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Screening for Viral Hepatitis within Behavioral Health Organizations

July 9, 2014 2:30 PM ET

SAMHSA-HRSA Center for Integrated Health Solutions

Colleen O'Donnell, MSW, PMP, CHTS-IM
(webinar moderator)
Director HIT Technical Assistance and Training
SAMHSA-HRSA Center for Integrated Health Solutions,
National Council for Behavioral Health

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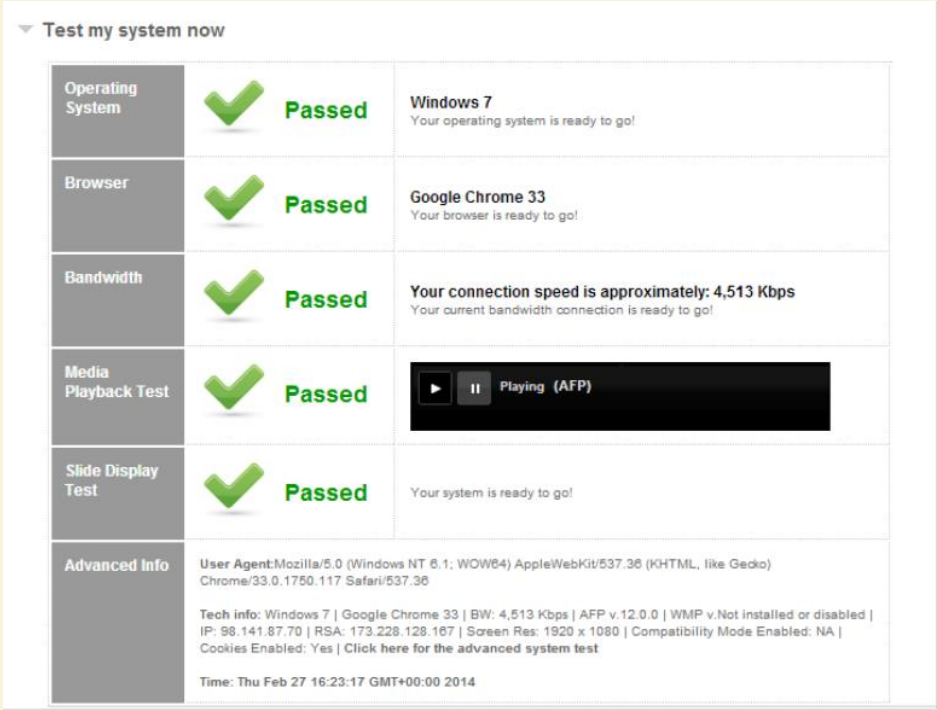

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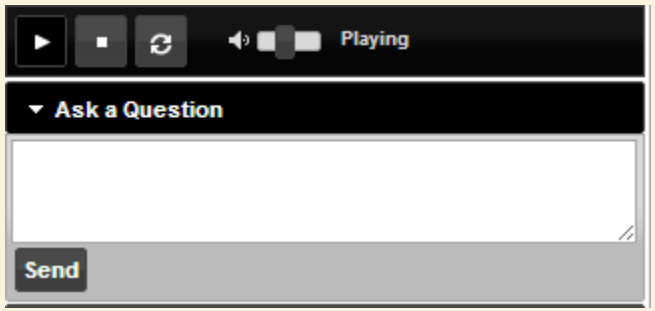
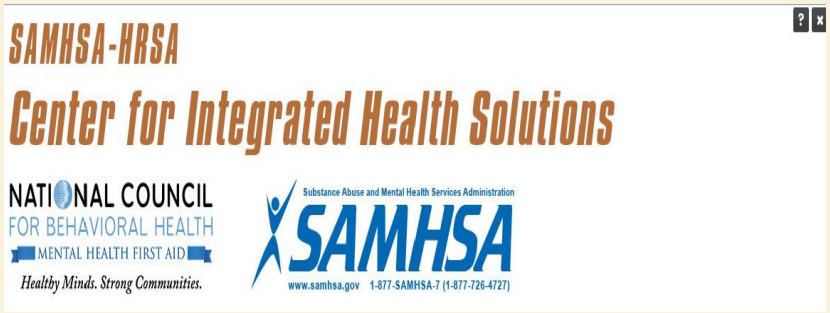




Outline

- Two Webinars
  - Today, LIVE
    - **Outreach, education and psychosocial support** - the clinical and public health perspectives on education, prevention, identification and treatment
  - Available now, RECORDED
    - **Medications, treatment issues and protocols** – the psychiatric and primary care provider perspectives on cost concerns, anticipated changes in the approaches to treatment, and the role of behavioral health

Objectives

1. Create a shared frame of reference for the basics about viral hepatitis, including epidemiology, prevalence and implications for patient care
2. Understand the impact of undetected, untreated infection among patients with mental health and substance use disorders (MH/SUD)
3. Education, prevention and identifying MH/SUD patients as candidates for screening; supporting their participation in treatment

