Treating HCV in an Urban Vulnerable Population

Bridging the gaps from diagnosis to cure

Dr Subrata Chakravarty

Addiction Medicine, Edmonton, Alberta

THE STORY: FROM TREATMENT GAP TO PRACTICAL ACTION

01	02	03	04
DEFINE THE GAP	**BRING CARE CLOSER**	**LEARN FROM EXPERIENCE**	**ACT ON BARRIERS**
Why urban vulnerable populations remain underserved.	How addiction medicine and ECHO+ integrate HCV care.	What our clinic observed across the care cascade.	Practical steps to keep patients connected through cure.

Problem → integrated model → clinic evidence → practical next steps

THE HCV BURDEN IS HIGH—BUT TREATMENT REACH REMAINS LOW

36.9%

Chronic HCV prevalence among people who injected drugs in Canada

2021 estimate

~50%

Of PWID with chronic HCV estimated to be unaware of infection

Canada, 2021

10.6%

Of HCV-aware PWID had ever received treatment

Canadian Tracks, 2017–2019

3.8%

Of HCV-aware PWID receiving treatment at survey

Canadian Tracks, 2017–2019

CORE GAP: High prevalence and low awareness are compounded by very limited treatment uptake.

THE TREATMENT GAP REFLECTS MULTIPLE, OVERLAPPING BARRIERS

CLINICAL	SOCIAL	SYSTEM	TRUST & ENGAGEMENT
Injection drug use Mental health and substance-use challenges	Unstable housing Financial insecurity	Incarceration and care transitions Limited primary-care access	Stigma Previous healthcare experiences

IMPLICATION: Address competing priorities while reducing the number of pathways patients must navigate.

ADDICTION MEDICINE CREATES A PRACTICAL ENTRY POINT FOR HCV CARE

EXISTING ADDICTION-CARE RELATIONSHIP

- Longitudinal care
- Routine laboratory monitoring
- Medication management
- Substance-use and mental-health assessment
- Established therapeutic relationship

INTEGRATED HCV CARE

Assess and treat HCV within the setting patients already use—supported by specialist expertise through ECHO+.

RESULT: Fewer referrals, fewer handoffs, and a simpler route from diagnosis to treatment.

INTEGRATION REMOVES FRICTION FROM THE CARE PATHWAY

CONVENTIONAL PATHWAY	INTEGRATED ADDICTION-CARE MODEL
Separate specialist referral	HCV care within an established clinical relationship
Additional appointments	Care incorporated into existing visits
Multiple transitions between providers	**Fewer handoffs**
Specialist access depends on referral pathway	Specialist expertise available through ECHO+
Follow-up across different settings	Follow-up remains connected to the addiction clinic

VALUE: Expert-supported care becomes easier to enter and easier to sustain.

BRINGING CARE CLOSER REDUCES THE BURDEN ON PATIENTS

THE CHALLENGE

Substance use, unstable social circumstances, and competing health priorities can make multiple healthcare settings difficult to navigate.

THE MODEL

Integrate HCV care into addiction medicine and add specialist expertise through ECHO+— without a separate pathway for every patient.

THE BENEFIT

Care happens where patients are already receiving ongoing support.

WHY IT MATTERS: Fewer transitions mean fewer opportunities to be lost between diagnosis and cure.

THE ECHO+ MODEL TURNS SPECIALIST INPUT INTO A REPEATABLE CARE PATHWAY

1 IDENTIFY	2 ASSESS	3 PRESENT	4 PLAN	5 TREAT	6 FOLLOW
HCV screening and diagnosis within the addiction clinic	HCV, liver and substance-use history, medications, and investigations	Discuss the patient case through ECHO+	Develop specialist-supported treatment recommendations	Manage HCV treatment through addiction medicine	Confirm completion and assess viral clearance

The model keeps specialist expertise connected to the team that already knows the patient.

AN ECHO+ CONSULTATION CONVERTS PATIENT CONTEXT INTO A TREATMENT PLAN

1 PATIENT CONTEXT

- Demographics and ethnicity
- HCV and substance-use history
- Mental-health and relevant medical history
- Current medications and concomitant therapies

2 CLINICAL ASSESSMENT

- Netcare records and investigations
- HCV RNA and liver-related results
- FIB-4 and APRI
- Fibrosis assessment
- Imaging, when available

3 TREATMENT PLANNING

- Drug–drug interactions
- HCV treatment options
- Relevant comorbidities
- Medication considerations

OUTPUT: A collaborative, patient-specific plan that the addiction-care team can implement.

FOR THE PATIENT, INTEGRATED CARE MEANS FEWER HANDOFFS AND FASTER DECISIONS

ASSESS IN PLACE
HCV assessment occurs within an existing addiction-care relationship.

