ESTABLISHING AN INTEGRATED CARE CLINIC FOR HCV-INFECTED PEOPLE WHO ACTIVELY INJECT DRUGS (PWID) AT A HARM REDUCTION CENTER IN WASHINGTON, DC (ANCHOR MODEL)

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Background:
Sharing injecting equipment is the most common mode of hepatitis C (HCV) transmission, yet PWID are often excluded from HCV treatment and have numerous barriers to healthcare. To combat risk for HIV acquisition, HCV re-infection, and opioid overdose, models integrating comprehensive medical treatment and harm reduction are needed to improve outcomes in PWID.

Description of model of care/intervention:
We collaborated with a pre-existing harm reduction drop-in center in Washington, DC to establish a clinic that provides HCV treatment, opioid agonist therapy (OAT) and pre-exposure prophylaxis (PrEP) for PWID. Prior to clinic initiation, no medical care was provided on-site; services included syringe exchange, case management, showers, meals, and clothing. Key to the model's success were:

1) Culturally competent environment (leveraging existing relationship of the organization in the community);
2) Low-barrier medical care (flexible scheduling, walk-in always available, no medical restrictions based on drug use);
3) Collocation of services (treatment for HCV and OUD, PrEP and naloxone dispensation by same provider, concurrent syringe-exchange, housing assessments);
4) Community health workers to provide testing, recruit patients, facilitate transportation and visit adherence, and provide ongoing clinic engagement.

Effectiveness:
100 patients initiated HCV treatment. Medical visit adherence was high, sixty-six(66%) patients came to all 3 on-treatment visits and 93% received the full 3-months of medication. Of 67 patients not on OAT at time of engagement, forty-nine(73%) initiated collocated OAT. Seventy-three(73%) patients were ever dispensed naloxone during medical visits. Twenty-three(23%) initiated PrEP.

Conclusion and next steps:
Creation of a low-barrier medical clinic embedded in a harm reduction organization facilitated high uptake of HCV treatment, OAT, naloxone and moderate uptake of PrEP in a highly marginalized population not linked to medical care. Models of care aimed at providing culturally competent, integrated care are essential for eliminating HCV while addressing overall health in PWID.

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