

## **HEPATITIS C TREATMENT AMONG PEOPLE PRESCRIBED METHADONE MAINTENANCE AT A U.S. OPIOID TREATMENT PROGRAM DURING COVID-19 VIA TELEHEALTH AND SIMPLIFIED CARE PATHWAY**

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### **Background:**

The COVID-19 pandemic has disrupted healthcare delivery. People with opioid use disorder (OUD), at heightened risk for COVID-19, face challenges accessing OUD and hepatitis C virus (HCV) treatment given reduced in-person visits. U.S. HCV treatment dropped by over 30% at the pandemic's start, and has not recovered.

Co-located HCV and methadone plus harm reduction (HR) facilitate prevention and cascade to cure. Rhode Island (RI)'s only non-profit methadone maintenance program (MMP), CODAC, started their embedded HCV clinic in 2014.

### **Description of model:**

From March 1, 2020-February 28, 2022, our program adapted to loss of in-person HCV visits. Already in place was the physician-nurse navigator-pharmacist team and single, universal, opt-out blood draw upon MMP entry, repeated annually (HCV antibody with reflexive RNA/genotype, HIV, hepatitis A/B, liver panel, CBC, creatinine, PT/INR, treponema) with APRI/FIB-4 calculations.

HCV clinical visits moved to telephone-health. On-treatment labs were stopped. A free HR vending machine moved on-site. Challenges included MMP staff attrition and suspension of on-site phlebotomy, requiring patients to access off-site laboratories for baseline and sustained virological response (SVR) bloodwork.

### **Effectiveness:**

Seventy-five patients initiated DAAs, mean age 42 (26-63 years), 28% female, 61% genotype 1, 28% genotype 3; 93% had public health insurance (88% Medicaid, 5% Medicare), 7% private. Of DAA initiation visits, 89% were conducted via telephone, 11% in-person, per patient choice and in accordance with an in-person HCV care option permitted towards the end of the assessment period, with most choosing continued remote care. Modified intent-to-treat SVR was 90% (36/40); 4 patients did not achieve SVR, 13 remain on-treatment or await SVR 12 weeks post-end-of-treatment, 22 were lost to follow-up, with overall SVR 58% (36/62).

### **Conclusions:**

At a co-located HCV/MMP/HR clinic, telephone contact enabled continued HCV treatment under COVID-19. Patient inability to access telephones and off-site phlebotomy continue as barriers to expanded capacity.

**Disclosure of Interest Statement:** Nothing to disclose