

Perceived Barriers Related to the Management of HCV Infection Among Physicians Prescribing Opioid Agonist Therapy: The C-SCOPE Study

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Abstract

Background: The high prevalence and burden of HCV infection among people who inject drugs (PWID) attending clinics for opioid agonist therapy (OAT) make this an ideal setting for targeted strategies to enhance HCV testing, linkage to care, and treatment. This study evaluated perceived barriers to HCV care among physicians practicing in clinics offering OAT.

Methods: C-SCOPE is a study consisting of a self-administered survey among physicians practicing at clinics providing OAT in Australia, Canada, Europe, and the United States during April and May 2017. A 5-point Likert scale (1=not a barrier, 3=moderate barrier, 5=extreme barrier) was used to measure responses to perceived barriers for HCV testing, evaluation, and treatment across the domains of the health system, clinic, and patient.

Results: Among 203 physicians (38% practiced in a substance use center, 29% psychiatrists, and 40% from a city >500,000), the majority perceived HCV testing (85%) and treatment (82%) among PWID as important. Many physicians perceived that patients should be stable on OAT (52%) and with regard to alcohol use (58%) in order to receive HCV treatment. Major perceived health system barriers to HCV testing, evaluation, and treatment included lack of funding for non-invasive liver disease testing (mean 2.78), long wait times for patients to see an HCV specialist (mean 2.71), lack of funding for new DAA therapies (mean 2.76), and reimbursement restrictions based on drug and/or alcohol use (mean 2.73). Major perceived clinic barriers included the need for off-site referral for liver disease assessment/treatment (mean 2.31), lack of peer-support programs (mean 2.27), and the lack of case managers or link-to-care coordinators (mean 2.35). Major perceived patient barriers included patients having difficulty navigating the health system (mean 3.01), non-attendance for referral appointments (mean 3.01), patient fear of side effects (mean 2.99), and lack of motivation to receive treatment (mean 2.90).

Conclusion: Physicians treating HCV infection among PWID attending OAT clinics recognized the importance of HCV testing and treatment for this population. This study highlights several important, potentially modifiable barriers to enhance HCV testing, evaluation, and treatment for HCV infection among PWID attending OAT clinics. Further research is needed to better understand physician-perceived beliefs about patient treatment readiness.

BACKGROUND

- Hepatitis C virus (HCV) is a major health problem both in the U.S., affecting 2.7 to 3.9 million people,¹ and globally, affecting 71.1 million people²
- The prevalence of HCV is high among people who inject drugs (PWID)³
- There are barriers to HCV care at the level of patient, provider, system, and society⁴
- In the DAA era, little is known about barriers to HCV care for physicians and physicians' perceived competency to test, manage, and treat HCV infections among PWIDs at clinics offering opioid agonist therapy (OAT) to treat HCV

OBJECTIVES

- To evaluate the perceived barriers to HCV care among physicians practicing in clinics offering opioid agonist therapy to treat HCV

DESIGN/METHODS

Data

- Data from the 2017 *Survey on the Management of HCV in Addiction Clinics Treating Patients on Opiate Agonist Therapies (C-SCOPE)* were analyzed
- C-SCOPE is a self-reported, cross-sectional survey of physicians practicing at clinics providing OAT in the United States (U.S.), Canada, Europe, and Australia
- Respondent physicians were identified via opt-in online web panels, research databases, and/or public and proprietary lists of clinics providing OAT in each country
- Respondent physicians completed an online survey regarding their knowledge, attitudes, and practice patterns toward HCV screening, diagnosis, or treatment

Sample

- The present sample included physicians practicing in clinics providing OAT across the U.S. (n=82), Canada (n=16), Europe (n=92), and Australia (n=13) (Total N=203) collected between April 2017 and May 2017. European countries included: Belgium, France, Germany, Italy, Portugal, Netherlands, Spain, Sweden, and the United Kingdom (UK)
- Up to 2 physicians per clinic were allowed to participate to ensure a representative sample of physicians within clinics
- Inclusion criteria:
 - Had to specialize in addiction medicine/psychiatry or have received training or certification in addiction medicine
 - Certified to prescribe OAT
 - At least 50% of time spent in clinics providing OAT, treating patients or in management responsibilities
 - Minimum of 2 years treating patients in clinic providing OAT
 - Currently treating people who inject drugs with OAT
 - Working at a clinic, center, department, or institution providing OAT
- Exclusion criteria:
 - Working at same clinic, center, department, or institution as 2 previous qualified respondents
 - Unwillingness to comply with study protocol

