Application: Opportunistic HCV treatment initiation in hospital

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CTN+ Seed Funding Competition

Summary

ID: 0000000008
Status: In Review
Last submitted: Mar 18 2026 09:41 AM (PDT)

Seed Funding Full Submission Form

Completed - Mar 18 2026

Seed Funding Full Submission Form

ctn+ CIHR Pan-Canadian Network for HIV and STBBI Clinical Trials Research | Réseau pancanadien pour des essais cliniques sur le VIH et autres ITSS

Please read the CTN+ Seed Competition Guidance document prior to completing your submission.

Please use the form below to submit your project as a CTN+ Seed Funding study to receive support from your CTN+ Regional Team. Your application will be reviewed by the CTN+ review committee panel before receiving final adjudication at the next CTN+ Steering Committee meeting. In the case of incomplete information, you may be contacted by a CTN+ administrator with a request to provide additional details or documents.

If you have any questions or concerns about this process, please send an email to submissions@hivnet.ubc.ca.

Principal Applicant

First and Last Name

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Email Address

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Institutional Affiliation

UBC; BC-CfE

Is the Principal Applicant a CTN+ Researcher?

Please note that only applications from CTN+ Researchers and CTN+ Postdoctoral Fellows are eligible to receive Seed Funding.

Principal Applicant is a CTN+ Researcher

Submitter

Leave blank if this form is being submitted by the Principal Applicant.

First and Last Name

Kate Salters

Email Address

ksalters@bccfe.ca

Study Overview

Study Title

Evaluation of a Hospital-Initiated Hepatitis C Treatment Quality Improvement Initiative for Patients with Untreated Infection

Name of Study Lead

Kate Salters

Please list all study team members.

Format: First and last name, Affiliation, Role within the study

Kate Salters, UBC & BC-CfE, nominated principal applicantVictor Leung, UBC & Providence Health Care, co-applicantMark Hull, UBC & Providence Health Care, co-applicantJulia MacIsaac, UBC & Providence Health Care, co-applicantAlnoor Ramji, UBC & Providence Health Care, co-applicantJunine Toy, UBC & BC-CfE, co-applicantJulio Montaner, UBC & BC-CfE, co-applicantEdward Tam, UBC & Providence Health Care, co-applicantMichelle Gnyra, Providence Health Care, co-applicantOtto Vonbischoffshausen, VCH & Ribbon Community, co-applicant & Peer Navigator

Which CTN+ Region is this study most closely aligned with?

BC & Yukon

Which CTN+ Think Tank is this study most closely aligned with?

Treatment & Management

Type of Study

Select all that apply

Responses Selected:

Epidemiological/Observational Study

Study Details

Research Question

Please summarize in one sentence.

This study will evaluate whether a structured hospital-initiated hepatitis C treatment protocol increases treatment initiation among persistently untreated patients HCV persons while assessing feasibility, patient experience, and integration into routine inpatient care.

Lay Language Description

(250 words maximum)

Hepatitis C (HCV) is a viral infection that can cause serious liver disease or death if left untreated. In British Columbia, highly effective medications are publicly funded and can cure most people with HCV (over 95% of the time). However, many individuals remain untreated, especially people who use drugs or those facing barriers such as unstable housing, mental health challenges, or stigma in healthcare settings. Many of these individuals interact with the healthcare system through hospital admissions but may not receive treatment for HCV during these visits.

This project aims to improve access to HCV treatment by offering treatment initiation during hospitalization at St. Paul's Hospital in Vancouver. Hospital stays may provide an important opportunity to identify untreated HCV and begin treatment for people who may find it difficult to access care in community settings. Over a six-month period, hospitalized patients with untreated HCV documented in their charts will be identified and offered treatment while in hospital, when appropriate. A peer navigator (someone with lived or living experience with HCV) will help support patients by providing information, answering questions, and assisting with follow-up care after discharge.

