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Hot Topics in HCV: A Multidisciplinary Online Minicurriculum - Activity 3: Anticipating the Impact of the COVID-19 Pandemic on Vulnerable Populations

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DR. FRANCO:
Welcome to Activity 3 in this three-part Hot Topics in HCV Mini Curriculum COVID-19 and HCV, Anticipating the Impact of the COVID-19 Pandemic on Vulnerable Populations. I am Ricardo Franco, Associate Professor of Medicine in the School of Medicine, Division of Infectious Diseases at the University of Alabama, at Birmingham, in Birmingham, Alabama. And with me today is Dr. David Wyles, Chief of Infectious Diseases at Denver Health, and Professor of Medicine at University of Colorado School of Medicine in Denver, Colorado. Welcome, Dr. Wyles.

DR. WYLES:
Thanks, Ricardo. My pleasure to be here.

DR. FRANCO:
While the COVID-19 pandemic has taken such a broad scale toll across all sectors of our society, already vulnerable persons have been particularly hard hit. David, what do you think are the factors behind this disproportionate toll? And how has the impact been manifested?

DR. WYLES:
Sure, Ricardo, I think that's, you know, a great place to start with our discussion about how hepatitis C and COVID-19 pandemic have interacted. And as you point out, vulnerable populations have really been hard hit. There are really a myriad of different potential factors that combine, and many vulnerable populations experience more than one of these factors. It can be financial insecurity, ethnic and cultural vulnerabilities that are maybe perceived, it can be things like domestic violence or instability in the household. And you know, particularly as we've gone through the COVID-19 pandemic, what we've seen, and this has been my personal experience is, a lot of these vulnerable populations have been just dramatically adversely impacted by COVID-19.

I think one of the best examples at our safety net institution, probably 70, 80% of persons hospitalized with COVID-19 have been Hispanic or Latinx. And what you see in a lot of these families, one of the things that's listed here is, you know, financial circumstances. And then place of residence. And what we see is, there's multiple generations living in the same household. And you know, whereas for some folks, it's easy if somebody in the household is maybe sick or not feeling well for them to isolate within the household. In some of these folks that are more vulnerable, they have multiple generations living in one household that maybe has one or two rooms. And so there's no ability to self-isolate in the home. And then with - what tends to happen for a lot of these folks who need to go to work to

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receive a paycheck, they can't stay home, they can't work remotely.

So it's just been all these factors that have kind of come together and really had a disproportionate toll with COVID-19 on this population. At the same time, this is the same population that really is burdened with hepatitis C infection, a higher prevalence, and probably less access to therapy.

And then we can flip it around and talk about the provider side. I think all of us probably come in as much as we try with some biases. And as we talk further in this Mini Curriculum about how to kind of manage hepatitis C through the pandemic, I think one of the things that I've certainly seen in other providers, and I think even in myself, I think about some, as we talk about different ways to provide care and maybe doing things remotely or not necessarily always seeing patients in person before we, say, prescribe hepatitis C treatment, our concerns about adherence, and will they stick with the treatment plan? Can they maintain that can they adhere to the plan? And that's, I think one of the biases that really comes up that needs - to within providers that we really need to work to try to do education on and kind of overcome some of those biases so we can use all the innovative technologies we can to overcome some of the isolation and restrictions from the pandemic to maintain screening and treatment for hepatitis C in these vulnerable populations.

And I've touched on this already, you know, how COVID-19 has really hit these - some of these groups. Some other examples has been during the vaccine rollout, right. What we've seen when we had vaccine rollout, folks could go online to a web portal and register for the vaccine, right? All of our vulnerable populations, that's tremendously difficult for a lot of them. Either they're not native English speakers, they're not familiar with navigating on the internet, you have to specifically outreach, they need to see persons that they're familiar with. So this - person's from their own community delivering the message about vaccine and safety and how to access this care.

And then finally, I'll just say you even need to take services kind of mobily. We looked at this going to some of the more vulnerable counties and districts in Denver in the surrounding communities. Taking mobile vaccination vans and things out there. And that's something we can also look at for hep C, where mobile treatment has been one of the considerations about ways to kind of break down walls and meet people where they are in terms of their access to hep C care and treatment.

DR. FRANCO:
We all said, David. That - there is a lot going on in disparities. And in these statistics that stick with me, is if you look at the counties that are disproportionately black, they comprise 22% of the counties in the nation, but they're - they account for almost 60% of the COVID diagnosis and DAPs, not to mention that the impacting Latinx population like you said so well.

