CONNECTING CARE PODCAST // EPIDSODE #9 // TRANSCRIPTS

Holistic Care for Hepatitis C: Experiences from Boston Health Care for the Homeless Program

Alex Walley:

Preventing and treating Hepatitis C should be a public health priority but it often goes overlooked, especially in communities facing a myriad of other immediate challenges like housing insecurity, substance use disorder and poverty.

Jessica Taylor:

We need to be recognizing where Hep C sits in the syndemic of overdose and opioid use and homelessness and incarceration and poverty and racism and there's just so much challenge out there for people to navigate and hepatitis C treatment is important to prioritize. It seems benign because it's very silent and it takes a long time to progress. Also, there is an absolute public health argument here to be eliminating hepatitis C and that's been articulated by the World Health Organization and we are far behind where we need to be.

Alex Walley:

You're listening to Connecting Care. I'm Alex Walley an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. Today I'm joined by my colleagues, Dr. Jessica Taylor, Dr. Sim Kimmel, and a special guest Maggie Beiser a nurse practitioner and the director of hepatitis C virus services at Boston Healthcare for the Homeless Program. This is the second of a two-part series about treatment for hepatitis C among people with opioid use disorder. During today's podcast we're going to take a closer look at some of the challenges and opportunities related to treating hepatitis C among people who inject drugs and learn from a program which has successfully delivered hepatitis C treatment to vulnerable patients, experiencing homelessness.

Alex Walley:

You're listening to Connecting Care, the intersection of HIV and opioid use disorder. I'm Alex Walley, I'm an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts and I'm joined again by my colleagues, Dr. Jessica Taylor and Dr. Sim Kimmel. Last podcast we describe the intersection of hepatitis C virus and the opioid and HIV epidemics. We discussed the tremendous opportunity we have to treat hepatitis C among people with opioid use disorder and also some of the clinical and policy challenges preventing hepatitis C elimination among people who inject drugs. Today we're going to take a deeper dive into some of these issues and learn from a program which has successfully delivered hepatitis C treatment to vulnerable patients experiencing homelessness. We're thrilled to be joined by Maggie Beiser, a nurse practitioner and the director of hepatitis C services at Boston Healthcare for the Homeless Program. Hi Maggie.

Alex Walley:

One of the issues we focused on during our last discussion was about the importance of delivering hepatitis C treatment to people who use drugs wherever they are, including in primary care, addiction treatment and harm reduction settings. You're here today, you developed and lead a robust hepatitis C

treatment program at Boston healthcare for the homeless, you and your team deliver treatment to a group of patients who many other hepatitis C treatment programs would have excluded. Thank you for being with us and all that you do. Can you tell us about your program, how did it start? What gaps did you see that needed to be filled?

Maggie Beiser:

Thank you Alex for having me, I'm really happy to be here. So our hepatitis C treatment program was founded in 2014 but there were underpinnings that began earlier than that and actually in 2011 we were the recipient of a Special Projects of National Significance grant to try to improve hepatitis C treatment access for people coinfected with HIV and unfortunately the drugs were still pretty toxic and poorly tolerated and not very effective and we only treated two people but we did learn a lot and were able to develop a lot of sort of comfort and expertise with hepatitis C treatment assessments and decision-making and liver health assessment and that led us to being able to feel confident that we could do this in primary care but there are a number of other factors. So Monica Bharel who's now our commissioner of department of public health had published some claims-based data describing that 23% of patients at Boston Healthcare for the Homeless Program had hepatitis C and that that contributed to disproportionate hospital utilization and cost.

Maggie Beiser:

And then Travis Bagets mortality study which the headline on that was really that drug overdose is the main cause of death for our patients but additionally they looked at cancer deaths and other causes of death and found that liver cancer deaths were disproportionately experienced by our patients compared to age matched controls in Massachusetts. So we had a high prevalence, we had morbidity and mortality and we had some internal data suggesting that very very few of our patients were getting treated and then we had some new clinical expertise to bear and all of a sudden in 2013, 2014, we had these incredibly effective, shorter, better tolerated medications available to us and so it was really a confluence of those things that led us to decide that we could take this on and integrate it. I had some additional support from the Kraft Center for Community Health to work on developing a policy and so we got going in 2014 and at this point we've treated over 1,000 patients and our team has grown considerably.