Our proposal will assess how well this intervention works to both increase uptake of treatment and also how it is received by patients. We will evaluate how many patients start treatment, complete treatment, and are cured of HCV, as well as patients' experiences with receiving care in the hospital. Findings will help inform future efforts to expand hospital-based HCV treatment programs across British Columbia.

Number of Study Participants

(Total N, and N per Arm if applicable)

Target sample size is 90 patients (total number approached over a 6-month period) or 15 patients a month

Please list the participating sites.

(Use 1 row per site. Leave any unused rows blank.)

	Site Name	Participating Research Team
Site 1	SPH- Department of Medicine- Individuals admitted to hospital to one of the participating units (Internal Medicine, Infectious Diseases, Addiction Medicine) who have documented HCV viremia will be approached as part of this protocol	Clinical: Drs. Leung, Hull, Ramji, MacIsaac, & Tam Research/evaluation: Drs. Montaner, Salters, Toy, Mr. Vonbischoffshausen and Ms. Gynra and Ms. Beck.
Site 2		
Site 3		
Site 4		
Site 5		
Site 6		
Site 7		
Site 8		
Site 9		

Please provide the rationale for the need for seed funding for this study, the feasibility of completing the study in one year, and how this study will support/inform future planning of a larger study, interventions or grant application.

(750 words maximum)

Despite the availability of highly effective, publicly funded hepatitis C virus (HCV) treatments in British Columbia, important gaps in care persist, particularly among people who use drugs (PWUD) and individuals with multiple co-morbidities and structural barriers to healthcare engagement. Patients experiencing unstable housing, substance use disorders, mental health conditions, and stigma within healthcare settings are more likely to remain persistently untreated for HCV despite frequent interactions with the health system. Addressing these gaps remains critical to achieving HCV elimination goals.

Hospitals represent an important and often under-utilized opportunity to engage individuals who may face substantial barriers to initiating treatment in community settings. Many individuals who remain untreated for HCV have repeated hospitalizations related to complications of substance use, infections, or other chronic conditions. Hospital admission may therefore provide a unique window to identify untreated HCV infection, initiate therapy, and establish linkage to ongoing care.

Emerging evidence supports the effectiveness of hospital-based treatment strategies. The OPPORTUNI-C trial (Midgard et al., 2023) demonstrated that hospitalized PWUD who received an opportunistic “test-and-treat” intervention were significantly more likely to initiate and complete HCV treatment within six months compared to those patients referred to standard outpatient care. Time to treatment initiation was also substantially reduced, highlighting the potential of hospital-based strategies to overcome barriers to treatment and reduce inequities in HCV care.

Building on this evidence, our research team is implementing a quality improvement (QI) initiative at an inner-city Vancouver hospital (St. Paul’s Hospital) which will allow us to identify hospitalized patients with untreated HCV infection and facilitate treatment initiation during hospitalization whenever feasible. The goal of this evaluation is to comprehensively assess the impact of this initiative on treatment uptake, progress across the HCV cascade of care, and patient-reported experiences measures. The proposed project will implement and evaluate this clinical intervention over a six-month implementation period, followed by six months of follow-up to assess key clinical, therapeutic and patient reported outcomes.

Considering the multiple barriers that have historically impacted access to HCV treatment for this population, a key innovation in our protocol is the inclusion of a Peer Navigator to support engagement and linkage to treatment. Involving people with lived and living experience has been widely recognized as an effective strategy to improve engagement in care among individuals facing multiple structural barriers, including stigma, mistrust of healthcare systems, and competing social priorities. The Peer Navigator will provide bedside engagement, education, and support for linkage to outpatient follow-up after discharge. In Vancouver, people who use drugs and those experiencing housing instability account for a large proportion of untreated infections, making hospital-based treatment pathways an important opportunity aligned with provincial and national HCV elimination strategies.

Additionally, we anticipate that up to 25% of the patients approached through this QI protocol will be Indigenous, based on preliminary data analytics. As such, we will be co-planning and refining the study protocol with the Providence Health Care Indigenous Wellness Reconciliation team (Lindsay Beck). We will want to ensure that both the ways in which we approach patient discussions about initiating HCV treatment and discussing barriers to treatment are done so in culturally safe and appropriate ways, without introducing harms to patients.

