



C’s the Day. Hospital-Based Hepatitis C Treatment for Inpatients with Barriers to Outpatient Care: Implementation of an Integrated Treatment Team

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Observed treatment completion: 14.9% during the intervention vs 5.4% at baseline
Limited ability to contact patients after discharge was the most common barrier to DAA prescribing.

Background and Methods

Hospitalization offers an opportunity to treat hepatitis C virus (HCV) among people unlikely to engage in outpatient care.

Design: Two-hospital NYC quality improvement initiative, September 2024-August 2026, with a 12-month pre-implementation baseline.

Eligibility: Adults with detectable HCV RNA, able to consent and not on direct-acting antiviral (DAA) treatment, identified through an Epic dashboard or HCV consult order.

Exclusions: Decompensated cirrhosis, transplant, active malignancy, pregnancy/breastfeeding, discharge to law enforcement, limited life expectancy not improved by HCV treatment, or death during the encounter.

Interventions: Phone or bedside assessment/counseling, DAA prescribing for select patients with inpatient or outpatient initiation, bedside delivery, low-barrier follow-up.

Selection for DAA Treatment: Investigator made prescribing decisions based on anticipated feasibility of treatment completion, including the patient’s ability to take DAA reliably and maintain contact after discharge.

Team: Infectious diseases attendings and one social worker.

