

December 2005 HepTalk Listserv

Announcements from HepTalk

Welcome to the December 2005 edition of the Listserv. Once again, we're pleased to have three guest editors, **Ms. Judy Norton, Dr. Keith Bletzer, and Dr. Tina Castaños**. Ms. Norton heads the program on Hepatitis C at Arizona Department of Health Services; Dr. Bletzer is a medical anthropologist who has worked with migrant workers for a number of years (including research on substance use and HIV); and Dr. Castaños works as a family physician for a migrant clinic in the Northwest and is nationally known for her work with the migrant community. Thanks very much to Dr. Bletzer, Ms. Norton, and Dr. Castaños for their contributions.

In the November listserv Dr. Bletzer included information from his research on farmworkers and substance abuse. **In December, we continue with Substance Use and Migrant Labor: Part Two.** Dr. Bletzer's work is a rare scientific look at the actual substance use realities for migrants. In addition, the guest editors have again selected and reviewed four articles, this time focusing on Hepatitis C, and integration of hepatitis services, in addition to STDs and HIV, into drug rehab programs.

- 1. Substance Use and Migrant Labor: Part Two**
- 2. "Effects of hepatitis C virus co-infection on survival in veterans with HIV treated with Highly Active Antiretroviral Therapy"**
- 3. "Integrating Hepatitis, STD, and HIV Services into a Drug Rehabilitation Program"**
- 4. "The impact of barriers to Hepatitis C virus treatment in recovering heroin users maintained on methadone"** (HepTalk project note: one of the agencies and some of the authors involved in this study are from the Oasis agency, one of MCN's peers in the Viral Hepatitis Education and Training co-hort of current CDC Division of Viral Hepatitis grantees. We are planning to use some of Oasis' excellent educational materials in our clinician training.)
- 5. "Knowledge of and interest in hepatitis C treatment at a methadone clinic"**

If you have questions for Dr. Bletzer or Ms. Norton, please send them to the listerv administrator Kathryn Anderson at dempander@earthlink.net.

Two Important Notices from the Migrant Clinicians Network

1. MCN Announces the New **MCN Clinical Systems Tool Box** for clinical systems materials, your online connection to resources for best clinical practices in migrant and community health centers. MCN has been collecting forms, policies, and protocols from health centers across the United States in an effort to make them available to others working to provide quality health care to the underserved. We have reviewed hundreds of documents and selected these examples for you to use and adapt to your own clinic needs. We have catalogued material in the following major categories:

- * Clinical Policies and Procedures
- * Clinical Guidelines
- * Quality Management
- * Human Resources
- * Medical Records
- * Patient Education Materials
- * HIPAA
- * Clinic Brochures
- * Language and Translation
- * Practice Management

Go to <http://www.migrantclinician.org/clearinghouse> to find out more.

2. **From the Immunization Project: Pepín is here!** In August and November, we sent letters to all of our HepTalk clinics with information about the ***Pepín*** comic series. These are culturally and linguistically appropriate educational support materials for Vaccine Information Statements (VIS). The format is a four-color, animated comic book using the character of a boy named ***Pepín***. In addition, a movie of the Pepin Series ***"The Adventure of Pepin and the Vaccines"*** is available in Spanish or English, both in DVD or VHS format.

As a result of collaboration between the staff of the immunization project and HepTalk team, the Hepatitis B comic as well as the movie have been reproduced for distribution to the health centers and health departments participating in HepTalk. **It is free of charge, and postage is free as well!** We only ask that you order a minimum of 25 comic books at a time. If you have colleagues at other clinics who would be interested in these materials, please help us make them aware of our hero, *Pepín*.

To order, go to

http://www.migrantclinician.org/surveys/vacunas_orderform.php

Place your orders as soon as possible. While only one of the comics is concerned with hepatitis, and only part of the movie, you may find the other issues useful for your patient population.

We are always on the look out for quality patient and provider education materials. I hope that these will be useful to you. We have already received and shared some wonderful materials from a number of you. If you develop or learn of other materials that would be useful to others, I hope you will forward them to MCN so that we can pass them along, and please pass along information about the Pepin series to other colleagues and clinics.