Opening Remarks

Elinore F. McCance-Katz, MD, PhD

Chief Medical Officer,
Substance Abuse and Mental Health Services Administration

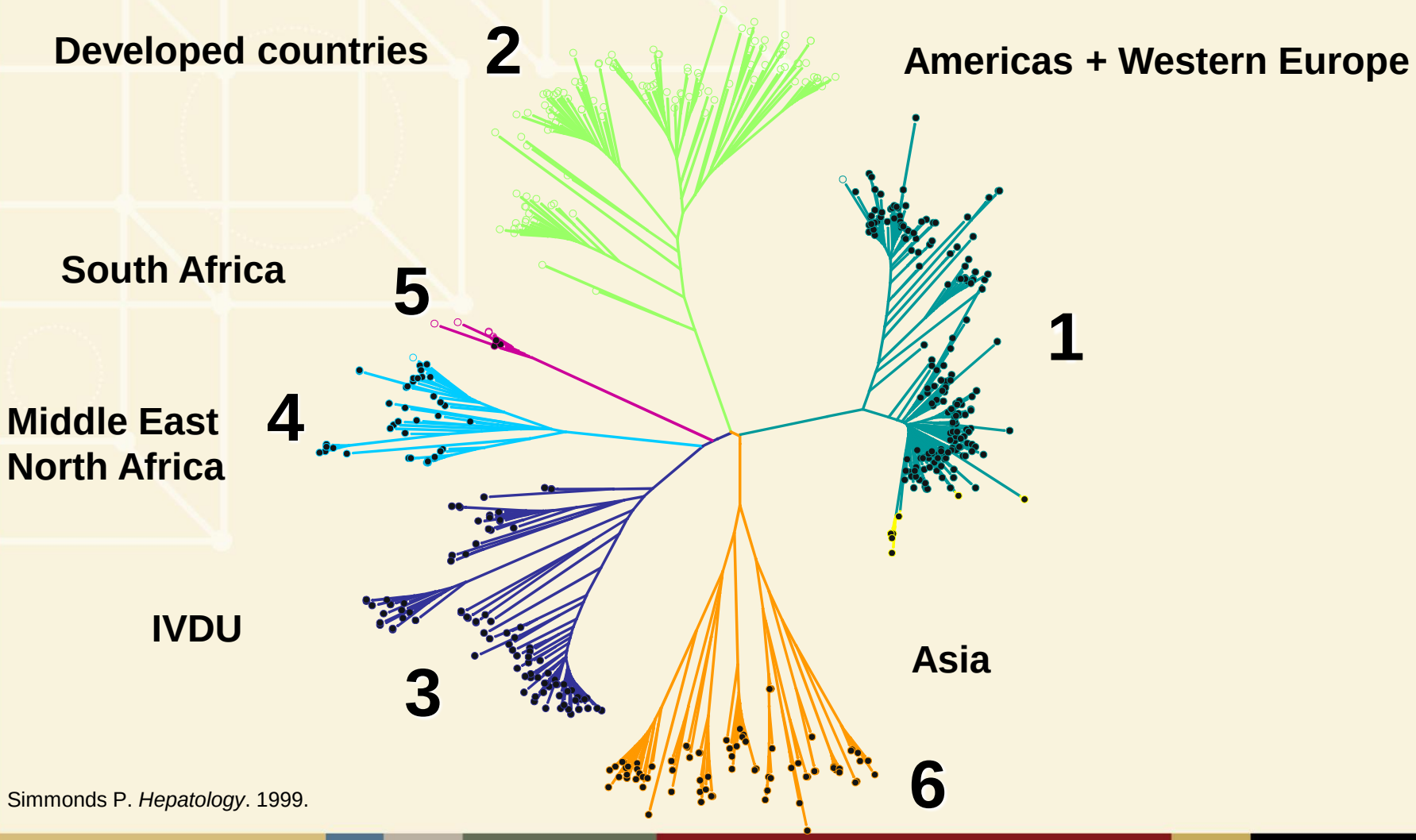
First Presenter

Maggie Chartier, PsyD, MPH is the National Public Health Clinical Psychologist for the Veterans Health Administration's HIV, Hepatitis, and Public Health Pathogens Program in the Office of Public Health/Clinical Public Health. She is also a staff psychologist at the San Francisco VA Medical Center. She completed her M.P.H. in Epidemiology at the University of Washington, Seattle and her Psy.D. from the PGSP-Stanford Consortium in Palo Alto, California. She completed her clinical internship at the University of California, San Francisco and her postdoctoral fellowship in HIV/HCV Psychology at the San Francisco VA Medical Center. In 2013, she was awarded a James Besyner Early Career Award for Distinguished Contributions to VA Psychology by the Association of VA Psychology Leaders.

The Basics on Hepatitis C

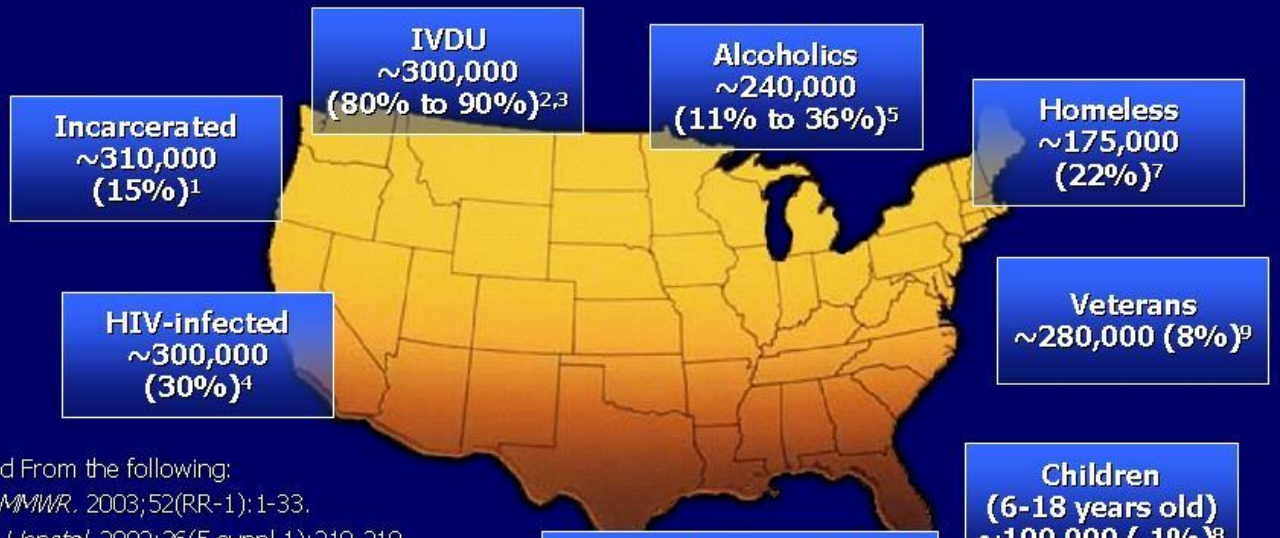
- Hepatitis = inflammation of the liver
- Can be caused by different viral infection (i.e. hepatitis A, B, C, D, E) or damage from alcohol
- Vaccines are available for A and B, not for C
- Hepatitis C is a blood-borne viral infection with different modes of transmission and different genotypes
- 70-80% of those infected with HCV have mild or no symptoms
- Treating HCV can prevent long-term consequences (i.e., end stage liver disease; hepatocellular carcinoma)
- HCV screening can detect antibodies, which indicates exposure
- Further testing can determine the HCV genotype (1-6) which plays a role in determining course of treatment
- Previous and some current treatments include: Interferon-based therapy (pills, injection) has many side effects, difficult to tolerate, may take from 24-48 weeks to complete
- Some interferon-free treatments are available, and more are on the horizon with much shorter treatment duration

Genotype Distribution



Simmonds P. *Hepatology*. 1999.

Prevalence of HCV in Select Populations



Adapted From the following:
[1]CDC. *MMWR*. 2003;52(RR-1):1-33.
[2]Edlin. *Hepatol*. 2002;36(5 suppl 1):210-219.
[3]NHSDA Report 2003.
[4]Poles et al. *Clin Infect Dis*. 2000;31:154-161.
[5]Labreque, Sandt. In: *Hepatitis C Choices*. 2002.
[6]Alter et al. *N Engl J Med*. 1999;341:556-562.
[7]Nyamathi et al. *J Gen Intern Med*. 2002;17:134-143.
[8]Bräu et al. *Am J Gastroenterol*. 2002;97:2071-2078.
[9]Jonas. *Hepatol*. 2002;36(5 suppl 1):S173-S176.