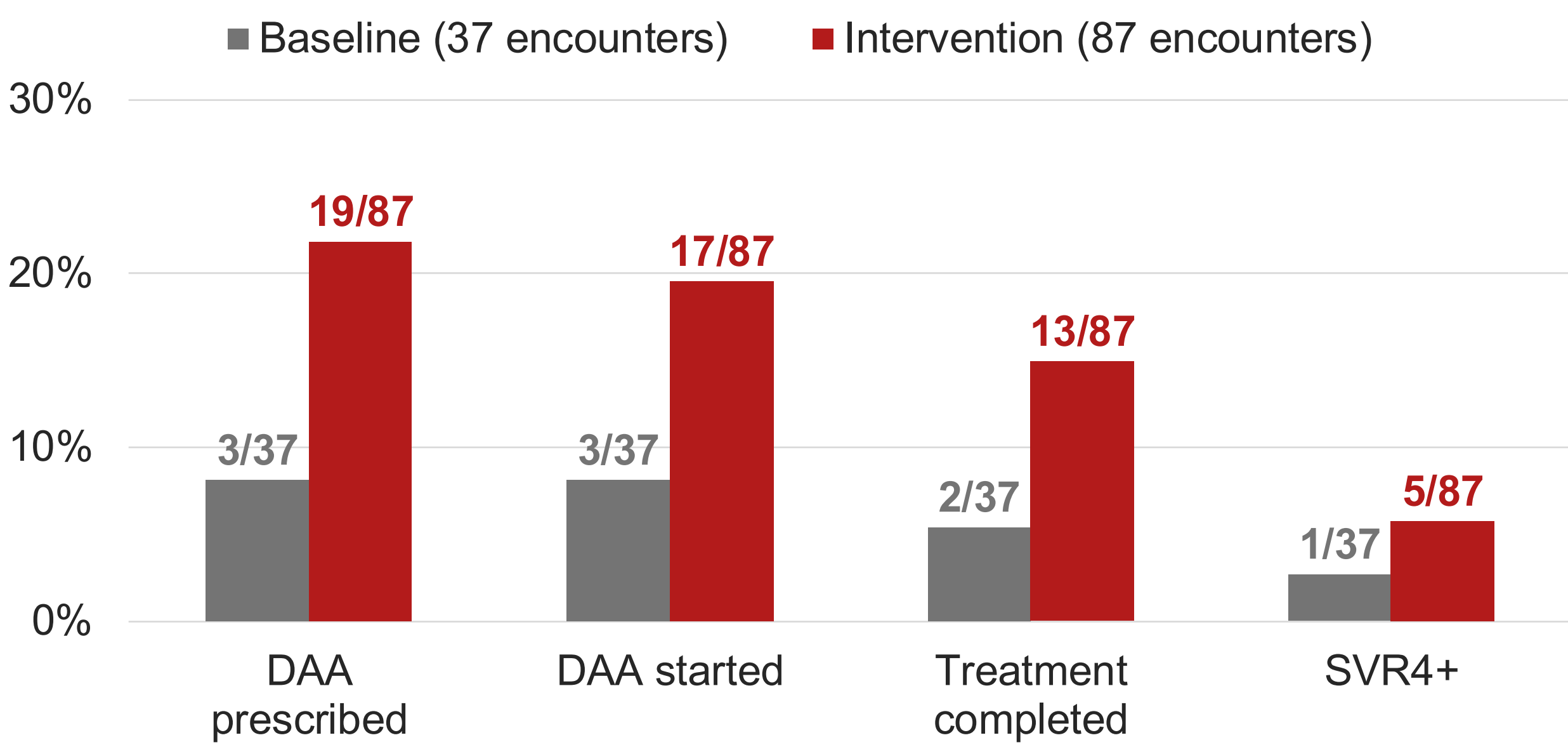
Eligible encounters

Characteristic	Baseline (n=37)	Intervention (n=87)
Age, years, median (IQR)*	57 (45, 65)	44 (38, 51)
Female	11 (29.7%)	20 (23.0%)
Race*		
White	15 (40.5%)	63 (72.4%)
Black	5 (13.5%)	12 (13.8%)
Other	17 (45.9%)	12 (13.8%)
Hispanic/Latinx ethnicity*	19 (51.4%)	23 (26.4%)
Medicaid insurance*	22 (59.5%)	71 (81.6%)
Unstably housed*	21 (56.8%)	71 (81.6%)
Working telephone*	18 (48.6%)	16 (18.4%)
Current injection drug use*	15 (40.5%)	73 (83.9%)
HIV	6 (16.2%)	8 (9.2%)
Compensated cirrhosis*	5 (13.5%)	2 (2.3%)
Length of stay, days, median (IQR)	10 (7, 22)	10 (6.5, 24.5)
Patient-directed discharge	8 (21.6%)	25 (28.7%)

*p<0.05. IQR, interquartile range.