Please note that the articles and links below do not comprise recommendations from HepTalk, or from the CDC. They are mainly intended to stimulate discussion of issues you may find relevant to your client population.

Check the HepTalk webpage on the Migrant Clinicians Network website at <http://www.migrantclinician.org>. You can get to our page by clicking on "Clinical Excellence" on the Home page, and then clicking on "Hepatitis" on the menu at the left (<http://www.migrantclinician.org/excellence/hepatitis>).

If others at your clinic would like to be on the listserv, or if you have questions about the listserv or resources listed here, or if you would like to add something to the posts, please contact Kathryn Anderson, HepTalk listserv administrator, at dempander@earthlink.net. You can also contact the listserv administrator if you would like to unsubscribe from the list.

Research

1) 1. You'll find **Substance Use and Migrant Labor: Part Two** by Dr. Keith Bletzer posted on the Migrant Clinicians website at <http://www.migrantclinicians.org/excellence/hepatitis> This is a very

interesting look at data on patterns of substance use by farmworkers. Part One is also available there.

Article Reviews

2) Lisa I. Backus, Barbara R. Phillips, Derek B. Boothroyd, Larry A. Mole, Jane Burgess, Michael O. Rigsby, and Sophia W. Chang, 2005, **“Effects of hepatitis C virus co-infection on survival in veterans with HIV treated with Highly Active Antiretroviral Therapy,”** Journal of Acquired Immune Deficiency Syndrome Volume 39, Number 5, pages 613-619.

This study considered the issue of co-morbidities in relation to treatment and prognosis in persons co-infected with hepatitis C (HCV) and HIV. These co-infected individuals often have further problems with alcohol abuse, hard drug use and a prior history of psychiatric illness.

Investigators for this study examined charts from 12,216 military veterans who first received Highly Active Antiretroviral Therapy (HAART) between January 1, 1997, and February 28, 2003. These records were part of the Immunology Case Registry (ICR), an automated database on HIV patients electronically generated by the Veterans Administration (VA) from all its facilities. The cutoff was 1997, as HAART medications before that year were often irregular. The outcome measure was “all-cause mortality,” taken through one additional month, March 31, 2003. Several analyses were conducted, such as comparing those positive for HCV with those HCV negative, and controlling for variables such as timing and duration of HAART, receiving HCV treatment (interferon α -2b, pegylated interferon, and/or ribavirin), facility characteristics and patient co-morbidity (like alcohol use, psychiatric illness, and hard drug use). Virological categories were defined variously as undetectable HIV viral replication (defined as viral loads less than 500 copies/mL), and HIV viral load and CD4 count closest to six months after starting HAART. Almost all the study records had a “near-complete” death ascertainment, but a few had missing data. Veterans sampled for this study comprised 43 percent of all available charts in the ICR maintained by the VA.

Those individuals among the 12,216 who were HCV-positive were significantly older, more likely to be Black or Hispanic, to have received VA care longer before starting HAART (and thus have less overall exposure to HAART), and/or to have a history of psychiatric illness, alcohol abuse and hard drug use ($p < .0001$ for each factor).

Those HCV negative and those HCV positive were likely to have had a prior AIDS Opportunistic Infection; those who were positive were more likely to have had a diminished immune response and they had a higher mortality rate (6.4 deaths) than those who were negative (4.0 deaths, $p < .0001$). Participants with an increased risk of death were those "off HAART," as well as those who were older, had a higher baseline HIV viral load, were diagnosed with an AIDS Opportunistic Infection and had received Nucleoside Reverse Transcriptase Inhibitor (NRTI) therapy before beginning HAART. HCV positive status for those who were receiving HAART on the other hand had a lower risk of death (1.77) than those who were HCV negative and receiving HAART (2.04, $p < .0001$). Risk of death for the HAART-treated patients was 30% to 80% higher for those who were infected with HCV. Initially the researchers divided the sample into two groups and "fit" a model to each. Those cases with a probability value less than 0.05 in both were included in the final model that was estimated for the full sample.