Seed funding is essential to support the implementation and evaluation of this initiative, including patient engagement activities, peer navigator support, and prospective data collection on patient experiences and treatment outcomes. The proposed study is highly feasible within a one-year timeframe given the existing clinical infrastructure at St. Paul's Hospital, established HCV care pathways, and the experience of the clinical and research team.

Findings from this pilot project will generate critical preliminary data on the feasibility, acceptability, and effectiveness of hospital-based HCV treatment initiation in Vancouver. These results will inform the development of a larger implementation study and support future funding applications aimed at scaling hospital-based HCV treatment pathways across acute care settings in British Columbia. Ultimately, this work will contribute to efforts to reduce inequities in access to HCV treatment and accelerate progress toward HCV elimination.

Additional Study Details

Please provide additional details about the following aspects:
(2,000 words maximum)

1. Primary objective
2. Secondary objective(s)
3. Study population (including inclusion/exclusions criteria if applicable)
4. Exposure or intervention (if applicable)
5. Primary outcome/measures
6. Secondary outcomes/measures
7. Analysis plan (including sample size justification, with power calculation if appropriate)
8. Detailed recruitment plan
9. Expected results/implications and plan for using results

The overarching goal of this project is to enhance treatment uptake among patients with hepatitis C virus (HCV) infection who remain untreated but have some engagement with the health system. Specifically, this project aims to improve uptake of HCV therapy among hospitalized patients with untreated HCV infection and to evaluate outcomes associated with initiating treatment during hospitalization (versus referral to outpatient care in the community). We hypothesize that a structured hospital-based HCV treatment pathway with peer navigation will increase treatment initiation and progression through the HCV care cascade compared with standard of care (referral to outpatient care in the community).

Primary objectives of this proposal are to:
1. Determine the proportion of individuals that initiate HCV therapy in hospital among those offered treatment (overall and across specific demographic variables);
2. Determine outcomes across the HCV treatment cascade for individuals who initiate therapy in hospital compared with those referred to outpatient services for treatment initiation.

Secondary objectives of this evaluation project are to:
1. Assess and characterize previous HCV testing and treatment histories, as well as patient-identified barriers to treatment;
2. Describe patient-reported experiences (patient satisfaction, treatment self-efficacy, treatment attitudes, and quality of care).

Study population (intervention): Over a 6-month period, patients admitted to four units at St. Paul's Hospital will be eligible to be approached for this intervention if they have evidence of untreated HCV infection. Individuals will be identified through the hospital electronic medical record if they have a hepatitis C RNA viral load documented within the preceding 12 months. The reason that this population is being targeted is because these are likely individuals who are experience barriers or obstacles to initiating HCV treatment in other settings (e.g., primary care). We anticipate approaching approximately 90 patients over the six-month period and offering enrolment into the study (approximately 15 patients a month). Based on preliminary data analytics from St. Paul's Hospital, we estimate that this is a reasonable target sample size and would expect treatment uptake among approximately 68% of the sample (based on data from the previous trial). Individuals who are uninterested in initiating HCV treatment in hospital will be offered linkage to outpatient care to initiate HCV therapy following hospital discharge (control group). All participants, regardless of eligibility for inpatient treatment initiation or not, will be invited to participate in the study (further described below).

