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Brief articles

Assessment of methadone clinic staff attitudes toward hepatitis C evaluation and treatment

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ABSTRACT

We used a 25-item, self-administered questionnaire to assess staff's perceived barriers and willingness to engage in onsite treatment of hepatitis C virus (HCV) at the Beth Israel Medical Center methadone maintenance treatment program (MMTP) at its Harlem sites. Of 80 participants, 50% were counselors and 24% were directly involved in referral or HCV testing. Although 92% of the MMTP staff indicated that they discuss HCV evaluation and treatment with patients at least annually, 70% believed that less than 25% of patients accept referral for HCV treatment and attend their initial appointment. Most staff (66%) supported onsite HCV evaluation and treatment, although support was higher among those with a bachelor's degree or higher ($p = 0.046$). Lack of infrastructure was perceived as the greatest obstacle to onsite treatment. Educational interventions and skill building for staff to confidently engage and support MMTP patients in HCV treatment may be necessary prerequisites for onsite HCV management in MMTPs.

1. Introduction

1.1. Reasons for limited hepatitis C virus treatment uptake among methadone maintained patients

Hepatitis C virus (HCV) infection is a leading cause of chronic liver disease with an estimated global prevalence of more than 170 million and up to 5 million infected individuals in the United States (El-Serag, Lok, & Thomas, 2010; World Health Organization, 2002). Of those who are exposed to the virus, the majority (50%–80%) will develop chronic infection that can result in fibrosis, cirrhosis, and hepatocellular carcinoma. Currently, injection drug use is the leading risk factor for HCV acquisition, and HCV seroprevalence ranges from 60% to >90% among long term injection drug users (IDUs) (Hagan et al., 1999; Lorvick, Kral, Seal, Gee, & Edlin, 2001; Mehta et al., 2008; Thomas et al., 1995; Tseng et al., 2007). Although drug users represent the majority of the HCV disease burden in developed countries, HCV treatment uptake among these individuals remains low (Grebely et al., 2008; Mehta et al., 2008; Stephenson, 2001). Currently, HCV evaluation among IDUs ranges from 21% to 65% with less than 20% of evaluated patients receiving treatment (Grebely et al., 2008; Mehta et al., 2008; Schackman, Teixeira, & Beeder, 2007). Challenges to full implementation of HCV treatment among IDUs exist on multiple levels (Morrill, Shrestha, & Grant, 2005), including limited HCV-related knowledge among both drug users and drug treatment staff (Munoz-Plaza et al., 2008; Strauss et al., 2006, 2007a).

As HCV prevalence and incidence are highest among drug users, integration of HCV management into drug treatment, particularly methadone maintenance treatment programs (MMTPs), may be an effective strategy by which to engage disenfranchised populations into clinical care for HCV and to reduce viral transmission. Staff employed within the MMTP is crucial for successful integration of HCV care into these facilities and has the potential to be important conduits for knowledge dissemination about HCV. These individuals are also important for patient engagement into clinical evaluation and treatment of the infection.

While patient-centered barriers and facilitators to engagement of drug users in HCV management have been studied in detail, few data exist addressing MMTP staff attitudes toward, involvement in, and comfort with participating in HCV management services (Bini et al., 2011; Brown et al., 2009). However, previous work conducted in a large national study has shown that health care provider's volition plays a significant role in the pursuit of infectious disease treatment among patients in drug treatment programs (Tracy et al., 2009). Our objective was to assess MMTP staffs' current practices regarding HCV testing and management, what staff perceives to be obstacles to

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MMTP patients accepting an HCV evaluation and treatment, staffs' willingness to engage and to support patients in the onsite treatment of HCV, and their level of comfort in disseminating knowledge about HCV to MMTP patients. To assess these parameters, we designed and administered a survey to MMTP staff at the largest hospital-based MMTP in the United States.

2. Materials and methods

2.1. Description of MMTP program

The Beth Israel Medical Center (BIMC) MMTP clinics are primarily located in medically under-served regions of the New York City boroughs of Manhattan and Brooklyn. The BIMC's 18 MMTP clinics constitute the largest hospital-based methadone maintenance treatment system in the United States treating approximately 8,000 unduplicated opioid-dependent individuals annually with an active census of 6,500 patients. The recruitment site for this study was a cluster of eight clinics located in Central Harlem of which 70% of the patients are male, 52% Hispanic, 35% African-American, and 13% Caucasian. In terms of ages, 29% of the patients are aged 45 years or less, 39% are aged 46–55 years, and 32% are older than 56 years. Almost 60% of MMTP patients are HCV seropositive (Seewald et al., 2010). These clinics were specifically targeted for inclusion in this study as they had not participated in any educational or treatment programs devoted to viral hepatitis. Other clinics in the program have participated in interventions to increase patients' pursuit of evaluation or vaccination for viral hepatitis.

