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How to Improve Hep C Treatment Among Those With Opioid Use Disorder

Researchers reviewed numerous studies to inform their detailed tips for better engaging people who inject opioid drugs in hepatitis C care.

March 1, 2019 By Benjamin Ryan

Now is the time for medical and addiction-treatment clinics to do whatever is necessary to engage people who inject drugs (PWID) in widespread testing and successful treatment for hepatitis C virus (HCV). If the United States is ever to move significantly toward the ultimate goal of eradicating the virus, it is vital that stakeholders streamline the pathways between medication-assisted treatment (MAT) programs—those that provide methadone, buprenorphine and naltrexone to people with opioid use disorder (OUD)—and clinicians who prescribe direct-acting antiviral (DAA) therapy for HCV.

This is a fundamental message conveyed in a new paper published in the journal Hepatic Medicine: Evidence and Research, in which a team of Spanish clinicians who are experts in hep C treatment assessed available research on treating HCV among people with OUD and devised a road map for doing just that in this traditionally challenging-to-treat population. While their paper is informed in part by their own clinical experience in Spain, the paper's authors assert that their recommendations are generalizable to other settings around the world.

U.S. residents who have OUD are an estimated nine times more likely to have hep C compared with the general population. Perhaps 40 percent of PWIDs are living with the virus. And according to the Centers for Disease Control and Prevention (CDC), the opioid epidemic has caused a dramatic rise in annual rates of new infections across the country, in particular among whites and young people18 to 29 years old.

Both the medical community and insurers have long maintained biases against treating hep C among PWID, based on the presumption that such individuals will not properly adhere to DAA medication regimens or attend the clinic visits necessary for monitoring those undergoing such treatment. However, various recent studies have strongly refuted the notion that PWID are destined to fail courses of therapy that last as little as eight to 12 weeks. These papers have stressed that, provided the kind of wraparound medical, addiction-treatment and psychosocial care that nurtures success in hep C treatment, PWID can indeed achieve high cure rates on DAAs. Consequently, certain researchers have concluded that those who inject drugs should not be excluded from DAA treatment.

So how to go about setting up programs that best facilitate a streamlined process between testing, linkage to medical care, treatment and ultimately a cure among those with OUD?

Reviewing the evidence

The authors of the new paper combed scientific publication databases and came up with 57 studies for their analysis that specifically focused on treating HCV among people with OUD. This included 22 full research articles, 23 presentations from major conferences, seven consensus recommendations and five review papers.

The investigators divided their recommendations into four major steps along the hep C care continuum:

1. Engagement

Education is the name of the game when it comes to drawing people with OUD into testing for hep C. There are myriad ways to get the message across about the importance of testing and treatment, including, for example, workshops and Q&A sessions, videos and pamphlets.

Meanwhile, health care providers, including those working in primary care and drug treatment services, also need to be brought up to speed on treating HCV in this population. Recent research has found that primary care physicians and other nonspecialists can successfully treat HCV, a particularly promising finding given the limited availability of liver and infectious-disease specialists compared with the size of the hep C population. (An estimated 2.4 million Americans have HCV, but most are unaware of their infection.) However, concerningly, primary care physicians tend to do a poorer job of shepherding people with HCV through treatment compared with specialists.

Providing information on hep C testing and treatment to those at high risk of the virus is of limited value if it doesn’t then prompt such individuals to get tested and then, if they test positive, engage with the medical system. So the paper’s authors suggest that clinics run pop-up and short-term services that facilitate such engagement with medical care in neighborhoods with high rates of the virus.

Keeping patients with hep C from feeling stigmatized is paramount if clinicians are to build the kind of trust and rapport that best supports consistent engagement in medical care for the virus. Additionally, peer support systems can help further address any feelings of mistrust toward the medical system that may compromise an individual’s willingness to work with health care providers to address his or her HCV infection.

2. Screening

Today, dried blood spot testing can provide in a single step both HCV antibody testing and the RNA testing that is used to confirm a positive antibody test.

Primary care offices should screen patients to identify those at risk for the virus. Health care practices that provide general medical care in areas that have a high rate of injection drug use, or such practices located at drug treatment centers, are particularly likely to identify new cases of the virus.

Another way to identify at-risk individuals is to ask peers to help spread the word through, for example, their injection-drug-use network. Those PWID who test negative for hep C should be retested annually because of their high risk of contracting the virus if they share drug-use equipment, including needles and syringes and other drug "works."

3. Workup/referral

People with hep C need to have their liver disease "staged," by undergoing tests to determine the severity of any liver damage. Historically, this required an invasive liver biopsy; but more recently, noninvasive methods have proved reliable. So the new paper's authors recommend liver disease be staged using the ultrasound technique Fibroscan as well as blood tests that can estimate the severity of fibrosis, or scarring, of the liver. Such blood tests can be rolled out at drug treatment centers, primary care offices, supervised injection centers, street-based outreach programs and in prisons.

To provide proper linkage to medical care for those with the virus, the Spanish researchers recommend tailoring approaches to individuals' needs. Again, educating health care providers and providing people with hep C with peer support can help strengthen this vital bridge between testing and treatment for the virus.

4. Treatment

Ideally, all the needs of people receiving HCV treatment would be addressed under one roof and by a multidisciplinary team in a "one-stop shopping" model that can help keep people from falling through the cracks of medical care. This setting doesn't have to be a traditional medical clinic. It could also be a drug-treatment facility, a syringe services program or a prison.

Medical doctors need not be the ones to prescribe DAAs. Nurse practitioners and even pharmacists can provide the medications to people with hep C, whether in primary care settings, prisons or clinics led by pharmacists themselves.

And for those for whom seeing a hep C–focused health care provider in person may be challenging—whether because they live in a rural area without nearby specialists or face other transportation-based obstacles—research increasingly supports telemedicine as an effective means of providing them medical care for the virus.

To help ensure that people with OUD adhere to their DAA medication regimens, the paper's authors advise various forms of psychosocial support, including ongoing counseling and case management. Additionally, they recommend screening such patients for psychiatric conditions and, if necessary, providing referrals to mental health providers, peer-support groups or buddy systems.

Because PWID who are cured of HCV are at such high risk of reinfection with the virus, it is important that the same practitioners who engaged such individuals in medical care in the first place endeavor to provide this population with ongoing monitoring, including testing for the virus as well as assessment of any risk factors for reinfection.

Conclusion

“It is essential, now,” the paper’s authors write, “to address limits to therapy access if HCV treatment uptake is to be available to all and eradication of the infection is to be achieved.” They continue by stressing that, under the current systems that govern hep C treatment, “[m]any citizens with greater need for HCV therapy cannot navigate pathways to get the HCV care they need.”

The researchers note that their recommendations focus on clinic-based factors and acknowledge that numerous other social and provider-based factors also affect how readily people with OUD make their way from getting tested for hep C testing to obtaining a cure.