Eligibility criteria for inpatient HCV treatment initiation includes:

• Being an admitted patient with an anticipated duration of stay greater than 5 days

• HCV viral load without documented sustained virologic response (indicating clearance or treatment)

• No medical comorbidity deemed by the assessing physician to represent a contraindication to treatment initiation (e.g., sepsis, decompensated liver disease, significant drug interaction, or other clinical concerns)

• Ability to provide informed consent for HCV treatment and linkage to care

Overview of the intervention: We will conduct a longitudinal evaluation of a six-month quality improvement pilot at St. Paul's Hospital in downtown Vancouver, BC. Patients admitted to St. Paul's Hospital with an HCV viral load documented within the previous 12 months will be identified. HCV-viremic individuals will be identified within the CST/Cerner electronic medical record using the Dynamic Worklist, which has been developed to identify patients admitted to hospital with a detectable hepatitis C viral load within the preceding 12 months. The Antimicrobial Stewardship Program will generate an order set for baseline HCV-related laboratory investigations, including liver enzymes, renal function, liver function testing, hepatitis A and B serology, HIV serology, and HCV genotype testing if not previously performed. At the same time, a consult will be generated for the John Ruedy Clinic (JRC) HCV nurse.

The HCV nurse will review each identified case with an HCV physician (Drs. Hull, Tam, Ramji, or MacIsaac), or with the Infectious Diseases physician for patients admitted to the Infectious Diseases unit or concurrently followed by the Infectious Diseases consult team. Patient charts will be reviewed to determine clinical eligibility for treatment discussions. If patients are eligible for treatment initiation, a Special Authority application will be generated and the ward pharmacist will be notified to arrange access to medication once approval is obtained.

Individuals initiating therapy during hospitalization will either complete therapy in hospital if their length of stay permits, or will continue therapy following discharge. Patients discharged prior to treatment completion will be connected to outpatient care at St. Paul's Hospital, including the John Ruedy HCV Clinic, the Rapid Access Addictions Clinic (STBBI service), the Digestive Health Centre clinic, or the Hope to Health primary care clinic (in community). Patients already connected to community-based care will be linked back to their existing provider when appropriate. Linkage to care and coordination of remaining HCV therapy through a community pharmacist will be facilitated by the HCV service nurse and pharmacist. A Peer Navigator will also be available to support discharge planning and facilitate linkage to care at the time of hospital discharge.

Study design & methods: Recruitment protocol for this study will be strictly from the dynamic worklists, which will be reviewed by the HCV nurse and physician and follow-up and engagement will be actioned by the Peer Navigator and then the Research Coordinator. These reviews will occur three times a week. All participants invited into the intervention, regardless of HCV treatment initiation (in-hospital or referred to community), will be invited to participate in the evaluation study (target n=90 over 6-months). A part-time Research Coordinator will work closely with the Peer Navigator to visit each patient and explain the research protocol in-person. All consented participants will complete two brief surveys administered by the Research Coordinator with the Peer Navigator present (upon request) and will consent to the research team accessing their health records to confirm medical history, treatment experiences and clinical outcomes. Survey time points will include one at baseline, when treatment is offered, and a follow-up survey approximately three months later (offered either by phone or in-person). Surveys (approximately 15 minutes in length) will assess socio-demographic characteristics as well as patient-reported outcomes including prior treatment experiences, attitudes toward HCV therapy, treatment self-efficacy, quality of care, and satisfaction with hospital-based treatment initiation. The survey tool will be co-developed by research and community partners on the study. Participants will receive a $30 cash honorarium for each survey they complete (up to 2 surveys). To contextualize study findings, we will also conduct a retrospective review of inpatient HCV case outcomes prior to implementation of

the intervention.

Data sources: Multiple data sources will be used to assess clinical and patient-reported outcomes. Clinical data related to eligibility, treatment initiation, laboratory results, and treatment outcomes will be extracted from the Providence Health Care electronic medical record (CST/Cerner). Relevant laboratory data will include HCV RNA viral load measurements, liver function testing, genotype testing, and other baseline laboratory investigations ordered as part of the standardized order set.

Patient-reported outcomes will be collected through surveys administered at baseline and approximately three months following treatment offer. These surveys will capture socio-demographic characteristics, prior HCV testing and treatment experiences, treatment attitudes, treatment self-efficacy, satisfaction with care, and perceptions of the hospital-based treatment initiation protocol.

Where possible, clinical outcomes related to the HCV treatment cascade (e.g., treatment completion and sustained virologic response) will be verified through laboratory records documented in the electronic medical record or communicated by linked outpatient providers. These multiple data sources will allow for comprehensive assessment of treatment uptake and progression along the HCV care cascade.