Jessica Taylor:

This is a podcast so folks can't see us right now but everyone else who's on right now just clapped when Maggie said they treated more than 1,000 patients. We're all just really incredibly grateful and impressed by the work that your team has done and we all practice in Massachusetts but our audience today is across the country and we know that across the country people face a lot of different barriers to accessing treatment, which can include program restrictions, insurance restrictions, even just to become eligible to be treated and we were wondering if you could walk us through a particular patient's journey, maybe someone who's actively using substances and perhaps actively injecting drugs and talk us through how your program is able to support them in overcoming all of the potential regulatory, programmatic stigma based barriers to get them to be able to start treatment and then stick with treatment to have a successful outcome?

Maggie Beiser:

Absolutely and I will say right at the outset, those restrictions, so many of them, most of them are not evidence-based and there has been a lot of work over the last several years to remove restrictions related to abstinence, fibrosis criteria provider type, those have been grassroots efforts made on the

part of states and providers and consumers and so this has been an really incredible area of advocacy over the last seven years but there's still a lot of work to do and one of the things as a clinical program that we can do is try to navigate this process as expertly and efficiently as possible even when some restrictions and barriers still exist and so at Healthcare for the Homeless we have treated so many people but to share one particular case with you, I want to tell you about a couple actually. So we had a male and a female couple both 36 years old that actually walked into clinic a couple of months ago.

Maggie Beiser:

And they said we have not used substances in the last week and we are here because we want Hep C treatment and we take referrals from all over so people can come to our hepatitis C treatment program by self-referring, we also take referrals from all members of our staff, case managers, nurses, providers, front desk staff, what have you, as well as our external partners like the syringe service program and all of those referrals are sort of funneled through one point of contact which we don't have a formalized hospital referral process which we think basically slows things down and then usually patients meet with a nurse or a provider and get a baseline history in labs and then when we have all of the clinical information we need, we pass that to our care coordinators who navigate the prior authorization and pharmacy navigation pieces which are different and frustrating depending on which one you're looking at, some are fast, some are slow, many are frustrating.

Maggie Beiser:

And hopefully in those cases we're able to get people sort of from that point of initial contact to treatment decision making about which medication we're going to use and then start them medication usually within about two weeks and so when people are on treatment, there are a lot of different ways that we try to support adherence. There's actually great evidence at this point that in a lot of settings hepatitis C adherence support can be fairly minimal. The MINMON study recently published actually just contacted patients twice from treatment initiation to SVR and showed really great outcomes. We don't find that in our program to be the most successful and so actually what we try to do is really optimize adherence from the very beginning and at the very least, we are talking to people on the phone once a week or texting once a week.

Maggie Beiser:

And then we also are able to do more intensive support like weekly visits and just giving patients a week of medications at a time. Sometimes we can do directly observed therapy either in the clinic or out in the field and a lot of that is done in collaboration with our other sort of Boston Healthcare for the Homeless staff that are out there already. I know you interviewed Meghan Sandra earlier. She is a wonderful champion for us and for those situations that call for it. So we have looked to minimize labs. We've tried to minimize really touch points that were not necessary especially since COVID and really work on trying to retain people from treatment completion to SVR which I think is still a pretty big challenge for folks who are not super well connected to care otherwise.

Sim Kimmel:

Thank you and I just want to highlight something you said that we really cannot emphasize enough which is that past restrictions on eligibility for hepatitis C treatment have not been evidence-based, really they've been arbitrary and when we talk about this we're talking about requirements for example, to be sober for six months or to have reached a certain level of fibrosis. In the past these requirements really effectively excluded people with substance use and especially ongoing substance use from treatment but they are not necessary and Maggie your program has demonstrated just how possible it is

to treat people that are actively using substances have recently used substances, have different degrees of fibrosis. So if you're practicing in an area still facing this with your insurers or your programs, really great opportunity for advocacy to make this treatment as available as possible.

Maggie Beiser:

I'm not sure if you're interested but we have recently updated our research and I can share that in 867 patients treated almost 92%, so 91.8% completed treatment and then 78% presented for SVR. So we do still lose track of folks in that moment, that doesn't mean they're not cured it just means they're hard to bring back and of the ones who did come back, 87% are cured and that's on par with all of the other sort of general population evidence for a sustained virologic response. When you look at intention to treat, everybody who starts medication, 68% are cured and so we're looking really intensively about how to retain people through the process. Where are we losing track of folks because SVR is not reflective of medication efficacy at this point, it's really reflective of your ability to support and retain people and maintain contact.