Measures

Physician and institution characteristics

- Physicians' institutional characteristics assessed include region of institution (U.S., Canada, Europe, and Australia) and location of institution (metro/urban, suburban/rural)
- Physicians' specialty of medicine was assessed and included the following categories: addiction medicine, addiction psychiatry, psychiatry, primary care provider (PCP)/internal medicine (IM), and other

Self-reported importance of HCV testing and treatment

- Two items used a 5-point scale to measure the level of importance of HCV testing and treatment among PWID
- Response options included: 1=Not at all important, 2=Not very important, 3=Somewhat important, 4=Very important, 5=Extremely important
- Scores were grouped into the following categories:
 - Score of ≤3 = Not important
 - Score of ≥4 = Important

Self-reported perceived barriers for HCV testing, evaluation, and treatment

- Physicians evaluated 29 potential barriers for OAT patients to entering pathways to HCV care (testing and diagnosis) and 35 potential barriers to continuing pathways to HCV care (treatment), for a total of 64 potential barriers rated on a 5-point Likert scale
- Items measured the degree to which physicians perceived barriers for HCV testing, evaluation, and treatment
- Response options included: 1=Not a barrier, 2=Minor barrier, 3=Moderate barrier, 4=Major barrier, 5=Extreme barrier
- Items were categorized as:
 - Health system barriers
 - Clinic barriers
 - Patient barriers

Statistical Analyses

Descriptive statistics

- Descriptive statistics were run and are reported in counts and percentages for categorical variables and means and standard deviations for continuous variables

RESULTS

Table 1. Physician and Institution Characteristics (N=203)

		Total N=203 n (%)
Setting of Institution	Opioid agonist therapy (OAT) clinic or center	31 (15%)
	Substance abuse clinic/center	77 (38%)
	Department in a hospital that treats patients with OAT	41 (20%)
	Other institution or office that treats patients with OAT	54 (26%)
Location of Institution	Major metropolitan area (>500,000)	82 (40%)
	Urban area (between 100,000 and 500,000)	59 (29%)
	Suburb of large city (>100,000)	26 (13%)
	Small city (between 30,000 and 100,000)	27 (13%)
	Rural or small town (<30,000)	9 (4%)
Macro-Region	USA	82 (40%)
	Total EU	92 (45%)
	Canada/Australia	29 (14%)
Physician Specialty	Addiction medicine	43 (21%)
	Addiction psychiatry	40 (20%)
	Psychiatry	58 (29%)
	GP/FP/IM	53 (26%)
	Other	9 (4%)

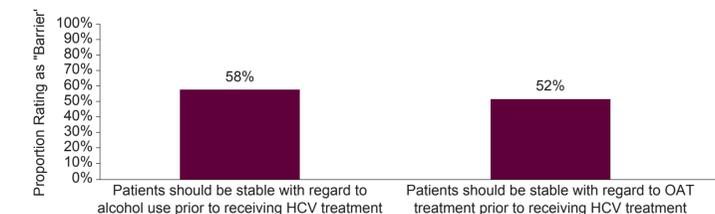
Sample Characteristics

- Among the 203 physicians, 40% were from the U.S. (n=82), 45% were from Europe (n=92), and 14% were from Australia/Canada (n=29)
- A total of 21% of physicians were addiction medicine specialists, 20% addiction psychiatrists, 29% psychiatrists, 26% PCP/IM, and 4% "other"
- A total of 38% of physicians practiced in a substance use center and were from a metro area/city >500,000

Importance of HCV Testing and Treatment

- The majority of physicians perceived HCV testing (85%) and HCV treatment (82%) to be important

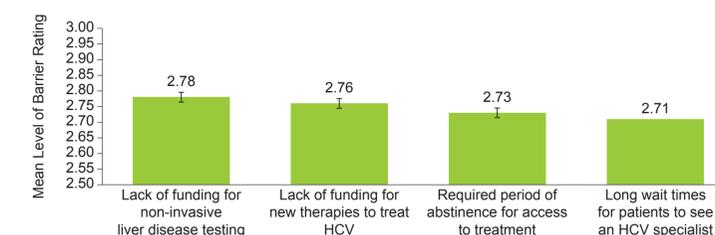
Figure 1. Barriers to HCV Testing and Treatment



"Barrier" included answer choice responses of 5=Extreme Barrier and 4=Major Barrier. All other answer responses (3=Moderate Barrier, 2=Minor Barrier, and 1=Not a Barrier) were categorized as "Not Major Barrier."