In the eight sites that were surveyed, onsite management of HCV consisted of screening for hepatitis upon admission, delivery of medical test results by the medical staff, and a referral for offsite evaluation and treatment to a BIMC hepatology practice located 5 miles (four subway stops) from the MMTP or to providers of their choice. Staff educational programs for HCV were provided as part of new staff orientation and annually to all clinical providers as recommended by accreditation bodies (The Joint Commission).

2.2. Survey instrument

A 25-item self-administered questionnaire was developed by experts in the fields of hepatology, infectious diseases, addiction medicine, psychiatry, and epidemiology. The instrument was distributed to MMTP staff during staff meetings, prior to annual HCV training sessions, and was collected anonymously at the meetings' conclusion. Participation was entirely voluntary and staff helped develop and approved the instrument's content and distribution. The study was conducted consistent with a protocol approved by the BIMC institutional review board.

The survey assessed information encompassed in three domains: HCV management (Section 1), staff comfort with HCV treatment (Section 2) and demographic information (Section 3). Section 1 included questions about HCV awareness among patients, the number and circumstances when patients are referred for counseling and testing, and reasons why and frequency of missed appointments. Section 2 included questions regarding the feasibility, readiness to participate, and factors that might promote an onsite HCV treatment program. Section 3 requested information about respondent's personal (e.g., age, gender, race, ethnicity) and professional characteristics (e.g., position within MMTP, level of education).

2.3. Data analysis

A total of 88 questionnaires were returned; eight were excluded as two contained no responses and six were obtained from individuals who were not involved in patient care. Consequently, 80 evaluable questionnaires (66%) were obtained from the 120 personnel with direct patient contact. Most of the physicians and counselors (6 of 7 [86%] and 40 out of 60 [67%], respectively) completed the questionnaire, followed by nurses (17 of 35 [49%]), physician assistants (3 of 7 [43%]), clinic managers (2 of 7 [29%]), and social workers (1 of 4 [25%]). Complete responses were obtained from 40 individuals. The survey was considered fully complete if responses were obtained to all questions. A section was considered partially complete if a response to at least one question was obtained. Section 1 was fully completed by 66% ($n=53$) of the participants, Section 2 by 80% ($n=64$), and Section 3 by 78% ($n=62$).

Response frequencies were calculated for the different items on the questionnaire. Fisher's exact and Cochran–Armitage trend tests were used to assess associations among the questionnaire items.

3. Results

3.1. Respondents demographics and position in MMTP

Among the respondents, most were 46 years or older (6 [7%] were 18–35, 12 [15%] were 36–45, 54 [68%] were >46, and 8 [10%] did not provide responses to the question). Sixty-five percent of respondents ($n=52$) were female. In terms of race, 41% ($n=33$) were African-American, 15% ($n=12$) were Caucasian, 4% ($n=3$) were Asian, 23% ($n=18$) were of other race and 18% ($n=14$) did not provide race information. A total of 68% ($n=54$) identified themselves as non-Hispanic. In terms of education, 39% ($n=31$) of the respondents had a bachelor's degree, 29% ($n=23$) had a master's or doctoral degree (MD, DO, or PhD), and 23% ($n=18$) had high school or associate degree. One half ($n=40$) of respondents were counselors, 21% ($n=17$) were nurses, and 12% ($n=9$) had advanced medical training (physician or physician assistant). Of the total sample, 24% ($n=19$) responded on the questionnaire that they were directly involved in either referring or testing patients for HCV.

3.2. Attitudes toward HCV management

Although the vast majority of MMTP staff indicated that they discuss HCV evaluation and treatment with clinic patients, the widely held perception was that very few patients adhere to the medical advice provided. Of the respondents, 65 of 71 (92%) indicated that they discuss at least one HCV-related topic with MMTP patients a minimum of once a year. About half of respondents indicated that they discuss HCV on admission to the MMTP and one third, respectively, indicated that they discuss the infection during monthly counseling sessions or when developing an individualized treatment plan.

To ascertain whether staff perceives that patients adhere to requests for evaluation and treatment, we asked: “Approximately what percentage of patients accepts a referral for HCV evaluation to assess if disease is chronic and to explore treatment options?” and “Approximately what percentage of patients appears for their first appointment for evaluation?” The vast majority of MMTP staff discusses referral for an HCV evaluation or treatment (30 of 34 [88%] and 46 of 62 [74%], respectively) with HCV seropositive patients at least annually. Of 27 staff who discusses HCV evaluation at least annually, 11 (41%) indicated that less than 25% of the patients accept referral and 14 (52%) indicated that less than 25% of the patients actually appear for their initial evaluation. Of 44 staff who discusses HCV treatment at least annually, 27 indicated that less than 25% (61%) of the patients accept referral for treatment. Fear of side effects of HCV treatment and the prolonged asymptomatic period of the infection were the two most common reasons staff cited to explain participants' declining an HCV evaluation or treatment or failure to appear for an HCV evaluation (Table 1).