Alex Walley:

What's your estimate Maggie of those people you've successfully treated? What's their substance use profile?

Maggie Beiser:

So in the entire population of people that we started treatment on, 68% of them were diagnosed with an opioid use disorder and about 75% were on medication for opioid use disorder and 45% reported any drug use in the last six months. When we look at factors associated with lower likelihood of SVR, the variables that emerge are related to substance use and housing. So recent substance use and being unstably housed, being younger, and actually being referred from an external source, so from a residential treatment program or a syringe service program were all associated with lower likelihood of cure, although we have to consider that that is reflective of also being just left to follow up for SVR assessment and a lot of those not cures are actually reflective of lower adherence. So there are some statistically significant differences there. We think that means that we need to be doing more focused intervention and support for people who are more vulnerable.

Alex Walley:

I'll just add that from a public health perspective and I think we brought this up in the last podcast is that those factors that you mentioned are actually compelling reasons to treat rather than to not treat so just because the success rates may be not as good in that population doesn't mean that we shouldn't be treating them, in fact those folks are also the people who are most likely to probably transmit the virus so from a public health perspective, I think it's really compelling that we do everything we can and instead of pulling back and not offering treatment, it's a reason for us to actually lean in and do more just like you all are doing.

Jessica Taylor:

I was just going to say I think what I take away from that is we need to be doing more and we need to be doing it better and there is evidence for treatment as prevention. We have good data on that from Australia and Iceland and also we need to be recognizing where Hep C sits in the syndemic of overdose and opioid use and homelessness and incarceration and poverty and racism and there's just so much challenge out there for people to navigate and hepatitis C treatment is important to prioritize. It seems benign because it's very silent and it takes a long time to progress but there are other factors besides

hepatic factors that have impacts in terms of risk for developing diabetes or cardiovascular disease, quality of life but also public health. There is an absolute public health argument here to be eliminating hepatitis C and that's been articulated by the World Health Organization and we are far behind where we need to be.

Alex Walley:

Yeah, I think those numbers are incredibly impressive and I think if you were to ask random people off the street what percent of people who are recently using drugs and experiencing homelessness would complete treatment, that it's an order of magnitude higher than what people might expect. One thing I wonder about is the patients who come to the clinic, there's an initial assessment and then there's this time period where you need to navigate to get the medications and get the prior approval, do you lose a lot of people during that process and the process of getting labs or that initial assessment?

Maggie Beiser:

I couldn't quantify it for you easily but yes, I think there is absolutely some drop-off there and in general, those kinds of barriers don't really, at this point 7 years into these very effective, very straightforward medications for which we have very simplified guidelines, there's not a lot of benefit to those types of barriers. I'm never going to make an argument to support prior authorizations but I think even more so now it is very clear that they are delaying care and they're presenting more challenges than providing benefits. So I think especially in places where they have the ability to do finger-stick NAAT testing to confirm RNA which unfortunately is not approved in the United States yet, a lot of places are moving to a test and treat model and so we say, you have hepatitis C, this is curable. Let's treat you now, here is your medication.

Maggie Beiser:

And I think that goes a long way to retain people. I mean, we do that with everything else really. Your blood pressure is high, here's a medication. You have diabetes, here's a medication and I will see you back with whatever adherence plan you need and to introduce so many barriers that are really cost driven and not evidence-based is problematic and challenging. It's interesting and I heard your last podcast and one thing I just wanted to clarify, the medicine was never $1,000 a pill. Camie Graham was wonderful at articulating that, that all of these medications, really the headline for them when they were approved was about cost rather than cure and nobody ever paid the headline price that every payer negotiated their own discount and over the years, those discounts have gone down and down and down and Medicaid, the CDC has actually done the research, how fast do we make our money back on treating rather than not treating in terms of the cost burden for people who have hepatitis C and we're there, it is more costly to not treat than to treat.

Alex Walley:

Thank you for adding that incredibly important and for the clarification too. You've treated a lot of patients and you've got a lot of stories, what have you learned? And what's been most surprising about this work?

