Training Tomorrow’s Providers and Expanding Access to Peginterferon/Ribavirin Combination Therapy for Chronic Hepatitis C in Underinsured/Uninsured Patients: Final Outcomes of a Pilot, Resident-Initiated, Multidisciplinary, Hepatitis C Clinic

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Published In/Presented At
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This poster is available at LVHN Scholarly Works: http://scholarlyworks.lvhn.org/medicine/123
Introduction:
Clinical trials have shown that at least 40% of patients with hepatitis C (HCV) achieve sustained virologic response (SVR) with peginterferon-alfa/ribavirin (Peg/RBV) therapy along with adequate medical and psychiatric support. Despite the availability of potentially curative therapy, a lack of insurance or inadequate insurance may prevent access to this treatment for many patients. Another potential barrier is the relatively small pool of physicians capable and willing to provide Peg/RBV therapy. SVR is achieved less often in clinical practice than in research trials, where patients with a history of mental illness or multiple medical comorbidities are commonly excluded. We proposed that an integrated, multidisciplinary approach to Peg/RBV therapy would result in SVR rates similar to those of clinical trials in a medically and psychiatrically complex cohort of patients, while training internal medicine residents to provide this therapy.

Methods:
A pilot HCV clinic was established in 2004, staffed by internal medicine residents, an attending gastroenterologist and psychiatrist, and a registered-nurse coordinator. All patients were underinsured/uninsured and underwent peginterferon alfa-2a/RBV therapy. The length of therapy was 48 weeks for genotypes 1 and 4, and 24 weeks for genotypes 2 and 3. Medical residents participated actively throughout Peg/RBV therapy by performing initial patient assessments and providing follow-up care including the management of medical and psychiatric side effects. The initial cohort completed follow-up in early 2008. Charts were retrospectively abstracted for demographics and baseline characteristics, virologic response, side effects, and reasons for discontinuation or non-initiation of therapy.

Results:
• Eight medical residents volunteered to participate in monthly HCV clinics over 3 years.
• Forty-eight patients were evaluated. None were co-infected with human immunodeficiency virus (HIV).
• Twenty-six patients (54%) were treated. Twenty-two (46%) were not appropriate candidates for therapy. Personal choice was the reason cited by 46% of those not treated, followed by unstable psychiatric illness (27%), comorbidities (18%), substance abuse (9%), viral clearance (9%), lack of follow-up (4%), and minimal fibrosis (4%).
• Ten (38.5%) treated patients achieved sustained virologic response in this mainly genotype 1-infected cohort.
• Thirteen patients discontinued therapy. Side effects were the most commonly reported reason for discontinuation (23%) followed by virologic null response, which occurred in 5 patients (19%). Other reasons cited were psychiatric (39%), poor adherence (3%), ongoing substance abuse (3%), and incarceration (3%).

CONCLUSIONS:
Despite a patient population with mostly genotype 1 HCV and significant medical/psychiatric comorbidities, we were able to achieve ETR/SVR rates comparable to those commonly reported. These data suggest that an integrative medicine practice can safely and effectively manage Peg/RBV therapy and serve as a model to expand access to antiviral therapy for many individuals with chronic HCV. Additionally, by incorporating a dedicated group of internal medicine residents, the pool of capable and willing providers of Peg/RBV therapy will be expanded.

References: