirmation.

• Only patients having completed intake ≥9 months prior to the time of chart review were included to allow a “wash-out period,” during which patients could complete all necessary steps.

• Risk factors were assessed at the time of intake and included: housing status, opioid use disorder (OUD) treatment status (including methadone-, buprenorphine- and abstinence-based recovery), risky alcohol use/use disorder, use of cocaine, known mental health comorbidities, established mental health treatment and history of criminal justice involvement (CJI).

• Delays in initiating HCV treatment or interruptions of HCV treatment due to CJI were extracted.

• Rates of treatment completion and SVR were compared using Chi-square and Fisher’s exact tests.

DISCLOSURES

• Supported by funding from the New York State Department of Health AIDS Institute [30567GG]