A Novel Approach for a New Era: Successful Integration of Multidisciplinary, Hepatitis C Care within an Established HIV Primary Care Practice

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Published In/Presented At

Yozviak, J., Penaloza, O., & Friel, T. (2011, April 11-12). *A novel approach for a new era: Successful integration of multidisciplinary, hepatitis c care within an established HIV primary care practice.* Poster presented at: The First International Conference on Viral Hepatitis, Baltimore, MD.

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Background

Clinical trials have shown that at least 40% of patients with chronic hepatitis C (HCV) achieve sustained virologic response (SVR) with peginterferon/ribavirin (Peg/RBV). Since patients with a history of mental illness, addiction, multiple medical comorbidities or unstable social situations are commonly excluded from research trials, SVR is achieved less often in clinical practice. These issues may present management dilemmas for clinicians unaccustomed to the needs of complex patients. We proposed that integration of an HCV treatment program into an existing multidisciplinary HIV primary care practice would better address these needs, resulting in improved treatment outcomes.

Description

An internist-led HCV treatment program was integrated into an existing HIV practice in northeastern Pennsylvania employing a successful chronic care model, akin to a patient-centered medical home. The HIV program was comprised of a multidisciplinary team of providers trained in the complex medical and psychosocial management of patients with HIV and its multiple comorbidities, including the treatment of HCV coinfection. Certain members of this team subsequently apportioned part of their clinical time to the development of a new "Hepatitis Care Center," focused on the treatment of HCV-monoinfected patients within the region.

Principle staff of the new HCV program included general internists with experience in viral hepatitis management, a licensed clinical social worker (LCSW), registered-nurse/case manager (RN), dietician, and clinical support staff (MAs, LPN). Fifty percent of the staff was bilingual and bicultural. Intensive patient education and adherence support were provided by the RN and LCSW, focusing on psychosocial issues, coordination of mental health services and resolving barriers to care. Emphasis was placed on stabilization of modifiable psychiatric and medical comorbidities to allow for initiation of Peg/RBV in patients who would not normally receive treatment. Treatment outcomes were continually monitored.

Results

- 76 patients initiated Peg/RBV. None were coinfected with HIV.
- Final outcome data is available in 61 patients. 15 patients remain on Peg/RBV.
- Adverse events (AEs) were typical of Peg/RBV.
- Reasons for discontinuation (18, 29%):
  - Medical (6, 10%): Symptomatic CAD (1), Encephalopathy (2), Psoriasis (1), Hepatocellular Carcinoma (1), New Onset Type 1 Diabetes/DKA (1)
  - Psychiatric (2, 3%): Depression (1), Aggressive Behavior (1)
  - Other: Self Choice (5, 8%), Addiction (3, 5%), Relocation (1), Incarceration (1)
- SVR was achieved in 35 patients (57%) overall, GT 1 (23, 51%), GT 2 (6, 86%), GT 3 (4, 67%), GT 4 (1, 50%), and GT 6 (1, 100%).

Table 1: Demographics

Sex	
Male	37 (49%)
Female	39 (51%)
Race/Ethnicity	
White	33 (43%)
Hispanic	31 (41%)
Black	8 (11%)
Asian	2 (3%)
Egyptian	2 (3%)