Maggie Beiser:

This is my favorite work to do really. I have absolutely loved it and I went into primary care as a nurse practitioner wanting to sort of specialize in something that ended up being HIV which was very exciting and evolving and then hepatitis C was in another order of magnitude rapidly evolving and exciting but in the end it's really the most satisfying to work with patients over time and be able to work with them to

reach their goals and talking to people what I hear a lot is that getting Hep C treatment is something that people associate with, whether or not it's recovery, their own care of themselves, that they are proud to be able to do this for themselves, that they feel really glad that they can do it and it helps sort of springboard them potentially into other engagement and care but we don't get to cure people that much, both from a medical provider standpoint and then patients don't necessarily get that kind of win.

Maggie Beiser:

And so being able to do this with folks who really don't have a lot of wins in general, I think it can be really powerful and in a lot of cases brings folks into other aspects of care that they might also benefit from. One thing that we've really tried to do across the board from several years ago now is we integrate into our formatted intake process, always asking about, do people want medications for OUD? When was the last time they were tested for HIV and do they need Narcan? And then also sort of pregnancy and family planning concerns.

Maggie Beiser:

So from the very beginning, people are like, yes, maybe, no, not ready and as you develop this relationship through the treatment process people become more interested or more ready and when you're seeing people weekly for meds, they might say actually, I do want start Suboxone or buprenorphine and so I can say, here's your prescription. I'm going to write it for you as your Hep C treater and also a buprenorphine prescriber and also let's update your HIV testing and start prep, that fits so well in a community health center setting or a setting serving people who are homeless, not making it you need a referral to another appointment or another building or another time. This works so well to go together for these folks.

Alex Walley:

I just want to reiterate that concept that you just laid out, which is that there's something about hepatitis C treatment in this population that is a magnet to the rest of other care. It's actually a powerful engagement strategy which I don't think is necessarily intuitive. I think you sort of marched out several of the reasons which are that it's curative. I've noticed that my patients are really interested and concerned about their hepatitis C and then what follows from that is they're very motivated to get treatment relative to some of the other things you mentioned on your list which we've talked about on this podcast, like prep, for example, prep is a serious sales job and we think we're being more and more successful but it takes a lot of effort and we need to do better in making prep more appealing to people.

Alex Walley:

Even HIV care or HIV testing unfortunately because we have a new surging epidemic, HIV testing and HIV treatment is an easier sell but there were many years where we just couldn't really get many people interested in HIV prevention and you mentioned opioid use disorder, treatment, buprenorphine, and methadone, and for people who are interested in treatment, that's very appealing but there's many people out there who just, this is not their interest right now but they are interested in hepatitis C treatment. So I'm reiterating this back to you. I guess my question is since 2013, 2014, have you seen the interest, the motivation on the part of patients, has it increased? Has it decreased? Are we starting to get to the end of the enthusiasm search for hepatitis C treatment?

Maggie Beiser:

That is a very good question. I feel as though we are seeing a little shift in the last year or two and I also think it goes in waves and I think it also depends on where we have a presence and so at residential

treatment programs where people are sort of newly motivated in a lot of different directions, we have a lot of interests sort of consistently across the board and for folks who are actively using substances for some, it is a priority and for some, it is not at all a priority and I think we're always wanting to have an open door policy and very very good education to make sure that people know that even if they're not ready now, that that is possible whenever they are ready and so as an example, a patient that I had seen, we actually treated him a few years ago and he achieved SVR and he was Hep C free for several years.

Maggie Beiser:

And he was recently re-exposed and we identified new infection that needs to be treated and he's in a space where people are injecting very very frequently for the most part, five to 10 times a day or more which is pretty typical in the environment where we are now and he was pretty concerned about his ability to avoid sharing any equipment cooker or water or anything like that and so I think that when you put that Hep C conversation into the context of active substance use, what you always need to be leading with is you deserve to be treated. You deserve to be cured. We want to treat you, we don't need to wait. This is a very very simple treatment and it's very well tolerated. It's extremely effective. We can do this now. I respect you. I want to treat you as you need to be treated.

Maggie Beiser:

And I also want you to understand what the likelihood is of re-exposure is a really tough conversation because I want to treat as many people as possible as quickly as possible so that that community viral load, that risk of re-exposure goes down and also it is a true fact that the risk for re-exposure reinfection is exceptionally high and hepatitis C reinfection is a story of, are we treating enough people? No. Is there enough harm reduction supplies in the setting? No. Are there enough treatment beds or is there enough access to medications for OUD and no. We are all, I think working overtime to try to improve those things and have made pretty significant inroads and we're still not there yet. Unfortunately we don't have 24/7 syringe exchange. We don't have supervised consumption spaces that might be able to reduce the potential of sharing.