CDC Recommendations for HCV Screening

- Adults born during 1945 through 1965 should be tested once (without prior ascertainment of HCV risk factors)
- Those who:
  - Currently inject drugs
  - Ever injected drugs, including those who injected once or a few times many years ago
- Have certain medical conditions, including persons:
  - Who received clotting factor concentrates produced before 1987
  - Who were ever on long-term hemodialysis
  - With persistently abnormal alanine aminotransferase levels (ALT)
  - Who have HIV infection

http://www.cdc.gov/hepatitis/hcv/guidelinesc.htm

CDC Recommendations for HCV Screening, continued

- Were prior recipients of transfusions or organ transplants, including persons who:
  - Were notified that they received blood from a donor who later tested positive for HCV infection
  - Received a transfusion of blood, blood components or an organ transplant before July 1992
- Persons who should be tested routinely for HCV-infection based on a recognized exposure:
  - Healthcare, emergency medical, and public safety workers after needle sticks, sharps, or mucosal exposures to HCV-positive blood
  - Children born to HCV-positive women

http://www.cdc.gov/hepatitis/hcv/guidelinesc.htm

1st Poll Question

Does your organization identify and ensure screening of patients who are “at risk” for hepatitis C (HCV) infection?

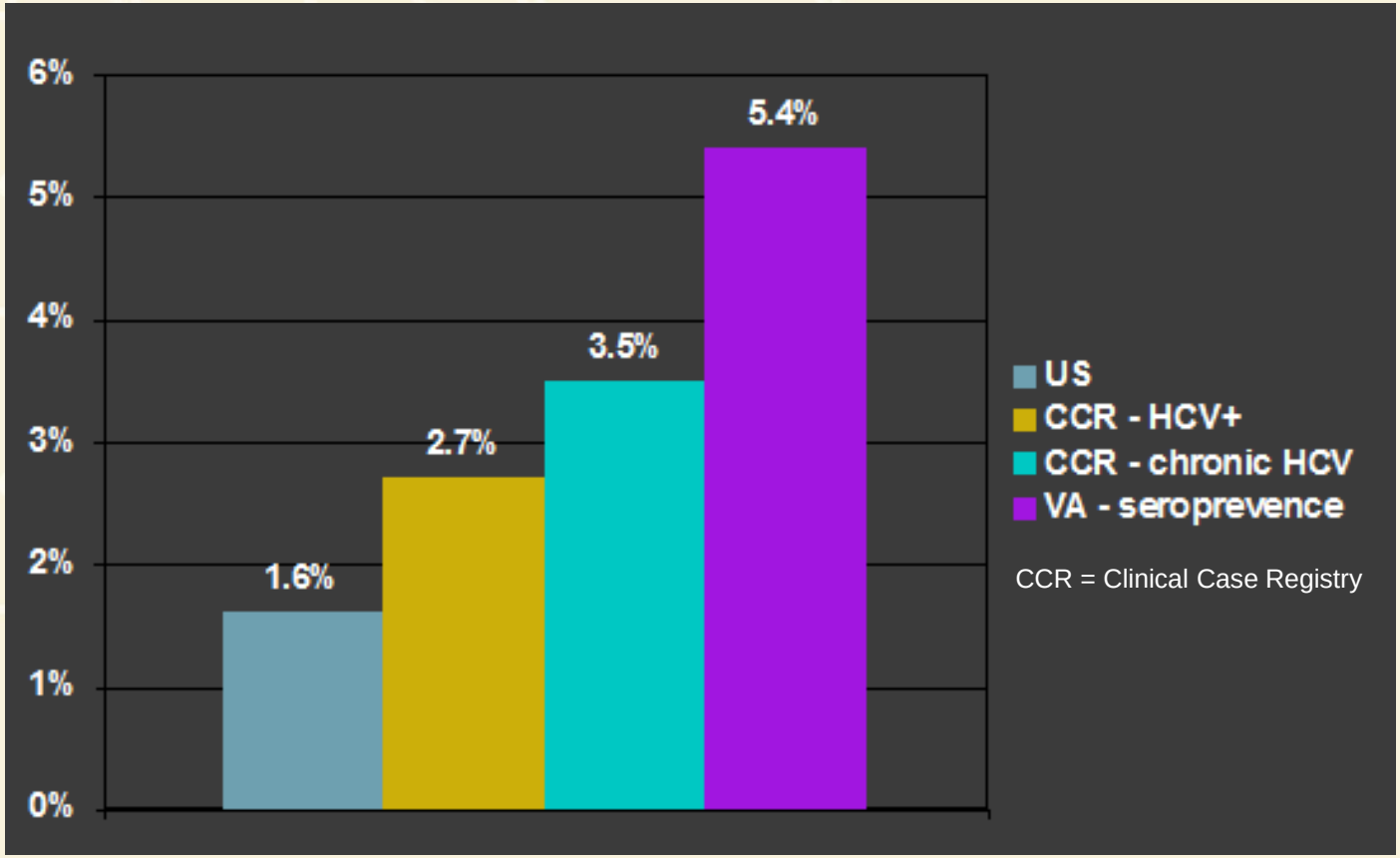
a) Yes b) No c) Not sure

Epidemiology

- Globally
  - Every year, 3–4 million people are infected with HCV
  - 130-150 million people are chronically infected and at risk of developing cirrhosis and/or end stage liver disease (ESLD)
  - 350,000-500,000 people die from HCV-related liver diseases every year
  - Antiviral therapy can successfully treat 50-90% of HCV infections, reducing the risk of cirrhosis and liver cancer
- In the US
  - ~3.2 million people have chronic HCV infection
  - 75%–85% of those infected with HCV will develop chronic infection