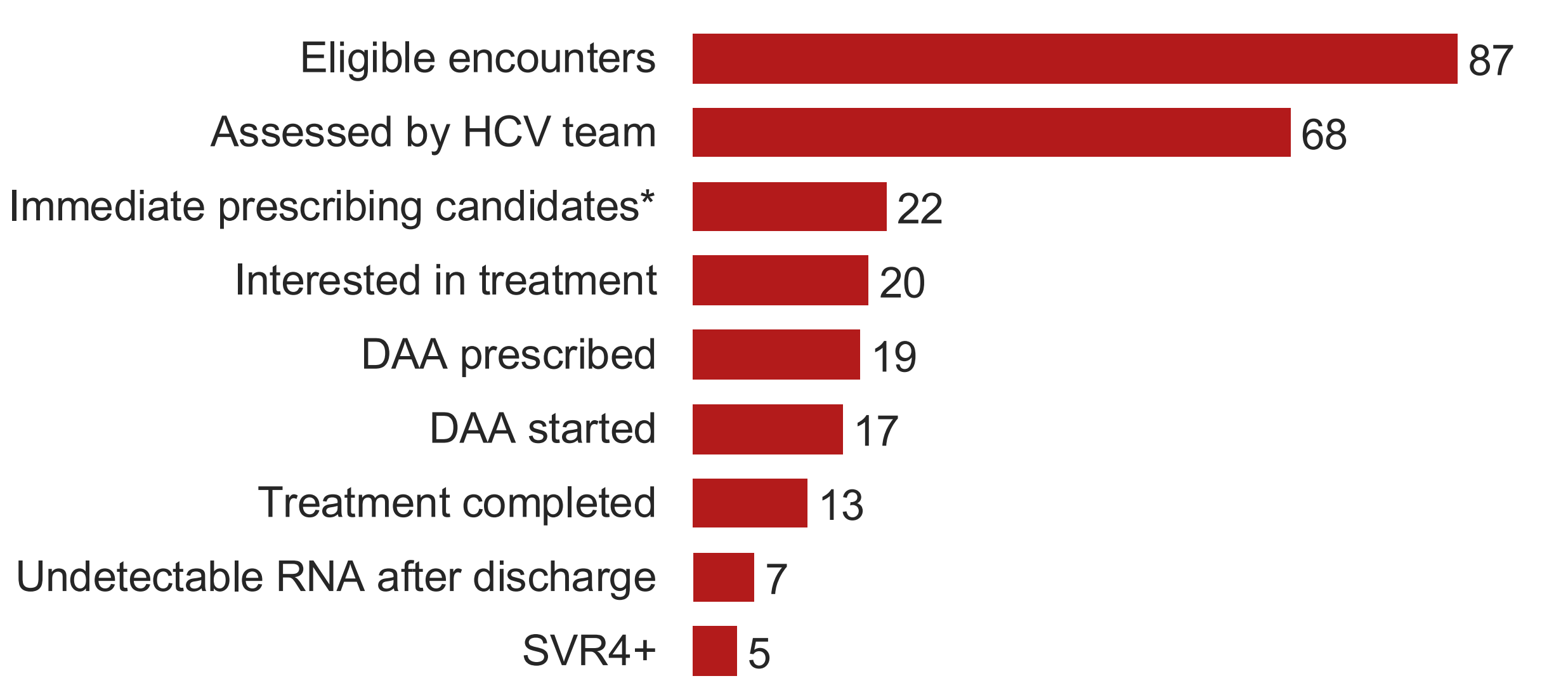
Treatment Outcomes

Pre/post comparison



SVR4+: HCV RNA undetectable at least 4 weeks after treatment completion (sustained virologic response)

Intervention care cascade



*Assessed by the investigator as able to take medication reliably and maintain contact after discharge.

17 starts: 14 inpatient and 3 outpatient

Treatment Feasibility

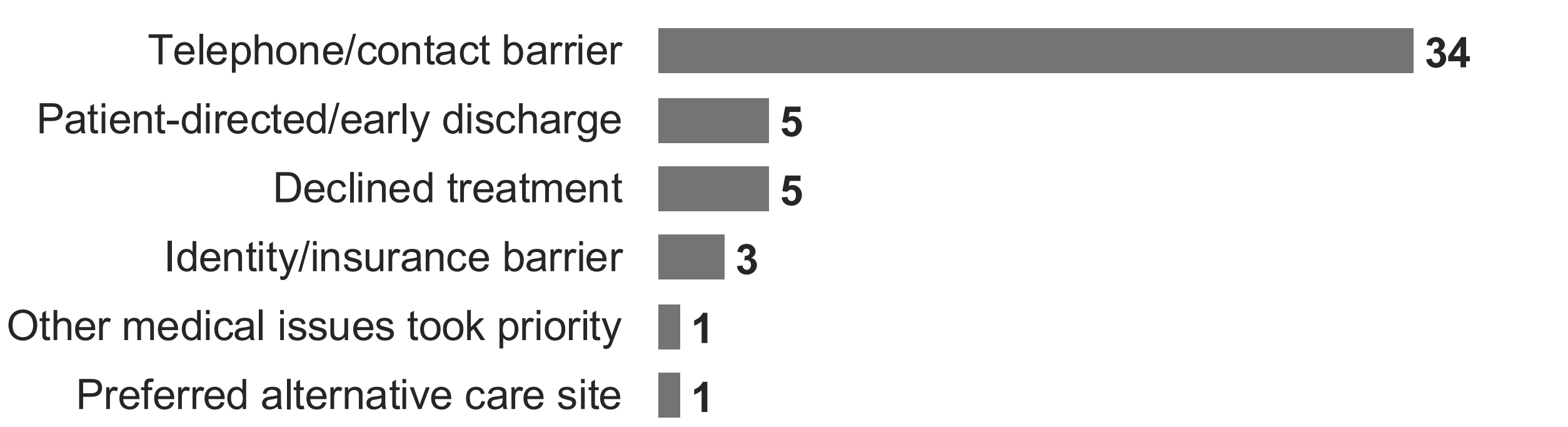
Candidates for immediate prescribing

Characteristic	Candidate (n=22)	Not candidate (n=46)
Age, years, median (IQR)*	49 (41, 62)	41 (37, 48)
Medicaid insurance	16 (72.7%)	40 (87.0%)
Unstably housed*	13 (59.1%)	42 (91.3%)
Lack working telephone*	10 (45.5%)	44 (95.6%)
Current injection drug use*	14 (63.6%)	43 (93.5%)
Length of stay, days, median (IQR)*	31.5 (12, 50)	11 (7, 20)
Patient-directed discharge	3 (13.6%)	13 (28.3%)