DR. WYLES:
That point is a great one to make. And I think it bears noting that that's even when you control for other medical comorbidities, right? You still see this disproportionate effect of COVID in some of these vulnerable populations that's not, for the most part, explained by perhaps more diabetes or higher levels of metabolic syndrome or obesity. There's something else there that I don't think we have a good handle on exactly what it is. But it certainly impacts these vulnerable populations.

DR. FRANCO:
So David, as we look at the very real possibility of ongoing and future COVID surges despite having a vaccine, how do we think we can do better in supporting these vulnerable individuals living with hepatitis C?

DR. WYLES:
Luckily, I think one of the things that may benefit us is we've already learned a tremendous amount, right, in the last year about some approaches. Obviously, we can get better and better. But I think it's continuing to put effort into maintaining services that were stood up and expanding them with the initial waves of COVID. Keeping those lessons learned and those programs active, even in times where we kind of take a breath and feel like maybe the COVID surge is waning, and we can get back to business as usual. Business as usual, for a lot of these vulnerable populations was really not serving them very well to begin with, right? And so COVID has taught us how to outreach a little better, have maybe more mobile services, colocalizing services, you know, whether it's treatment for substance use, other support services, doing primary care and hepatitis C care together, providing other even basic services, housing, food, you know, things like that. And then however we can wind in hepatitis C services at the same time, is the model that we need to continue to expand on.

DR. FRANCO:
HCV care capacity was tremendously reduced, or perhaps, deprioritized during the first year of the COVID-19 pandemic. What is the data out there that we have on these concerns?

DR. WYLES:
If I look at our own internal data, we have screening data from all our primary care clinics at Denver Health. So we have FQHC, so we have a string of a number of primary care clinics. And what we saw were - was testing or screening for hepatitis C really took a nosedive

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from March, April into June of 2020, almost a 70% decrease in the number of hepatitis C antibody, or antibodies with reflex RNA testing that was done. Now I am happy to say that we've kind of rebounded and in the beginning of 2020, we were actually above what our baseline looked like in 2019. So whether that's some of us playing catch-up to kind of get back on track.

And then maybe one of the silver linings is through COVID, and kind of outreach into these vulnerable populations, we actually saw increased enrollment in our primary care clinics after that. I think some folks in these vulnerable populations really felt with kind of the COVID scare that maybe they needed a primary care physicians.

DR. FRANCO:
What are we to extrapolate from these data? What might we see as the overall impact of the COVID-19 pandemic on HCV care delivery?

DR. WYLES:
Yeah, it's a great question. And as you mentioned, we have to extrapolate really to try to figure this out, or at least put some estimates on it. And so one study that's pretty widely cited that was presented at the European Association for the Study of Liver Disease, their annual conference this June was just that a modeling study used a Markov model and essentially modeled a one-year cessation of hepatitis C treatment activities. And what the figure - what figures were found was showed that with just a one-year delay, you're probably going to experience maybe up to 70,000 excess deaths from hepatitis C-related causes, whether that's decompensated liver disease or hepatocellular carcinoma. And you're going to see an increase - a tremendous increase in viremic infections that occur with that year delay. You know, probably over seven - around 700,000 increase.

So, while we like to think of hepatitis C as really being a chronic, more indolent disease, it certainly highlights that even a one-year delay and kind of all the efforts were trying to make to reach HCV elimination can have profound effects.

So as we look at ways to kind of catch up, so as we were talking about as we kind of gotten off track with this potential pause over the COVID pandemic, there's lots of things we can look at addressing the barriers, particularly as we talk about vulnerable populations. Telehealth can certainly be a great way to address some geographic barriers or lack of hepatitis C providers maybe in an area where a lot of our vulnerable patients reside. We can look at addressing stigma. And again, working with providers to realize that populations maybe with ongoing substance use or housing instability can still be adherent and have successful hepatitis C therapy.

So again, one approach is kind of having integrated colocalized telemedicine-based treatments. This is something kind of initially pioneered with the ECHO model. Now the ECHO treatment model was really a way to address provider issues. In other words, providing education to providers. Now we've really gone beyond that to take it where we're providing treatment through telemedicine for patients where the provider is in one physical location, the patient may be in a very different physical location.