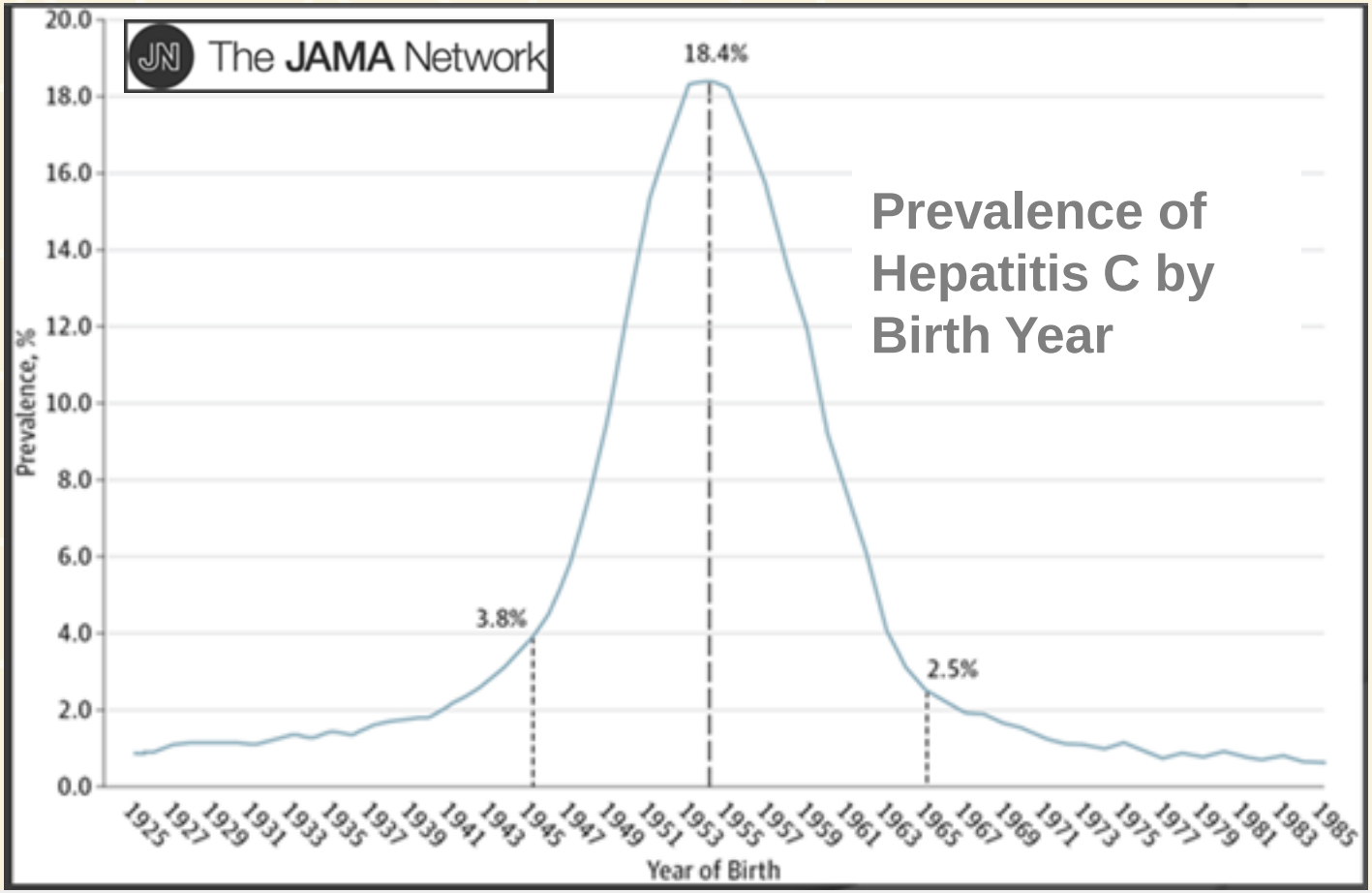
www.who.int/mediacenter/factsheets/fs/164/en/

Prevalence of HCV - US and Veterans Administration



Source: HCV Clinical Case Registry; Dominitz JA et al, Hepatology 2005;41:88-96

Birth Cohort

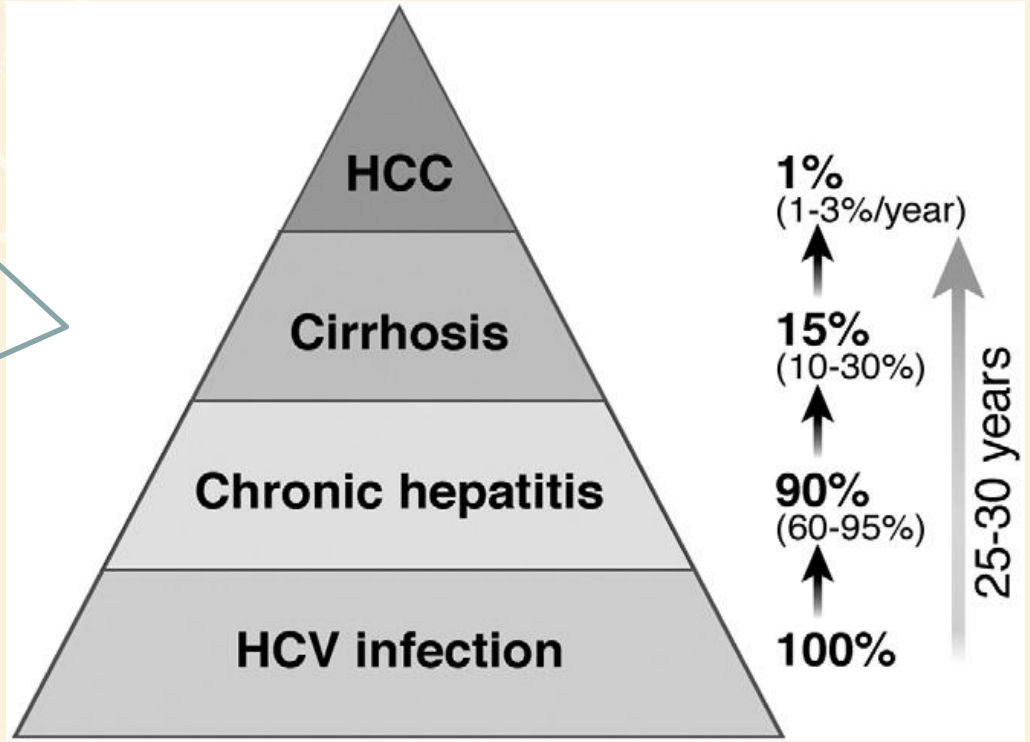


From: **Hepatitis C Virus Screening and Prevalence Among US Veterans in Department of Veterans Affairs Care**
JAMA Intern Med. 2013;173(16):1-3. doi:10.1001/jamainternmed.2013.8133

Backus, 2013

Natural History

75% of patients exposed to HCV will not develop significant disease



El Serag, Gastro 2007

Predictors of Histologic Progression

Potentially Modifiable Factors

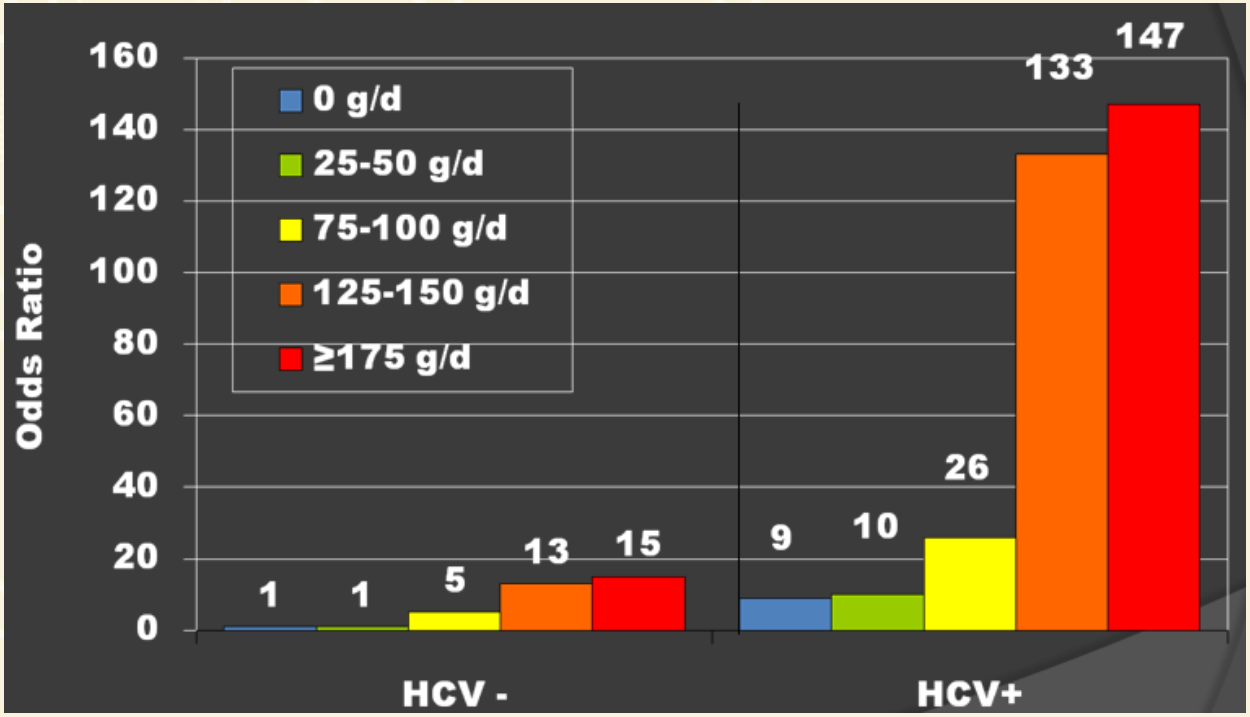
- Alcohol consumption
- HBV infection
- HIV infection
- Obesity/hepatic steatosis
- Insulin resistance
- Iron overload
- Tobacco
- Cannabis
- Immunosuppression (e.g. post-transplant)