The authors conclude by noting the challenge of treating individuals with co-morbidities, since heavy alcohol use accelerates the clinical course of HCV, and drug use and prior psychiatric history "complicate" the prognosis for persons co-infected with HIV and HCV. As an indication of the greater rigor in recent studies (including the others reviewed in this list-serve for the month of December), the authors attribute different methods for conflicting results on the effect of HAART on co-infection with HIV and HCV, as well as having one or the other but not both. One other study (a Swiss cohort) besides the present investigation found a negative HCV effect on probability of survival. Studies finding no similar effect have usually set their time origin for the sample at "clinic entry" and, at times, even included patients who had never received HAART.

3) Robert A. Gunn, Marjorie A. Lee, David B. Callahan, Patricia Gonzales, Paula J. Murray, and Harold S. Margolis, 2005, **"Integrating Hepatitis, STD, and HIV Services into a Drug Rehabilitation Program,"** American Journal of Preventive Medicine Volume 29, Number 1, pages 27-33.

Studies show that people who have been incarcerated are often at increased risk of acquiring sexually transmitted diseases (STD's), viral hepatitis and Human Immunodeficiency Virus (HIV). Providing screening services to these individuals upon their release, or while incarcerated, to identify, and if necessary to vaccinate to prevent these infections, has been problematic in many communities, particularly for inmates in short-stay detention. The short length of

stay combined with cost of delivering services has been a barrier. To examine these issues, this study sampled 930 enrollees in a nonresidential alternative sentencing drug rehabilitation program in San Diego, CA. Risk-assessment questionnaires were completed and enrollees were offered hepatitis B vaccination, serological testing for hepatitis B virus (HBV) and hepatitis C virus (HCV), STD screening, and HIV counseling-testing. Inmates were diverted from the correctional system to enter the program under mandates of the California Substance Abuse and Crime Prevention Act of 2000, by direct order of a judge or as a condition of probation. Clients attended rehabilitation services five days/evenings per week while working in the community and living in their own residence. A nurse and program assistant from the San Diego County STD and Hepatitis Prevention Program visited study sites to enroll participants and deliver services.

Of the 930 participants, more than 65% were screened for either HBV or HCV markers; overall, 11.1% were anti-HCV positive and 14.7% infected with HCV. Some 854 (92%) were eligible to start hepatitis B vaccination, and 42% completed the 3-dose series. Urine-based testing for Chlamydia and gonorrhea was offered. The rate of positive Chlamydia tests was only 2.0% and for positive gonorrhea, 0.7%. The estimated annual cost of delivering viral hepatitis and STD services at this drug rehabilitation program was \$31,994. These same services, if provided by the local health department, would cost \$32,000 per year. The estimated cost per client of \$122 is comparable to the cost of an office visit at a comprehensive clinic or physician's office and may even be less.

Even though outreach programs may cost about the same as providing these services at a fixed location, the high proportion of high-risk clients served and the increased yield of screening tests suggest that providing these services within an outreach approach is an efficient use of limited resources. Health departments should consider developing collaborative partnerships with drug rehabilitation programs in order to provide integrated prevention services.

4) Diana L. Sylvestre, Alain H. Litwin, Barry J. Clements, and Marc N. Gourevitch, 2005, "**The impact of barriers to Hepatitis C virus treatment in recovering heroin users maintained on methadone,**" *Journal of Substance Abuse Treatment* Volume 29, pages 159-165.

Through a sophisticated research design with multiple measurements of possible effects on viral response and adherence to treatment for hepatitis C virus (HCV), this study demonstrated that

methadone-maintained patients are able to receive successful treatment for HCV. The authors point out their “real world” sample from two cities (Oakland CA and Bronx NY) was “much more challenging” than those in prior studies in considering multiple treatment obstacles (e.g., active drug use concurrent with treatment; advanced liver disease; psychiatric history; limited time off drugs for most the patients). Fifty-eight of 76 methadone patients in their study completed treatment (18/76 discontinued). As an indication of the co-morbidities that often occur in working with this population, 27/76 patients used one/more illicit drugs at least once during the period of HCV treatment (24-week treatment for genotypes 2 and 3, and 48 weeks for the rest), at least 8 of these 27 were “daily users,” and a number of others used alcohol heavily and/or had a prior history of psychiatric illness.