For vulnerable populations, the one thing I want to highlight is we assume telemedicine may be kind of an avenue to do this, but we have to remember that a lot of our vulnerable populations are not going to have easy access to Wi-Fi, computers to do telemedicine. Even telephone calls where it's just a voice kind of telemedicine visit can be challenging for some of our vulnerable populations with housing instability. We find frequently patients run out of minutes towards the end of the month, and we can't get ahold of them. Or they don't have minutes on their phone, but they can text. So while these are great options, you really need to explore the populations you're trying to reach and make sure they fit for those populations you need to address.

And so recently, we heard of results of what was called the MINMON study. It was an ACTG study that looked at treating hepatitis C with what was considered minimal monitoring. This was an international study done at sites in the United States, in Africa, in Thailand, and Brazil. And it looked at providing sofosbuvir/velpatasvir. The trade name there is Epclusa. But it's a single pill regimen for hepatitis C that's typically taken one pill a day for 12 weeks. And this minimal monitoring approach was an initial visit with counselling, very basic laboratory studies obtained essentially to ensure that somebody had chronic hep C, so you confirm HCV RNA positivity, and to do some assessment to make sure you don't think the patients had decompensated liver disease. After that, patients were given the entire treatment course in a single - at a single time. So no getting refills, they got the entire 84 days of pills at the initial visit, only had brief telephone visit follow-up twice during the whole treatment. And then were assessed for their sustained response. They had no lab monitoring throughout the study, a baseline genotype was not done. And this was very successful. We saw a 95% SVR rate in this study, and that was including anybody who did not come back as a failure.

DR. FRANCO:
So David, switching gears a little bit, we have now had well over a year in which to access data on the impact of COVID-19 infection on the liver, both in healthy individuals, but also those with pre-existing liver disease. What do we know about the impact of COVID-19 in a healthy liver?

DR. WYLES:

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Yeah, it's been really interesting, Ricardo, to see this kind of evolution. I mean, the short answer is probably in a healthy liver, probably pretty minimal impact. I think, you know, we all - when we take care of patients hospitalized with COVID-19 have seen liver enzyme elevations, AST and ALT come up, maybe slight increases in bilirubin or alk phos, and that's probably multifactorial. Luckily, most patients with COVID-19 really are not suffering from fulminant hepatic failure, or liver-related deaths, particularly if they have an underlying healthy liver. And I think that's probably, again, due to the fact that we don't think there's a lot of primary replication in the liver, although it is possible.

DR. FRANCO:
With this evolving knowledge, what we now know is specific to individuals with hepatitis C?

DR. WYLES:
Yeah, I think you know, initially there may have been a lot of concern, but I think the good news is first, we don't see an overall signal of increased mortality and persons living with hepatitis C. As you might not be surprised though, in those with more advanced liver disease and cirrhosis, then we do maybe see an impact on severe disease and mortality related to SARS-CoV-2.

DR. FRANCO:
The summation of this recent presentation brings us back full circle to our patient's vulnerability. Patients with chronic liver disease experienced a substantial burden of COVID-19 on their daily lives. Social and financial aspects were among the most commonly impacted. The need for supportive care in patients with chronic liver disease was associated with having had a history of COVID-19 infection. Many of our HCV patients who may already experience vulnerability have now incurred or will incur an additional burden in the wake of COVID. So my question, David, is how can we best anticipate and accommodate our patient needs during new COVID-19 surges? Will we be ready?

DR. WYLES:
And so I think first is I hope providers can feel somewhat reassured that we've learned a lot, right? We've learned about expanding services beyond conventional doctor's office visits or provider office visits, not necessarily needing to come into clinic all the time, doing everything we can to outreach into the community and involve community leaders with lived experience that are peers for these vulnerable populations. And then we need to essentially not take our foot off the gas pedal, I think in terms of expanding these resources, right? We have to advocate again, for colocalization of services. And it's not just hepatitis C in primary care, it's all the other services these vulnerable populations need to really kind of keep up in their day to day lives, right? So I think with that, I'm hopeful that we will be able to. You know, are we going to get back on track for elimination in 2030? I'm not sure we'll be able to do that, but we're going to keep working as hard as we can to get closer and closer to it and really keep an eye on these vulnerable populations.

DR. FRANCO:
Thank you, David, for this great conversation.

DR. WYLES:
Thanks, Ricardo.

DR. FRANCO:
And thank you to our viewers for joining us. For additional clinical resources, please visit ExchangeCME.com/hottopicsHCV. And remember to complete the post-test and evaluation form to claim your credit. Please be sure to view the other two activities in this Hot Topics in HCV Mini Curriculum, Treating Hepatitis C in Primary Care and What the OB/GYN Provider Needs to Know. Thank you.

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