Non-Modifiable Factors

- Age at acquisition of infection
- Duration of infection
- Male sex
- Race
- Host genetic factors
- Baseline inflammation and fibrosis on biopsy

Missiha SB, Ostrowski M, Heathcote EJ. Gastroenterology 2008; 134:1699-1714.

Alcohol Use Increases Cirrhosis Risk



Lifetime Daily Alcohol Intake (LDAI, g/d)

Corrao & Aricò, Hepatology 1998;27:914-9.

Slide courtesy of Eric Dieperink, MD, Minneapolis HCRC

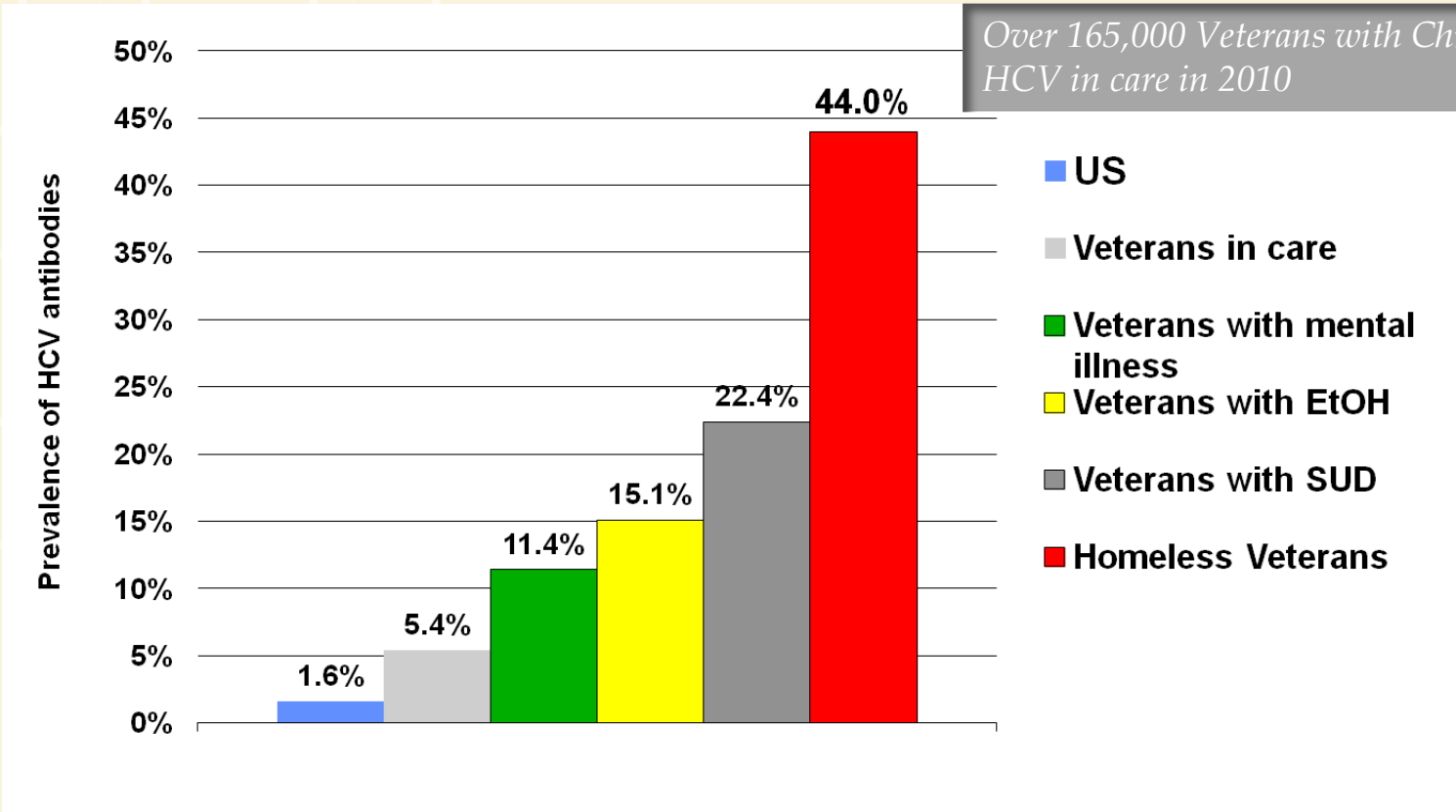
VHA is the Largest HIV and HCV Care Provider in the US

Year	2009	2010	2011	2012	2013
HIV	24,318	24,296	25,273	26,033	26,784
HCV	166,387	165,005	170,119	173,416	174,302

OPH/Population Health
http://vaww.hiv.va.gov/data-reports/ccr2010/Demo-InCare-Jan11-HIVPARV-2013-All.asp
http://vaww.hepatitis.va.gov/data-reports/ccr2010/Demo-InCare-HCVVir-2013-All.asp