Figure 1: Genotype Distribution

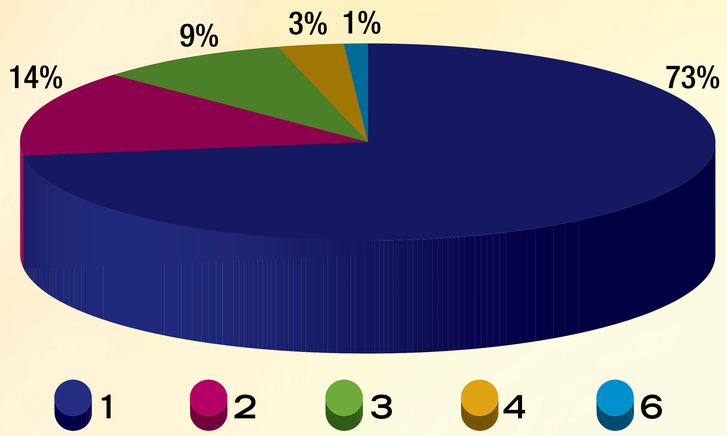


Figure 2: Peg/RBV Completion Percentage by Race/Ethnicity

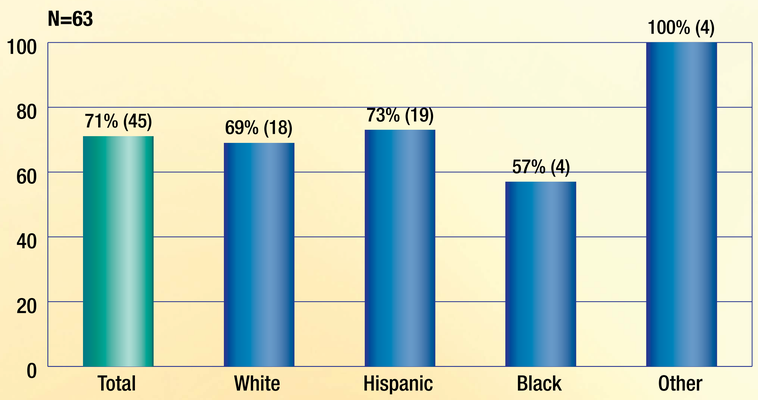


Figure 3: SVR by Genotype

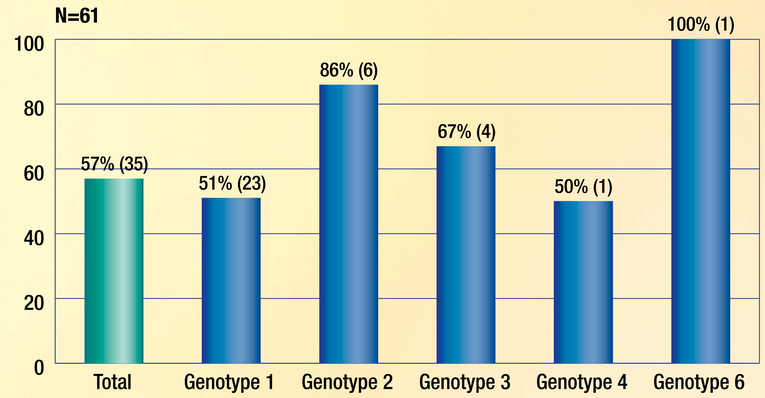
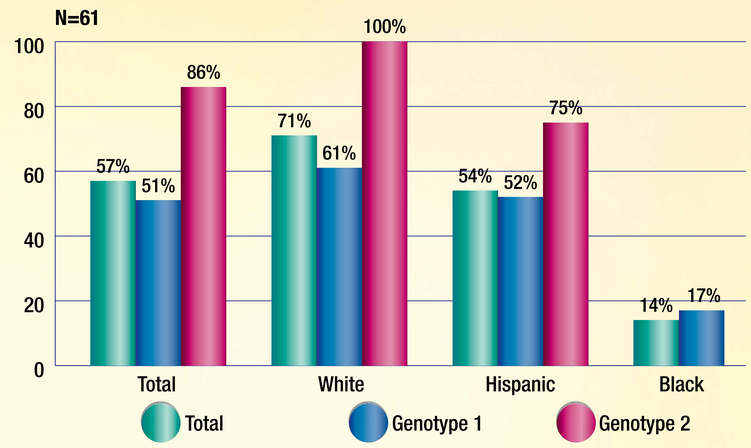


Figure 4: SVR by Selected Genotypes* and Race/Ethnicity



** No Black patients with genotype 2 HCV were treated.*

Conclusions

Integration of HCV monoinfection services into an existing multidisciplinary HIV clinical practice resulted in high rates of therapy completion and SVR in a diverse patient population. Providers experienced in the care of HIV and its many medical and psychosocial comorbidities are well poised to manage the diverse and complex needs of patients living with HCV in their communities. Focusing efforts on education, adherence support, health stabilization and patient preparedness for treatment allowed Peg/RBV to be provided to a broader population. Further evaluation of this model of care is necessary in HIV treatment centers and other patient-centered medical homes, where medical, case management, mental health, and nutrition services may be co-located.