Maggie Beiser:

We don't have enough treatment for homeless folks who want to get out of the environment they are in and every single person I treat for Hep C takes at least several days to get approved and medications in hand, if we could bring a lot to bear. I had told Sim earlier that my greatest wish is to be able to rapidly identify a group of people who want to get treated together and start them together and give them directly observed therapy in the field. So treating a network of users treating. We've done this with couples. I think we need to expand it much more broadly perhaps through working with syringe service programs or other places that are really outreach focused already to treat a big cohort together. People are going to continue to be re-exposed if we don't work on improving all of these things and I have control over one area of that space, I can't fix everything but I think we have to recognize that it's not just one intervention that will make a difference.

Sim Kimmel:

Thanks Maggie, that's such an important point. As we think about reinfection, I find that the way that you just presented it was talking to a patient about their individual risk profile, what they see as the pros and cons of being treated now in this moment compared to at another time and really making a patient-centered decision. I think when I talk to people about doing this work, I find that other providers often overestimate the risk of reinfection. When I mentioned that our program treats people that are actively

using substances be it by injection or intranasally, I hear a lot of stigma frankly and a lot of, well they'll just get reinfected, I think is a phrase we've all probably heard in our work and so I'm wondering if you could say a little bit more about what reinfection rates you do see in your population and perhaps how that compares to other populations that get treated for hepatitis C?

Maggie Beiser:

Sure. That's so many things to say. When people say they're just going to get reinfected, I kind of want to say, so what. [inaudible 00:24:49] to be doing better at this. The international meta-analysis out of Australia describes a reinfection rate among people who inject as around five reinfection per 100 person years in our research, our reinfection rate has remained pretty steady over the last several years at about 13 reinfections per 100 person years. So that is more than double what is reported internationally and you always have to remember that other countries have an incredibly different approach around all aspects of hepatitis C care and the care of people who use drugs but I think, to say it is what it is, is a very obnoxious thing.

Maggie Beiser:

We're going to see reinfection, it's a part of this process. There are wonderful experts out there that would say, if you're not seeing reinfection, you're not treating the right people but I think it is a sign that we are not doing enough to treat enough people with enough additional harm reduction and access to treatment for opioid use disorder. I think you can't divorce one from the other and I think the ideal is you identify reinfection and you retreat immediately. That is a new infection. It's not complex. It's just the same as treating them as if they're treatment naive. The medicines are going to work and as the medical providers, it is our job to not shame people.

Maggie Beiser:

It's our job to tell them that's okay. We can deal with this. One of my patients I've been taking care of for several years after an extended stay in the house of correction who was treated while incarcerated just recently, he was re-exposed and the very first thing out of his mouth was, are they going to treat me again? Are they going to pay for me to get treated again? What are we doing? It's ridiculous. This is just so frustrating that culturally we have done this.

Alex Walley:

Well, there's so many positive public health messages that we struggle to get out and somehow we've been very effective at getting out the message that these medications are expensive and people who use drugs are not worth it to treat and I'm mixed about whether there was some conscious campaign to do that but it's not only a issue that providers have but it's been internalized by a lot of people in the community and it's just amazing to me how that message has been so pervasive and Maggie you pointed out how, it's not even as expensive as people think it is.

Alex Walley:

So anyway, I'm just reflecting back that we needed to do a better job of understanding how this message has gotten out and use those methods somehow to get out more positive messages around hepatitis C. So you alluded in your summary of the reinfection studies in Australia, that in international settings, it's actually not a given that people who inject drugs are going to be infected with hepatitis C, it really is or it has been a given in the US that a large proportion of people who inject drugs in any cohort are going to end up with at least a primary infection with hepatitis C.

Alex Walley:

Can you reflect a little bit on what it is they're doing in other countries that we could learn from, I think you've already alluded to many of those things but if we didn't have any more treatment, if it is restricted, what should we be doing?