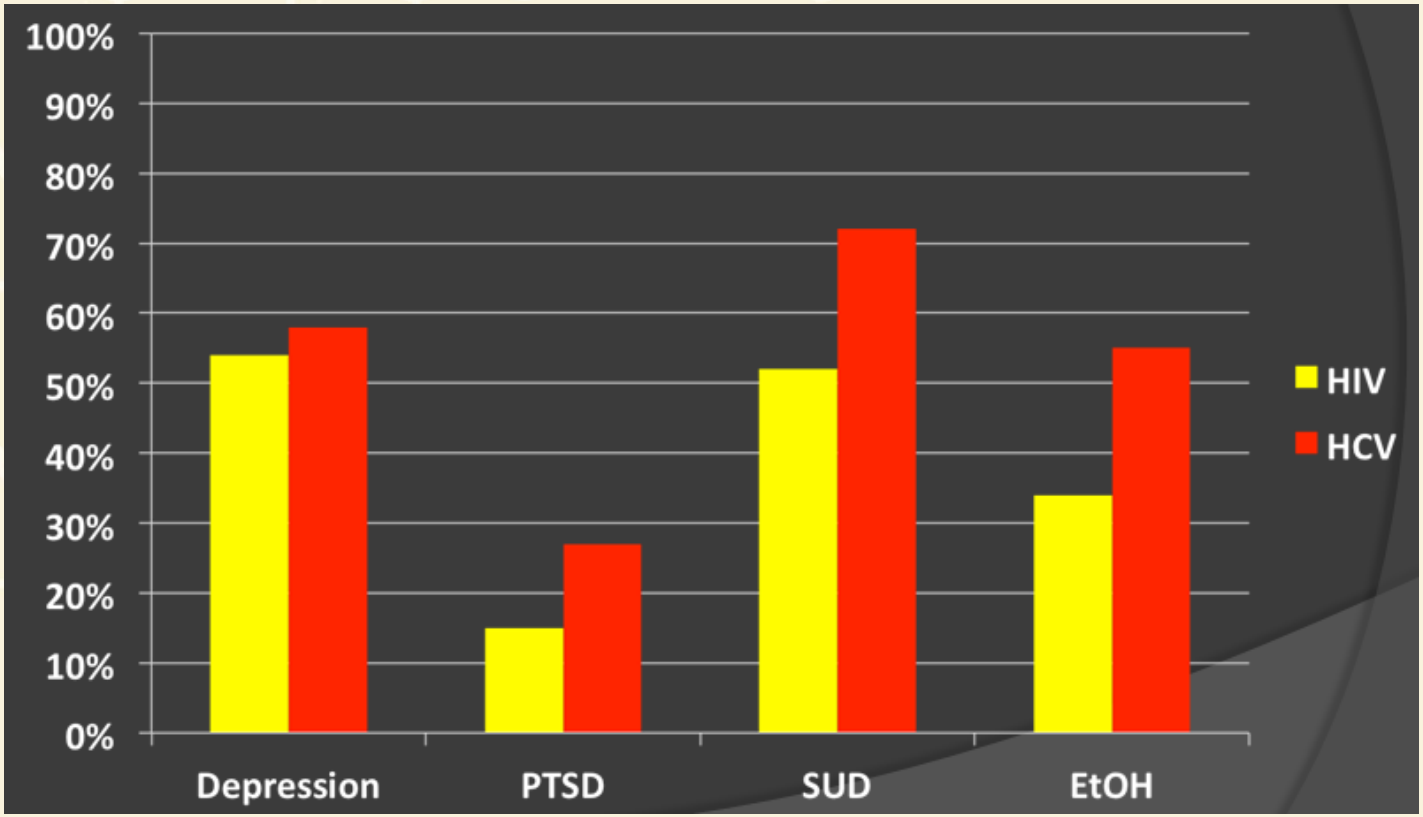
HCV and Mental Health/Substance Use Disorders (MH/SUD) Treatment are Major Clinical and Public Health Issues for VA

Over 165,000 Veterans with Chronic HCV in care in 2010



Dominitz JA, et al, Hepatology 2005;41:88-96
Desai RA, et al. Soc Psychiatry Psychiatr Epidemiol. 2003; 38:396-401