The study sample was men and women aged 18/over positive for HCV who had been on methadone for three months/longer who were willing to receive treatment for HCV; average age of the 76 methadone patients was 50 years (46/76 were male; 54/76 White, 10/76 Black, 12/76 Latino); duration of HCV exposure was 28 years, median duration of continuous methadone maintenance was five years, mean duration of lifetime heroin use was 21 years and median duration of abstinence from illicit drug use was one year (44/76 reported history of heavy alcohol use for median of 12 years); 45/76 reported previous psychiatric diagnosis. Initially, active drug users were excluded, but this criterion was dropped (after 25 patients) for participants attending at least 75 percent of the weekly clinics for two months/more. Data collection included clinical monitoring (hemolytic anemia, etc) as well as a monthly questionnaire on missed doses; assessment of drug use (self-reporting; random urine testing); administration of baseline survey, Beck depression Inventory; and HCV RNA PCR test (baseline, 6 months, end of treatment). The latter test is considered more effective in diagnosing HCV than an antibody test.

The authors found prior psychiatric diagnosis had more influence on HCV treatment than a short period off drugs or even concurrent drug use during treatment. They recommend “case by case” review in determining treatment regimens. Interestingly, those individuals who did not report a previous psychiatric history (35%) had a greater a sustained viral response compared to 22% who reported a psychiatric history ($p = .01$); neither presence nor absence of psychiatric history influenced dropout rates or adherence rates. Those who abstained from drug use had higher treatment outcomes (35% sustained response rate) than those who occasionally used drugs (21%) or regularly used drugs (zero percent); these results “approached” but did not “achieve” statistical significance ($p = .09$). The authors suggest

careful review and “alternative models of care” (such as treatment within a residential setting) rather than discontinuation of HCV treatment for these individuals. The authors speculate variations in their findings may reflect metabolic variation; they further note that anti-depressant use resulted in interferon-mediated neuropsychiatric toxicity within some individuals in their sample.

The main limitations to this study, among others, were its relatively small sample size, focus on recovering heroin users, and reliance on self-reported mental health history.

5) Alexander Y. Walley, Mary C. White, Margot Kushel, Yong S. Song, and Jacqueline P. Tulskey, 2005, **“Knowledge of and interest in hepatitis C treatment at a methadone clinic,”** Journal of Substance Abuse Treatment Volume 28, pages 181-187.

Twenty percent of heroin users in the United States receive treatment for opiate dependency at methadone programs. Prevalence of hepatitis C virus (HCV) infection among methadone clients is estimated to be between 66 to 93% in that population. While early treatment guidelines recommended that HCV treatment be delayed until six months after patients had stopped alcohol consumption and use of illicit drugs, later studies showed that injection drug users in treatment can be successfully treated for HCV. In light of this information, it has been felt that methadone programs might prove useful in improving access to HCV treatment for those who are infected.

This study assessed this possibility by examining knowledge about the natural history of HCV infection, including issues of transmission and treatment, among 110 opiate dependent patients at an opiate dependence treatment center in San Francisco. Study participants were asked if they had ever been treated for HCV or evaluated for treatment. After being educated about the risks and benefits of treatment, one-half (54%) stated they were interested in receiving treatment.

Accuracy about the natural history of HCV infection varied, yet nearly all the participants (92%) believed that a person could die of HCV. Knowledge about HCV transmission was more accurate, but only one-third (33%) knew that there was a treatment for HCV. None of the 110 participants reported taking Ribavirin or Interferon (two common medications for HCV infection) and only 30% reported that they had ever been evaluated for HCV treatment.

The most notable finding from this study was that none of the participants were being treated and few had been evaluated for

treatment. Additionally, while knowledge of transmission routes was high, knowledge of treatment was low among all participants. This result was especially marked among women and African Americans. Lastly, those who were receiving methadone treatment were HCV negative but did not know their HCV status predicted higher interest in treatment than those who knew that they were positive. These findings support the need for education about treatment options among all methadone patients with special efforts made to reach women and minorities. This is especially true for the majority of participants who, like those in the study, may not know that treatment existed until informed, making it unlikely that they would have thought about or considered treatment as an option for them.

Drug treatment programs including methadone programs are in a good position not only to educate clients about HCV, but also facilitate access to the appropriate treatment. Methadone treatment programs require adherence with clinic visits and could facilitate adherence to HCV evaluation, treatment and side effect monitoring.