REVIEW BEFORE DECIDING
Relevant clinical information is assembled before treatment decisions.

ACCESS EXPERTISE
ECHO+ provides specialist support without a separate visit for every patient.

CHECK INTERACTIONS
Medication and drug–drug interactions are reviewed collaboratively.

ASSESS FIBROSIS
FIB-4, APRI, and available imaging support staging.

TREAT AND FOLLOW
The existing addiction-care team initiates treatment and follow-up.

PATIENT IMPACT: One connected team can move from assessment to treatment with fewer transitions.

TREATMENT SUCCEEDS WHEN CARE EXTENDS BEYOND THE PRESCRIPTION

HCV treatment is one part of a longitudinal, multidisciplinary approach.

Engagement depends on the patient's overall health and the circumstances that shape their ability to remain in care.

OVERALL HEALTH

SOCIAL CIRCUMSTANCES

CONTINUITY & TRUST

CARE PRINCIPLE: Treat the infection while supporting the person through the full journey.

REGULAR FOLLOW-UP KEEPS HCV TREATMENT ON TRACK

FOLLOW-UP CADENCE: Every 2 weeks or monthly—based on patient need

ASSESS

Monitor treatment progress and overall health.

REVIEW

Review laboratory results and treatment milestones.

RECONNECT

Follow up after missed appointments, investigations, or milestones.

ADAPT

Activate contingency plans when treatment or follow-up is disrupted.

OUTCOME: Problems are identified early, interruptions are addressed, and patients remain connected through cure.

PHARMACY SUPPORT PROTECTS ADHERENCE AND TREATMENT CONTINUITY

MONITOR

Regularly assess medication adherence and compliance.

REVIEW

Reconcile HCV medications with the patient's other therapies.

IDENTIFY

Detect drug-related issues and potential barriers early.

SUPPORT

Maintain medication access, refills, and continuity.

COMMUNICATE

Escalate adherence or medication concerns to the clinical team.

OUTCOME: Medication risks are addressed before they become treatment interruptions.

SOCIAL WORK REMOVES PRACTICAL BARRIERS THAT CLINICAL CARE ALONE CANNOT SOLVE

Connect patients to healthcare and community resources.

ADDRESS BASIC NEEDS
Housing, financial, social, and practical barriers

WORK ONE STEP AT A TIME
Prioritize the patient's most immediate needs

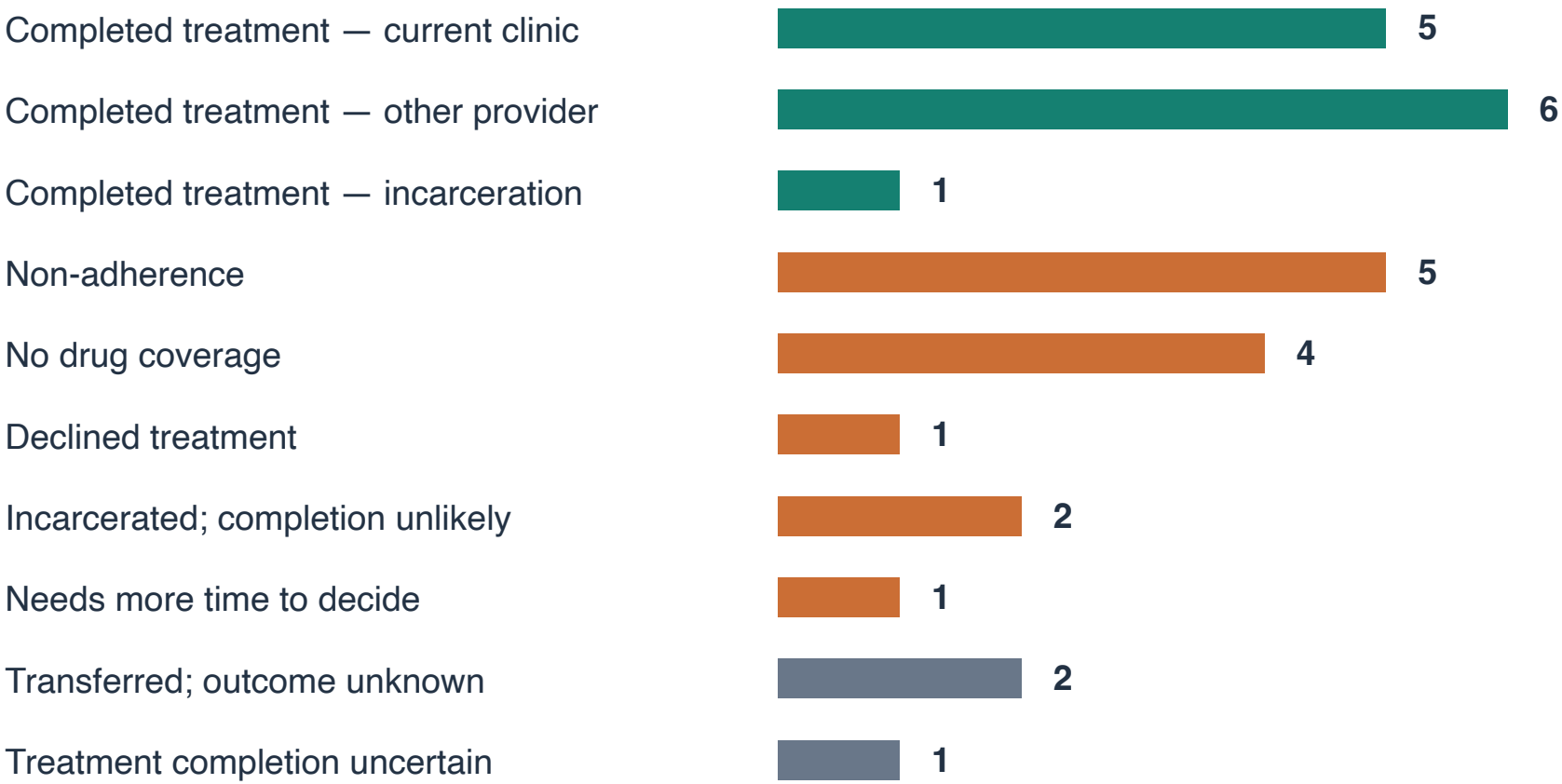
PROTECT ENGAGEMENT
Respond when social circumstances interfere with treatment