MH/SUD Are Prevalent Among Veterans with HIV and/or HCV



HIV and HCV Clinical Case Registries – 2010 snapshot

Slide courtesy of David Ross

MH/SUD in HCV Infected Populations Compared to the General Population

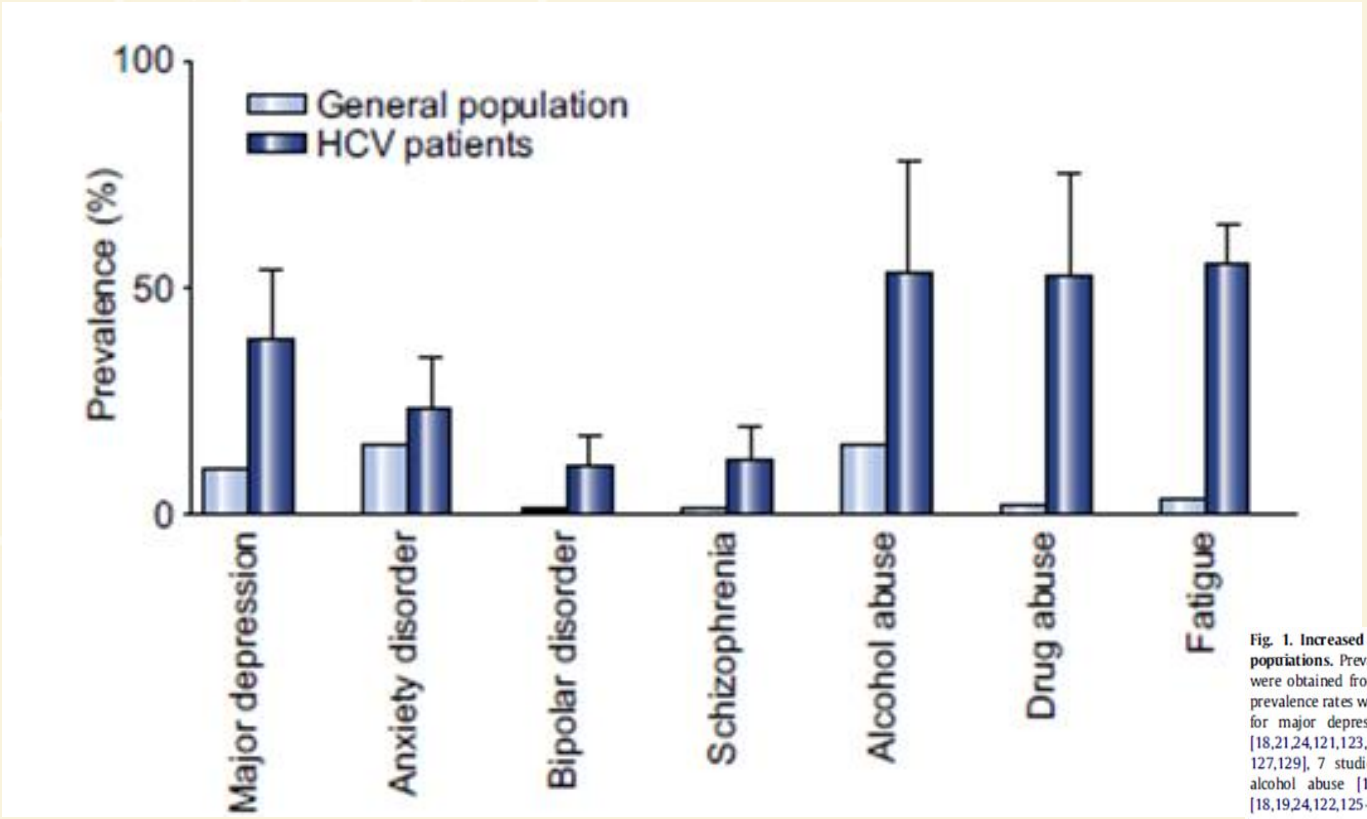


Fig. 1. Increased prevalence of psychiatric co-morbidity in HCV infected populations. Prevalence rates of psychiatric diseases in HCV infected patients were obtained from several publications and mean and standard deviation for prevalence rates were calculated for each disease. Results are based on 10 studies for major depression [18,19,24,121–127], 7 studies for anxiety disorders [18,21,24,121,123,127,128], 6 studies for bipolar disorder [18,19,122,124, 127,129], 7 studies for schizophrenia [18,19,122,126,127,129], 9 studies for alcohol abuse [18,19,24,121,122,124–127], 7 studies for other drug use [18,19,24,122,125–127], and 5 studies for fatigue [23,28,130–132].

Schaefer, 2012, Hepatitis C infection, antiviral treatment and mental health A European expert consensus statement

Barriers to Interferon Treatment Candidacy

- Majority of HCV patients not eligible for treatment or are deferred due to psychiatric and substance use co-morbidities
- 4,084 Veterans with HCV across 24 VA Medical Centers
  - 20.2% recent or on-going substance use
  - 18.3% active psychiatric disorder
  - 17.9% co-morbid medical illness
  - Only **17.7% of patients were actually treated** in this study
- 68-83% excluded from treatment across 8 VA studies
  - Main reason for exclusion was MH/SUD
- 25% of Veterans with HCV ever treated in VA (CCR, 2013)

CCR = Clinical Case Registry
Bini, 2005; Ho, 2008; http://vaww.hepatitis.va.gov/data-reports/ccr2012/RegMed-AnyFirstEverInCare-Jan13-HCVVir-HCV-2012-All.asp

Decisions Not to Treat HCV Patients in a Community Sample

Table 3. Documented Reasons for Not Treating Hepatitis C in 179 Patients

Reason	No. (%)
Alcohol and drug abuse with or without depression*	34 (19)
Severe comorbidity†	28 (16)
Depression without chemical dependency*	25 (14)
Refused – no further specifications	23 (13)
ALT, AST normal levels (NIH guidelines 1997)	19 (11)
No trial available, no money, no insurance*	15 (8)
Old age (70-85 y)	12 (7)
End-stage liver disease or cirrhosis	11 (6)
Pregnant at diagnosis, treatment not reconsidered*	3 (2)
End-stage HIV infection, with or without hemophilia	3 (2)
Severe language barrier*	3 (2)
Acute hepatitis C	3 (2)
Total‡	179 (100)

(31% due to MH/SUD)

ALT = alanine aminotransferase; AST = aspartate aminotransferase; NIH = National Institutes of Health; HIV = human immunodeficiency virus.

* Potentially reversible comorbidities, n = 80.

† Comorbidities include malignancies under treatment, previous cardiac or renal transplant, ongoing renal dialysis, diabetes with severe complication, vasculitis, multiple sclerosis–progression, ulcerative colitis, debilitating migraine headache, aortic aneurysm.

‡ The 179 patients represent 49% of the total 366 study patients.

Rocca, 2004 Management of patients with hepatitis C in a community population, diagnosis, discussions, and decisions to treat

Treating HCV in Patients With MH/SUD

- Patients with MH/SUD co-morbidities who are homeless or marginally housed or have other instability factors may face challenges in access to treatment
- People with MH/SUD can achieve Sustained Viral Response (SVR) similar to those without MH/SUD co-morbidities, when engaged in behavioral health
- Access to new and more efficacious drugs is critical in stemming the epidemic of advanced liver disease on the horizon

Bonner, 2012

Evidence-Based Reasons for Expanding HCV Therapy to Patients with MH/SUD

1. Higher prevalence of MH/SUD in HCV than in the general population
2. Large proportion of HCV patients are deferred from antiviral therapy owing to MH/SUD.
3. Despite clinical challenges, this group can be treated safely and effectively, with proper support from a multidisciplinary team that includes MH/SUD treatment professionals
4. Patients with MH/SUD can achieve similar SVR rates as patients without these comorbidities, when they are engaged in behavioral health treatment.

Bonner, 2012

Eight (8) Evidence-Based Reasons for Expanding HCV Therapy to Patients with MH/SUD

5. One out of every 30 “baby boomers” is infected with HCV. Over the next 20-30 years, a major liver disease epidemic is anticipated (if treatment rates continue)*.
6. If the majority of patients infected with HCV cannot access the new [more efficacious] anti-viral treatment, then the effectiveness of new therapies…will be minimal.
7. Patients who are “poor HCV treatment candidates” will likely face the same challenges to become suitable liver transplant candidates; thus, the prevention of disease progression in this cohort becomes paramount.
8. Individuals can experience significant HCV-related stigma, can have a detrimental impact on psychological and social functioning… receiving antiviral treatment may mitigate these negative influences.

Bonner, 2012
*CDC MMWR Recommendations and Reports http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6104a1.htm

The Rapidly Changing Face of HCV Treatment

- Interferon-free regimens on the horizon
- Reduction in pill burden, side-effects, and duration of treatment
- Shifting role for MH/SUD treatment providers
  - From pre-treatment evaluations to integrated care
  - Focus on adherence and general MH/SUD treatment

Summary

- Screening people at risk for HCV is critical.
- The majority of people with HCV have yet to be treated.
- One of the major reasons cited for ineligibility for HCV treatment has been MH/SUD.
- New and more efficacious medications to treat hepatitis C are available and more are in the pipeline, making it more critical than ever to screen and prepare patients with MH/SUD for treatment.
- There are evidence-based reasons for providing HCV treatment to patients with MH/SUD.
- Consequences of excluding this population from treatment is increasingly higher incidence of liver disease.
- Behavioral Health treatment providers will play a more active role in screening, coordination, collaboration and integration of care for infected patients with MH/SUDs.

2nd Poll Question

Does your organization have policies and procedures that implement education and prevention re: viral hepatitis infection for all MH/SUD treatment patients?

a) Yes b) No c) Not sure

(Note – we will also pause for Chat Box questions from audience)

Rebecca Goldberg, RN, BsEd, ACRN has been the Nursing Coordinator for the Hepatitis Clinic at the "Ruth M. Rothstein CORE Center" (Chicago, IL) for the past eleven years. She reviews and assesses new patients within a multidisciplinary team and conducts the patient education so vital to successful treatment of Hepatitis C. In this capacity, she also provides support and monitoring throughout the patient's treatment episode, creating linkages with community resources and facilitating additional testing when needed. She is certified to perform fibroscan testing, which she also uses as a tool in prevention and education. She brings twenty-one years of experience to the role working with those living with HIV/AIDS, and is certified in HIV/AIDS Nursing.