Maggie Beiser:

Well, first off, I don't expect that to change. I don't expect things to become more restricted hopefully but when I have talked to my patients about their risk behavior and our first question usually is when did you first learn you had Hep C or do you know how you may have gotten it, and over and over again what I hear are people who are worsening in their opioid use disorder and a increase or sort of a greater intensity of their use going from sniffing to injecting and not knowing how to do it and having somebody else do it for them or do with them, and then not knowing necessarily what their risk is around any sort of bloodborne illness in that moment and that's heartbreaking to me and I think so much of what other places do is the intangible like have less stigma, have fewer people sort of behind closed doors, trying to navigate things and dangerous situations without any help or any education and being afraid and vulnerable.

Maggie Beiser:

That's a very sentimental way to talk about it but I think that in the US we are bad at talking about sex and drugs. We do this also with sexually transmitted infections. We do this with HIV. We're just bad at it and this is a cultural thing we need to fix and improve upon and other places I think approach substance use in, whether it's decriminalizing drugs or having supervised consumption sites or just broader syringe access. We talked to our colleagues in other states who can't even get syringe access. I'm sure you probably have met him. There's a wonderful doctor who works on the Cherokee Nation in Oklahoma and their tribal council didn't want to enact syringe services there even though they knew that they needed it because they didn't want to be the only place in Oklahoma that had it and that would further stigmatize the Cherokee population there. We are shooting our own foot in so many ways and I think other countries have been better about recognizing evidence and where the science leads us in terms of reducing harm.

Alex Walley:

Thanks so much for sharing all those thoughts. I mean, it's incredibly powerful and you refer to that as sentimental but it's quite moving to hear you talk about your work and your passion. We've talked a lot about clinical challenges, how to improve adherence, we've talked some about syringe service access and also safe consumption and stigma. If you were the head of the Department of Public Health or even bigger, setting policy at a federal level, can you talk about some of the changes you'd like to see?

Maggie Beiser:

Sure. One thing I realized I've neglected to mention is how much we benefit from the investment in the support services in our program, which are funded by the Department of Public Health and so we have intentional investment on the part of the Department of Public Health to fund our care coordinators, a data manager, part of a nurse's time and those really tangible benefits result in people having the time to bring medications all over the state. My care coordinator brought meds to Lynn, Brockton, Framingham on Monday for patients who were in any number of situations and scenarios and the adherence support works. I've mentioned phone calls and texts but it also includes driving places and dropping things off. It involves going to hospitals and bringing, these very granular things like handing

medications to one hospital and making sure that they get to the next hospital are some of the only reasons that people are able to remain on care even after starting.

Maggie Beiser:

So those investments are not broad. We're one of the few programs in Massachusetts that benefits from that kind of investment and what I hear from my provider colleagues and other health centers is that they are not given any time or support to operationalize this and so people who use drugs, people who are marginalized are not going to hospitals and not necessarily even coming to our health center, they are in communities all over the place and we need to be able to educate and support providers in all of those spaces to integrate this into their work and that takes money. That frankly takes a very intentional investment. So I think that is a near term thing that I think would make a difference. I think things like removing prior authorizations that are no longer clinically beneficial or cost saving oriented, we could argue that for a while.

Maggie Beiser:

I'm going to be talking to some pharmacists in October and I'm excited to talk more about that but eight states have now removed the prior authorization. I think those are near term. I think if I were talking to Dr. Bharel now, I would want to stress how important it is to retain hepatitis C in the conversation of these vast leaps and bounds that are being made for people who use drugs. There is a lot of investment in drug user health and HIV happening rapidly and hepatitis C is often getting left out of the conversation. I totally agree that we need to be number one, keeping people alive, preventing overdose and trying to prevent HIV and treating HIV but when we don't include hepatitis C in the conversation which is endemic in that population, we're saying that it doesn't matter and it does.

Maggie Beiser:

It really does and I know all of you have taken care of people with advanced liver disease on the floor. We see them they don't necessarily go to see hepatology but we are managing them in the shelters and on the street and it's horrible and just because people look healthy now, if we don't prioritize things now, nothing will sort of transfer down the line. I think I've hit on some of the other things. I think a lot of the same public health strategies around harm reduction for people who use drugs are relevant here too.

Alex Walley:

I think treating networks of people who are using is a genius idea for what it's worth.