- Over half of physicians perceived patients needing to be stable in regard to alcohol use (58%) and on OAT as a barrier (52%)

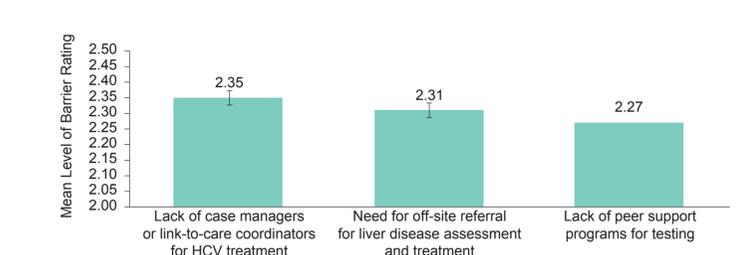
Figure 2. Health System Barriers to HCV Testing, Evaluation, and Treatment



Rating scale 1=Not a Barrier, 2=Minor Barrier, 3=Moderate Barrier, 4=Major Barrier, and 5=Extreme Barrier.

- The most highly rated barriers at the health system level were: lack of funding for non-invasive liver disease testing, lack of funding for new therapies to treat HCV, required period of abstinence for access to treatment, and long wait times for patients to see an HCV specialist

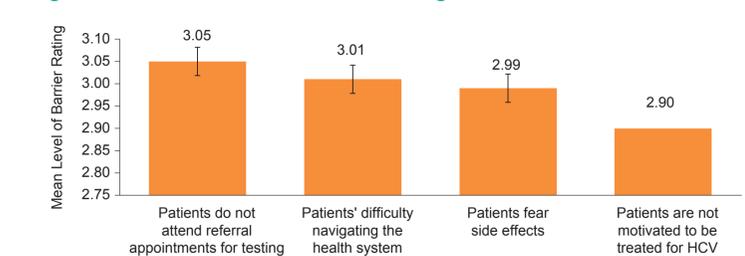
Figure 3. Clinic Barriers to HCV Testing, Evaluation, and Treatment



Rating scale 1=Not a Barrier, 2=Minor Barrier, 3=Moderate Barrier, 4=Major Barrier, and 5=Extreme Barrier.

- The most highly rated barriers at the clinic level were: lack of case managers or link-to-care coordinators for HCV testing and treatment, the need for off-site referral for liver disease assessment and treatment, and lack of peer support programs

Figure 4. Patient Barriers to HCV Testing, Evaluation, and Treatment



Rating scale 1=Not a Barrier, 2=Minor Barrier, 3=Moderate Barrier, 4=Major Barrier, and 5=Extreme Barrier.

- The most highly rated barriers at the patient level were: not attending referral appointments for testing, difficulty navigating the health system, fearing side effects, and not being motivated to be treated for HCV

LIMITATIONS

- Data in the present study are from a self-reported physician survey. As such, the responses are subject to recall bias
- The sampling strategy used in the C-SCOPE study was designed to increase the odds of achieving a representative sample. However, this sampling strategy can only guarantee representativeness at the regional level
- Due to the cross-sectional nature of the data, causality cannot be inferred

CONCLUSIONS

- The importance of HCV testing and treatment is recognized by the majority of physicians treating PWID
- Many barriers exist to HCV testing, evaluation, and treatment at the healthcare system, clinic, and patient levels
- This study highlights some of the major barriers as potentially modifiable targets for interventions to improve access to testing, evaluation, and treatment for PWID with HCV
- Future research should develop possible interventions to target and remove these barriers as well as to understand physicians' perceived beliefs about patients' readiness for HCV treatment

References

- Centers for Disease Control and Prevention (CDC). Hepatitis C FAQs for Health Professionals. <https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm>. 2017.
- Polaris Observatory HCV Collaborators. *Lancet Gastroenterol Hepatol*. 2017;2(3):161-176.
- Nelson PK, et al. *Lancet*. 2011;378(9791):571-583.
- Grebely J, et al. *J Int AIDS Soc*. 2017;20(1):1-8.