Engaging New Patients In Hepatitis C Treatment

Initial Screening and Appointment

- Patients connect either as walk-in or as referral
- Document of Hepatitis C infection and if patient has PCP
  - If patient verifies infection, schedule
  - If not, give them information and contact details for follow up
- Review and assess with Hepatitis Treatment Team (at patient initial appointment)

Establishing the Need for Treatment

Assessment and Evaluation

- Medical evaluation of treatment need, fibroscan imaging, and lab markers to stage degree of fibrosis (can also be used as a tool to foster positive health behaviors)
- Establish other needs (i.e. behavioral health, cardiology)
- Evaluate ability for adherence

Assessing for Adherence

- Template to Assess Potential For Adherence
  - Does the client make it to all appointments?
  - If co-infected, is HIV well-controlled?
  - Does the client report consistent adherence to other medications/treatment plans?
  - Is the client consistently reachable by telephone and will the patient contact us if he/she is having treatment issues?
  - Will patient attend teaching session prior to treatment and periodic lab draws?

Realities in Addition to Hepatitis C

- What we see in the clinic
  - Health challenges and psychosocial concern; comorbidities; Maslow's Hierarchy
  - Compounded with other issues including chemical dependency, mental health, domestic violence, incarceration, homelessness…sometimes all of the above
  - Historically poor access to consistent primary care provider and specialty medical care

Importance of Behavioral Healthcare Primary Care Perspective

- What happens when there is the opportunity to intervene (with prevention, education, treatment)
  - Peer support (patients who are HIV/HCV + receive additional training to orchestrate appointments & guide patients during first appointment, regularly provide additional support when need is identified by staff)
  - Patient navigators (linkage to care of new patients while in hospital with out-patient clinic)
  - Patient Educators (provide education and support Mental Health/Substance Abuse treatment)

How We Work with Behavioral Health Clinicians

- Screening is necessary for appropriate referral and to identify those who need more support
  - Ongoing communication between PCP and BH critical to success
  - Establish lines of communication (release of information, communication template letter from the PCP, template letter for referrals to Hepatitis Clinic and to Behavioral Health)
  - Co-located services are ideal (psychiatric, mental health and primary care, including hepatitis)
  - Structured outside services – communication with offsite providers is also necessary (template letter for clearance for psychiatrist)

Common Challenges in Primary Care Setting and Impact re: Behavioral Health Care (continued)

- Screening in the primary care clinic: at initial visit for behavioral health (BH) disorders
  - Substance use disorder treatment staff conducts screening for addiction; refer as appropriate
  - Insurance companies and the current guidelines recommend six months of abstinence from alcohol and drugs
  - Stabilized mental health symptoms is the ideal, support is a greater factor

Common Challenges in Primary Care Setting Impact re: Behavioral Health Care (continued)

- Co-morbidities (HCV and other chronic illness)
- Other chronic medical illness must be stabilized prior to treatment
- Prior to treatment initiation, medical screenings required include:
  - Cardiac stress test (Age >50),
  - Ophthalmology screening
  - Thyroid tests
  - Psychiatric clearance (as noted)

Common Challenges in Primary Care Setting Impact re: Behavioral Health Care (continued)

- Episodic care vs continuous care
  - Consistent primary care a requirement for Hepatitis C treatment
  - Must address barriers to primary care engagement (includes transportation, stable housing, social supports and stabilized co-occurring disorders including behavioral health, chronic medical illnesses, etc.)
  - Refer those without a Primary Care Provider to a Patient-Centered Medical Home Clinic within our hospital system

Common Challenges in Primary Care Setting and Impact re: Behavioral Health Care (continued)

- No shows for appointments
  - Established follow-up outreach phone-calls, or other preferred communication for missed appointments
  - No shows or failure to respond to outreach efforts may indicate patient is not ready for treatment

Common Challenges in Primary Care Setting and Impact re: Behavioral Health Care (continued)

- Referral to other social services (medications, income, shelter)
  - Housing needs to be stable for successful treatment (interim housing is acceptable if stable for duration of treatment)
  - Transportation barriers should be addressed
  - Expectations made clear on required number of visits, lab work
  - Building Community Network: Future goals are to better clarify the appropriate timing of the referral and best use of limited resources

Creating/Using Windows of Opportunity for Education

- Comprehensive Counseling
  - Medication Handling
  - Failures to Medication-missed doses
  - Controlled Medication Delivery
  - Alcohol Intake
  - Tylenol Use
  - Side Effects
  - Insurance Requirements
  - Lab Outcome Requirements

Expectations for Outreach

- Any contact with patient is an opportunity to discuss importance of adherence to Hepatitis C treatment
- Overlaps with the opportunity to discuss their adherence to other medical treatments
- Also represents an opportunity to talk about recovery from mental illness and substance use disorders
- Education to Case Managers and other support staff has been focused on screening for Hepatitis C

Obtaining Maximum Benefit From Limited Resources

- What gives the best return for outreach, prevention, education, treatment efforts?
  - Patients who are already engaged with primary and behavioral health care (i.e., in opioid replacement, integrated care)
  - Patients already being treated for other co-morbidities (including behavioral health disorders)
  - Patients who are housed (even temporarily) vs those who are homeless

Summary

- Best outcomes are among patients who have:
  - Stabilized MH/SUD, especially SMI (first priority)
  - Established primary care provider relationship
  - Addressed medical co-morbidities
  - Addressed social issues (housing, support, transportation, etc…)

3rd Poll Question

Does your organization vaccinate for Hepatitis A and Hepatitis B among those patients found to be at risk?

a) Yes b) No c) Not sure

(Note – we will also pause for Chat Box questions from audience and discussion)

Questions ?

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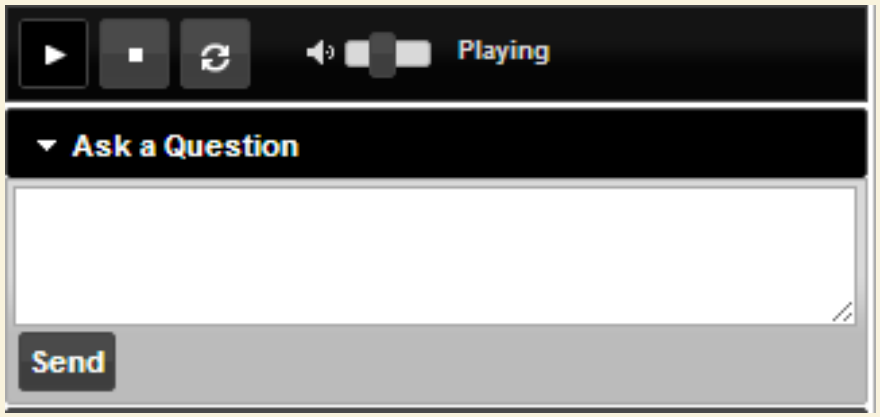

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