

## Primary care providers can effectively treat people with hepatitis C

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Primary care providers such as non-specialist physicians and nurse practitioners can be quickly trained to provide direct-acting antiviral therapy for hepatitis C with a high level of treatment success and provider satisfaction, according to a presentation at the 2016 AASLD Liver Meeting last month in Boston.

The advent of direct-acting antivirals (DAAs) used in interferon-free regimens has made treatment for chronic hepatitis C much more effective. In addition, DAA treatment is shorter – typically 8-12 weeks instead of 12-24 months – and simpler because it does not require interferon injections and management of its many side-effects.

In addition to the cost of the new DAA drugs, another barrier to expanded access to treatment is that there are not enough liver disease specialists to treat everyone with hepatitis C. But specialised treatment may not be necessary for most people with uncomplicated disease in the DAA era.

Sophy Wong of the Alameda Health Consortium and colleagues evaluated a simple, rapidly scalable model for building capacity among primary care providers (PCPs) to manage and treat people with hepatitis C in non-academic, non-specialist community health centres.

While primary care providers are often busy and even overburdened and suffering from 'burnout', Wong – herself a PCP – noted that they seldom have the opportunity to cure a serious disease themselves, and learning new skills to do so might improve job satisfaction.

In June 2015 a group of federally qualified health centres serving low-income urban populations in Alameda County, California (an area that includes Berkeley, Oakland and Fremont) launched a training and mentorship programme for primary care providers interested in treating hepatitis C.

The centres together serve more than 200,000 patients. About half are Latino/Hispanic, 23% are Asian/Pacific Islander, 19% are black and 15% are white. More than 70% are at or below the federal poverty level (about US\$12,000 for a single person or US\$24,000 for a family of four). A quarter are uninsured, 62% use MediCal/Medicaid (for low-income people) and 7% use Medicare (for seniors).

The training program was led by experienced non-specialist PCPs. The capacity-building model included provider-led half-day workshops on management and treatment of hepatitis C, quarterly updates and case discussions, locally developed and tailored treatment protocols and email or text/phone access to PCP mentors. Medication regimens for all hepatitis C virus genotypes are determined by each provider according to guidelines, and were obtained through normal insurance authorisations (no study medications were provided). In addition to medical information, PCPs were also taught the "nuts and bolts" of how to access medications, Wong said.

Program protocols – a simplified version of the [AALSD/IDSA hepatitis C guidelines](#) – specified that all people born between 1945 and 1965 should be screened for HCV regardless of risk, as well as anyone else at increased risk due to injection drug use, elevated ALT levels, incarceration or other factors. People who test HCV antibody-positive should receive a HCV RNA test within a month to determine if they have chronic infection, and if so they should receive an HCV genotype test.

A year and a half into the programme providers had identified nearly 800 people with chronic hepatitis C. Yet only three local hepatologists accepted Medicaid patients and the single site that accepted uninsured patients had a six-month waiting list, according to Wong. By training PCPs, the number of facilities able to treat low-income or uninsured hepatitis C patients increased to more than a dozen.

As of October 2016, 50 PCPs had been trained and 22 were treating people with hepatitis C. The number of PCPs providing treatment rose from four during the first quarter of the program to 22 during the most recent quarter – a 380% increase.

By July 2016 there were 215 people who were currently undergoing or had completed treatment. While only eight people started treatment during the first quarter, this rose to 55 during the most recent quarter – a 688% increase.

A total of 182 people completed hepatitis C treatment managed by the newly trained PCPs. Among the 112 who were followed long enough to determine sustained virological response at 12 weeks post-treatment (SVR12), the cure rate was 96%.

The researchers did a survey of PCPs who participated in the programme, 25 of whom responded. All respondents reported that their skills in identifying people for treatment,

interpreting lab results, understanding cirrhosis, and treating people had increased "quite a bit" or "a great deal."

Most responding PCPs (82%) said they were more satisfied, and all were at least as satisfied, with hepatitis C patient visits as they were with other primary care visits; 88% reported spending about the same or less time on hepatitis C visits as on other visits. One hundred per cent of PCPs said they would like to continue to include hepatitis C treatment as part of their clinical practice.

Based on these findings, the researchers concluded, "Primary care providers can be trained rapidly and effectively to provide hepatitis C treatment to high degrees of satisfaction, increasing access to hepatitis C care for underserved and vulnerable populations."