Analysis: Proposed analyses will focus primarily on descriptive evaluation of treatment uptake and progression along the HCV care cascade among individuals identified with untreated HCV infection during hospitalization. Given the pilot nature of this study, analyses will primarily be descriptive, with findings used to inform the design and implementation of larger-scale hospital-based HCV treatment initiatives.

First, we will describe the characteristics of the overall cohort of viremic individuals identified through the hospital worklist, including demographic characteristics, clinical characteristics, and prior HCV testing and treatment history. We will report the proportion of individuals who are assessed for treatment eligibility and the proportion deemed eligible versus ineligible for inpatient treatment initiation.

Second, we will assess uptake of HCV therapy following enrolment in the intervention. This will include the proportion of individuals who initiate treatment in hospital and the proportion referred to outpatient services for treatment initiation following discharge. Time to treatment initiation will also be assessed from the time treatment is offered to the time of treatment initiation.

Third, we will evaluate progression along the HCV treatment cascade among individuals identified with untreated infection. Cascade indicators will include treatment initiation, treatment completion, sustained virologic response at 4 weeks (SVR4) and/or 12 weeks (SVR12) following treatment completion, and loss to follow-up. These outcomes will be summarized using frequencies and proportions given the anticipated pilot sample size.
Comparative analyses will examine differences between individuals who initiate treatment during hospitalization and those referred for community-based treatment initiation. Categorical variables will be compared using chi-square or Fisher's exact tests as appropriate, and continuous variables will be compared using t-tests or non-parametric equivalents depending on data distribution. Time to treatment initiation may also be summarized descriptively and examined using time-to-event methods where feasible.

Patient-reported experience and outcome measures will be summarized descriptively, including measures of prior HCV treatment experiences, attitudes toward HCV therapy, treatment self-efficacy, satisfaction with care, and perceived quality of care associated with hospital-based treatment initiation. An equity-focused implementation lens will be applied to explore how social and structural factors

shape treatment uptake and outcomes. Descriptive and stratified analyses will examine differences in treatment initiation and cascade outcomes across key variables including age, gender, substance use history, mental health history, housing instability, and patterns of healthcare engagement. These analyses will help identify potential inequities in treatment access and inform the design of targeted strategies to improve equitable access to HCV therapy.

Anticipated outcomes: Findings from this pilot will inform the development of scalable hospital-based HCV treatment pathways that could be implemented across acute care settings in BC. Specifically, this project will generate evidence on the feasibility, acceptability, and effectiveness of initiating HCV therapy during hospitalization for patients who have previously remained untreated despite prior engagement with the healthcare system. The study will provide important insight into how hospital-based treatment initiation influences progression along the HCV care cascade, including treatment initiation, completion, and achievement of sustained virologic response. By comparing outcomes between individuals who initiate therapy in hospital and those referred to outpatient care, the project will help identify whether hospitalization represents a critical opportunity to overcome structural barriers to treatment engagement.

Patient-reported data will further characterize the experiences, preferences, and perceived barriers faced by individuals living with HCV, particularly among populations experiencing structural vulnerability. These findings will help identify patient-centered strategies to improve treatment uptake and continuity of care during transitions from hospital to community settings.

At the health system level, results from this evaluation will support the development of evidence-informed clinical workflows and implementation strategies for hospital-based HCV treatment initiation. This work will contribute to provincial efforts to expand equitable access to HCV therapy and accelerate progress toward hepatitis C elimination goals in BC.

The intent of the Seed Funding Competition is to provide the sole source of funds for the study. However, resources provided by your supervisor (if applicable) or institution may be used. If you are receiving this type of support, please provide a list of resources you are receiving here.