CONNECT THE PLAN
Link social needs to the patient's broader healthcare strategy

OUTCOME: Practical support makes it more possible for patients to remain engaged in treatment.

Hepatitis C Care Cascade I Outcomes and Barriers

Urban addiction clinic cohort • n = 28 patients



Documented completion

12 / 28

42.9% of cohort

Other statuses

16 / 28

13 with treatment barriers or deferred care; 3 with transferred/uncertain outcomes.

Interpretation: “Treatment completed” is not equivalent to confirmed SVR12. Categories are mutually exclusive as transcribed from the handwritten tally; verify against clinical records.

OUR EXPERIENCE POINTS TO FOUR LESSONS FOR INTEGRATED HCV CARE

01

SPECIALIST SUPPORT CAN TRAVEL

Decision-making can occur without every patient navigating a separate liver-care pathway.

02

CONTINUITY IS THE MAIN CHALLENGE

Offering treatment is not enough if follow-up is interrupted.

03

HCV CARE IS PART OF A BROADER LIFE

Substance use, mental health, housing, and social circumstances shape engagement.

04

THE CARE TEAM MUST STAY CONNECTED

Medication access and continuity with healthcare providers influence completion.

BOTTOM LINE: The clinical plan works only when the care pathway can withstand real-life disruption.

WHAT CAN WE DO NEXT?

Gap	Our Response	Goal
Missed blood work	Pair blood work with visits; follow up proactively	Maintain cascade progress
Delayed treatment start	Use a “ready-to-treat” pathway; track starts	Start treatment sooner
Medication adherence challenges	Pharmacy checks + medication reconciliation	Improve treatment continuity
Care disengagement	Outreach after missed visits or milestones	Re-engage patients early
Incarceration / transitions disrupt treatment	Contingency and transition-of-care plans	Reduce treatment interruptions
Medication coverage barriers	Identify coverage issues early; coordinate support	Reduce treatment delays
Provider changes	Strengthen transition communication	Maintain continuity of care

THE CLEAR CONCLUSION

HCV elimination requires treating the person—not only the virus.

Care must be simple to enter, continuous through disruption, and built around the patient's life.

SIMPLIFY THE PATHWAY

Use specialist-supported decisions without requiring a separate liver-care pathway.

PROTECT CONTINUITY

Anticipate coverage, incarceration, provider changes, and other care transitions.

MEET PATIENTS WHERE THEY ARE

Bring care closer, build support around patients, and stay with them through the journey.

OUTCOME: Diagnosis → treatment → cure—with no patient lost to system complexity.

THANK YOU

This work was possible because of the people who delivered, supported, and trusted the care.

We are deeply grateful to:

CLINIC TEAMS

To all staff at City Centre Clinic and the Addiction & Recovery Clinic (AHRC), Edmonton, for their commitment and compassion.

DR. SUZAN BELIM

For working alongside me through the cases and the preparation of this presentation.

ECHO COMMUNITY

Special thanks to the ECHO team, led by Dr. Sam Lee, for their expertise—and to Recovery Coach Angie Adams, who introduced me to the ECHO program.

MOST IMPORTANTLY: To our patients—thank you for placing your trust in us.