Maggie Beiser:

If you can figure out how to do it, I will help you. And it's really interesting I think recognizing the main priorities in the space of people who are actively using, particularly in the half mile radius of where we work and recognizing that adding more cooks into the kitchen and more people into that space isn't necessarily what will be helpful but strengthening and improving the depth of the staff that are already there to incorporate these other things is I think probably how that kind of thing might work and I also know that the people doing the day-to-day work on the ground, there are 1,000% overextended and unfortunately the intensity of overdoses and minute to minute safety considerations, wound care, maintaining people on prep is of absolute paramount importance. I readily agree that this is not the top priority but I think that we do a disservice by not including it in the conversation and so I think we will always want to think about how can we include this and incorporate this into our care.

Sim Kimmel:

Maggie I think you made the point incredibly well earlier that our patients' top priorities are not necessarily ordered by medical acuity and so if the hepatitis C treatment isn't prioritized and easily accessible and desirable in the way that it's offered, we then miss the next opportunity to pull someone in and engage around the substance use disorder or the HIV prevention piece or the vaccination piece or whatever comes next. I was just thinking back when you were talking to a conversation I had with someone recently who is at very high risk of a bad outcome from COVID-19 so has all of the co-morbidities that would put someone at risk of severe infection and complications of COVID-19 and I couldn't sell a COVID vaccination. I mean, all of the screening tools we learned, I tried and tried couldn't sell it and what he said is, no I want you to treat my hepatitis C because I could die from that.

Sim Kimmel:

I could have liver failure and as the physician of course, it's easy to react the hepatitis C thing is going to be an issue in 20 years or 10 years, we have a COVID outbreak going on right now and people who are unvaccinated we can't control their risk their at an extraordinarily high likelihood of being infected but it's humbling and a good reminder that we don't get to set priorities for our patients. We really have to look to them to tell us what is most important today and where they want to go next and be flexible and not as focused on the medical model and the medical acuity as driving priorities.

Jessica Taylor:

My first thought also is I wonder if you asked him why and my guess is that that person has had an experience with somebody else dying of liver disease close to them. I know what cirrhosis looks like. I am terrified of that. We need to do something about that now and I think I'm always trying to remember that a trauma informed approach is always useful and appropriate to employ even when we think that we're sort of talking on some very straightforward level. It's interesting and I think the benefit of having primary care providers trained and able to include hepatitis C treatment in their arsenal of tools just like buprenorphine prescribing or prep prescribing is you can respond with whatever the person's leading with. You don't have to say, well that's not important, you're going to have to go see this other person. So let's forget that.

Jessica Taylor:

And then you've dismissed that person and not met their need and they will remember that. These types of traditionally lived in a specialist land but they don't need to and there's wonderful evidence on the high quality of care of Hep C treatment in primary care by docs, NPs and PAs. In Scotland there's a wonderful data on pharmacy led hep C treatment models and so in some ways I think of it as a very special thing that we should prioritize and on the totally other hand, I'm like this is a normal primary care thing that we should just integrate and make it as routine as possible to lower the barriers so that people can access it wherever they are.

Alex Walley:

Well said, I think what's emerging from this second hepatitis C podcast that we've done that is a recurring thread throughout the whole series so far is this concept of a package of services that I think we can call together drug user health that are complimentary and not in competition. So we've given a lot of examples or Maggie, you've brought us a lot of examples today of how hepatitis C can be that magnet, it's the one thing of all the things that we've talked about that is curable. There's a lot of prevention that we can do but in the world of people who are facing lots of adversity, prevention is

usually not first on their list and we have to relentlessly work to try to elevate that and make prevention more accessible.

Alex Walley:

And the other piece that you brought up which has come up in other podcasts is the real advantage of multidisciplinary care in drawing on the strengths of not just the medical model but also outreach, social services, mental health, and what you were talking about today was even network care and that doesn't just work for hepatitis C, that works for all the other things that are part of that package. So thank you so much and I hope that a lot of people get to hear this podcast and we're going to build on what we learned today in future podcasts and I imagine we may ask you to come back to share more of the magic that you're getting out there.

Maggie Beiser:

Thank you very much for having me. I was really glad to talk today.

Alex Walley:

You're listening to Connecting Care. Our program was produced today by JSI and Boston Medical Center. Connecting Care is supported by the HRSA funded project Strengthening Systems of Care for People With HIV and Opioid Use Disorder. The project aims to enhance system level coordination and networks of care among Ryan White, HIV/AIDs, program recipients and other federal, state, and local entities. You can learn more about the project and find resources www.ssc.jsi.com.