Mobilizing Primary Care Providers to Treat Hepatitis C in Rural West Virginia

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BACKGROUND

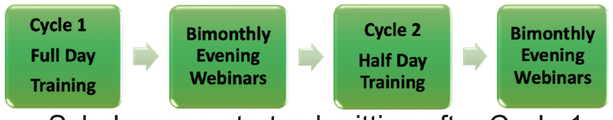
- WV has ranked 1st or 2nd for acute HCV incidence for over a decade but has few specialists and poor access to transportation, resulting in inequitable access to HCV care
- eliminating HCV in a state with large HCV burden is not possible without offering curative treatment locally
- most clinicians trained before 2016 are unaware that HCV is readily curable with minimal toxicity
- their experience was marked by the limited success and considerable toxicity of the interferon era and reality that HCV management was then the domain of hepatologists/GI
- persistent confusion about how to interpret HCV serology
- lack of confidence in diagnosing and treating a 'new' problem
- no easy access to expert guidance
- stigma due to connection to injection drug use

RESEARCH QUESTION

How can primary care and addiction care providers (PCPs) be empowered to diagnose, evaluate, treat and cure HCV?

METHODS

WVHAMP model: web-based, free, free CME/CE



- Scholars can start submitting after Cycle 1
- evening webinars are case-based
- Cycle 2 is ~6 months after Cycle 1

PCP DEMOGRAPHICS

Training	33 NPs (63%) 12 MDs/DOs (23%) 7 PAs (13%)
Gender: F/M	39 (75%) /12 (25%)
MOUD prescriber	11 (21%)

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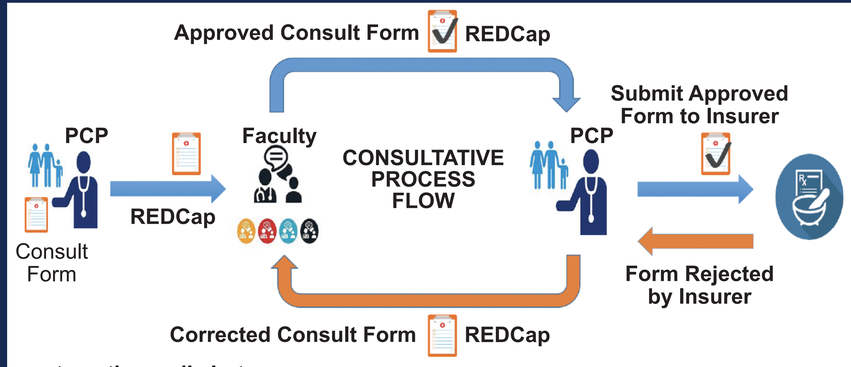
With guidance and support, rural PCPs who have never previously treated HCV can achieve the same rate of cure as specialists (>95%).

This approach can be expanded to underserved urban areas as well.



- **automatic email alerts**:
  - to faculty that new/updated consult is ready for review
  - to PCP that consult has been approved or requires revision/response
- **downloadable as PDF** - serves as a Prior Authorization request & contains all elements of work-up in one place for insertion into PCP's EMR

- REDCap is a customized, HIPAA-compliant, web-based data system. WVHAMP forms were designed to facilitate case-based bidirectional communication between PCP and expert faculty
- using an informatics platform available to all partners supports shared decision-making, fostering a learning network for HCV care, increasing self-efficacy and efficiency while enabling patients to receive care in the community from clinicians they know and trust

PATIENT DEMOGRAPHICS

Age (yrs)	mean 41.9 /median 40.0 range 22-79
Gender	M - 54.9%, F - 44.1%, Trans - 0.1%
Payer	Medicaid 87.7% Medicare 8.0% Private 5.3% Uninsured 1.3%
h/o IDU	Y - 82.1%, N -15.6%, ?- 2.5%
Other HCV exposure	Y- 22.6%, N- 55.4%, ?- 21.9%
Enrolled in SUD therapy	Y- 61.8%, N- 32.5%, ?- 5.8%
Genotype	1a/b - 64%, 2a/b - 12%, 3 - 25%, 4 - 0.4%. 6 - 0.2%
HIV Co-infected	2 (0.7%)
Fibrosis score	F0 - 52.5%, F1 - 12.6%, F2 - 17.1%, F3 - 4.8%, F4 - 6.1%, ? - 6.8%
Naïve/ Experienced	97.6%/2.4%

RESULTS

- 866 consultations reviewed since March '20
- 316 reached timepoint to assess SVR12
- 311/316 (98.4%) cured!

CONCLUSIONS

- PCPs can manage & cure HCV with adequate training and ongoing support
- rural PCPs are making a substantial contribution to HCV microelimination
- this model is readily replicable in any underserved area