*p<0.05

Reasons DAA was not prescribed

49 assessed encounters without a prescription



Why treatment was not completed

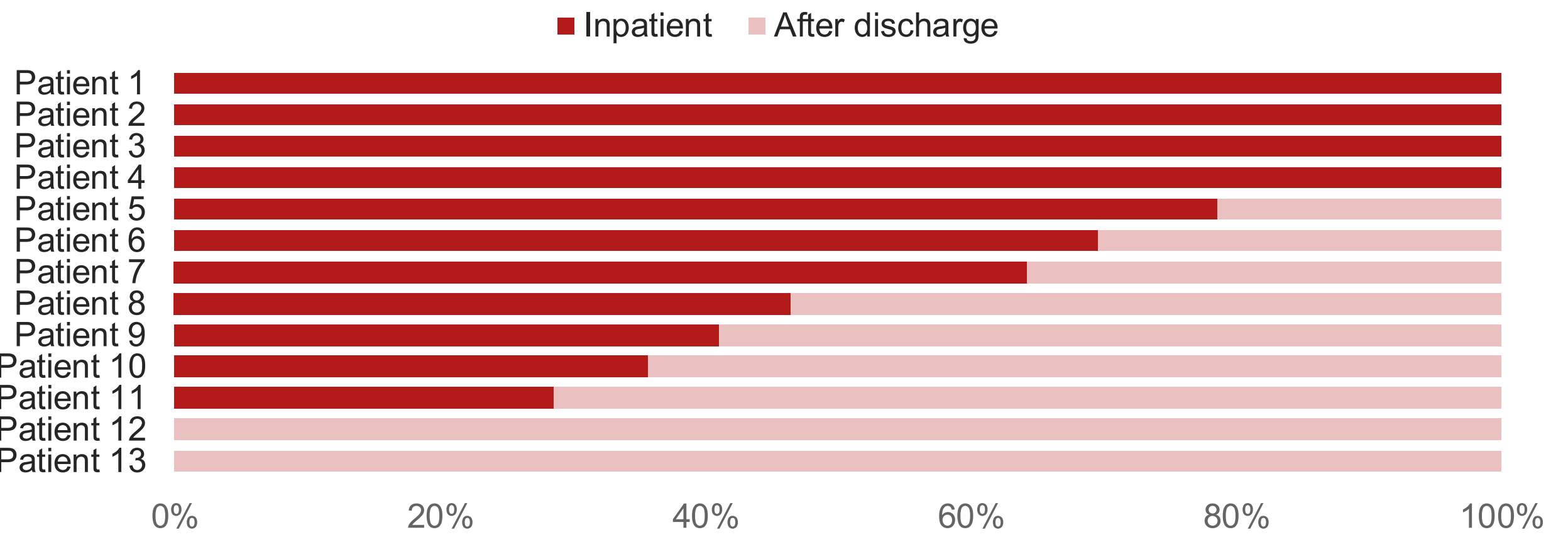
- Medication not collected from pharmacy (n=1).
- Patient-directed discharge before bedside delivery (n=2).
- Lost to follow-up after 2, 4, or 6 of 8 weeks (n=1 each).

Medication handoff near-misses

One course was in transit when a patient left via patient-directed discharge. Another course was nearly lost during an intrahospital transfer.

Delivery, Experience, and Conclusions

Where treatment was completed (n=13)



Qualitative evaluation

6 interviews: 4 providers, 1 patient, 1 caregiver

All six interviewees rated the program acceptable and liked the program. Difficulty contacting patients after discharge limited patient interviews. Themes included:

Bedside delivery reduced logistical barriers to treatment.

“Starting treatment was very, very easy to do because of how it was provided. The medication was provided right away. I didn’t have to go pick it up anywhere.” - Caregiver

Providers worried about care continuity after discharge.

“... there’s always this fear of, I get them started on treatment, and then they vanish into the ether vs making sure they get safely established as an outpatient and then starting... sometimes I feel more comfortable with that.” - Provider

Patients highlighted opportunities for family and community engagement.

“... it would be amazing for you to have a program... that would be able to talk to family... and have them tested [for HCV] as well...” – Patient

Providers identified a need for greater awareness of the program.

Conclusions

- DAA prescribing, initiation, and completion were higher during the intervention despite greater housing instability, more injection drug use, and more limited telephone access in the intervention cohort.
- Post-discharge contact and medication handoff remain barriers. No patients attended in-person follow-up visits.
- Scale-up requires standardized feasibility criteria, reliable medication custody, greater program awareness, and a sustainable multidisciplinary workflow.