(200 words maximum)

-The PHC Antimicrobial Stewardship program will offer in-kind support by reviewing Dynamic work list (with the HCV nurse) and ordering baseline testing for individuals who may be eligible for treatment
-HCV nurse will be supporting the project by reviewing the dynamic lists three times a week and will also work closely with the participating MDs in submitting Special Authority requests for treatment
-Peer Navigator role will be critical in supporting the engagement with the patient and provided by externally secured funds for the protocol
-The BC-CfE will offer in-kind support:
• for the survey to be programmed in Oracle
• to complete data cleaning and analyses
• to cover publication costs of the academic paper reporting the results of the study
• to present the results of the study at academic conferences: one National and one International

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Budget

The maximum amount that can be requested depends on how many Seed Funding projects have been selected for your Region in this application cycle, but will generally be no higher than $25,000 CAD (for Regions with two Seed Funding submissions) or $50,000 CAD (for Regions with a single Seed Funding submission), with the exception of the Ontario Region, which may award three Seed Funding projects at $20,000 each. Please confer with your Regional Team if you are unsure.

Funds: The study budget must include an itemized line for all requested funds (for example: for supplies, include quantity and unit cost; for participant reimbursement, include the number of visits and dollar value of reimbursement per visit; for staff time, include the hourly rate and number of hours that will be worked; for supplies and travel, include estimated costs).

Honorarium costs: $30 for ~180 participants x 2 interviews: $11,000
Research staff costs: Research Coordinator (0.5 FTE @ $76,000 annually, including benefits: $38,000), based at the BC Centre for Excellence in HIV/AIDS

Regional or National Centre In-Kind Services Requests

Please check any in-kind services requested from your CTN+ Region or National Centre to support your study.

Responses Selected:

Knowledge Mobilization

Please provide the study milestones.

This must include the estimated start date and the duration of the study, maximum allowed is one year.
(500 words maximum)

This 12-month pilot study will be implemented in three sequential phases: intervention and data collection (Months 1–6), follow-up completion and preliminary analysis (Months 6–9), and final analysis and knowledge translation (Months 10–12).

Months 1–6: During this phase, the hospital-based HCV treatment intervention will be actively implemented. Dynamic worklists will be reviewed three times weekly by the HCV nurse and physician, with patient engagement led by the Peer Navigator and Research Coordinator. Recruitment will occur continuously, with a target enrolment of 90 participants over six months (or ~15 patients a month). Baseline surveys will be administered at the point of treatment offer, and clinical data (e.g., eligibility, laboratory results, treatment initiation) will be extracted from the electronic medical record in parallel. A key milestone is achieving ≥90% of the target sample and successful integration of research procedures into clinical workflow. Concurrently, retrospective data extraction of pre-intervention inpatient HCV cases will be completed.

Months 6–9: Three-month follow-up surveys will be completed for all enrolled participants, with flexible in-person or phone administration to minimize attrition. Data cleaning, verification of clinical outcomes (including treatment initiation and early cascade indicators), and preliminary descriptive analyses will be conducted. A key milestone is ≥80% follow-up completion.

Months 10–12: Comprehensive analyses of clinical and patient-reported outcomes will be finalized, including characterization of the HCV care cascade and equity-stratified findings. Comparative analyses between inpatient and community treatment pathways will be completed. Key deliverables include a final evaluation report, stakeholder presentations, and development of scalable implementation recommendations to inform provincial HCV elimination efforts.

Please provide a list of barriers or potential risks that could impede the study and include mitigation strategies.

(500 words maximum)

Implementation feasibility will be assessed descriptively through documentation of workflow processes, treatment approvals, and linkage-to-care coordination during the pilot period.
Loss to follow-up after hospital discharge is a key concern for this protocol, given the complex health and social needs of the target population. To mitigate this risk, a dedicated peer navigator will play a central role in supporting participant engagement, discharge planning, and continuity of care. In addition, the study team has strong connections to community HCV treatment networks in Vancouver, which will facilitate timely linkage to outpatient care. The H2H clinic in the Downtown Eastside will serve as a key follow-up site, accepting community referrals and supporting post-discharge treatment initiation and monitoring.

Many participants are expected to have co-occurring substance use disorders, which may affect engagement during hospitalization due to intoxication or withdrawal. The study team will work closely with the Addiction Medicine Consult Service to ensure participants have timely access to inpatient addiction care for stabilization and treatment, as well as referral to ongoing addiction services following discharge.

Pharmacy-related workflows may also present implementation challenges, including dispensary capacity to manage HCV medication supply for an increased number of patients and coordination of medication delivery within the hospital. These risks have been mitigated through early engagement with pharmacy stakeholders during protocol development.
Processes have been streamlined where possible, including identifying community pharmacy partners, clearly delineating roles and responsibilities across the medication workflow, and involving the HCV pharmacist liaison in implementation planning. Potential constraints on ward pharmacist capacity to coordinate medication supply have similarly been addressed through consultation with clinical pharmacists across key services (clinical teaching units, psychiatry, addictions, and infectious diseases) to ensure feasibility and alignment with existing workflows.

Please provide your publication plans.

(250 words maximum)

Findings from this project will be disseminated through a combination of academic publications, conference presentations, and targeted knowledge translation activities for community leaders, healthcare providers and health system decision-makers. We are requesting in-kind support from CTN+ for knowledge translation activities. In brief, we anticipate preparing at least one peer-reviewed manuscript describing the implementation and outcomes of the hospital-based HCV treatment initiative, including treatment uptake, treatment completion, sustained virologic response, and patient-reported experiences with hospital-based treatment initiation. A second manuscript may focus specifically on implementation insights, including the role of peer navigation and barriers and facilitators to initiating treatment during hospitalization.

In future activities, we would seek to present these findings at various conferences (internationally and nationally). If the intervention demonstrates promising results, findings will inform the development of larger implementation studies and future grant applications aimed at scaling hospital-based HCV treatment pathways across acute care settings in British Columbia.

Please provide an overview of community engagement for the development of this project.

(250 words maximum)

In the early stages of this project, we have started reaching out for input and guidance from community partners (both individuals who are Peers as well as organizations that represent people with lived experience). We will invite input from community partners and collaborators (CATIE, BC Hepatitis Network, and individuals Peers with lived experience on the project) on the significance and role of this project to improve access to HCV treatment in hospital and community settings for under-served populations. In addition, we are requesting in-kind support from CTN+ to support the development of a knowledge translation and mobilization plan for this project, and propose that we include community partners as co-developers of knowledge outputs. This integration is critical as we plan to share research and evaluation findings with decision makers that support individuals living with HCV and communities disproportionately affected. These co-developed outputs may include brief presentations, summary reports written in accessible language, and other knowledge sharing events with community organizations involved in harm reduction and hepatitis C care.

How does your study demonstrate a core commitment to Equity, Diversity, Inclusion, Accessibility, and Justice (EDIAJ)?

(250 words maximum)

This project is grounded in a commitment to advancing equity in access to HCV treatment. Structural factors such as stigma, discrimination, criminalization, and limited access to primary care contribute to persistent inequities in HCV treatment access. By focusing on hospitalized patients with untreated HCV infection, this project aims to reach individuals who may not be well connected to traditional outpatient care settings. Lessons learned from this intervention will help identify potential inequities in care delivery and inform strategies to improve access to HCV treatment for populations who have historically experienced barriers to care.
Our proposed intervention also incorporates a Peer Navigator with lived experience with HCV to support patient engagement and help address stigma and mistrust that may exist within healthcare environments. Integrating peer support throughout recognizes the importance of lived experience and promotes more patient-centered and culturally safe approaches to care.
In our analysis, we will apply an equity-focused lens to examine how factors such as age, gender, substance use history, mental health history, and patterns of healthcare engagement influence treatment initiation and attitudes towards treatment. Importantly, early preliminary data have demonstrated that a disproportionate number of clients we may reach through this intervention are Indigenous. As such, will work with the Providence Health Care Indigenous Wellness Reconciliation team and data governance group, which will importantly inform our study design and intervention as well as in any collection, analysis and synthesis of data.