

Hepatitis C Screening Opportunities and Challenges for U.S. Emergency Departments

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Faculty

**James Galbraith, MD
Associate Professor
Department of Emergency Medicine
University of Alabama at Birmingham**

Overview

- **Background and Rationale**
- **Emergency Department HCV Testing: Findings from the front lines**
- **Real-world Challenges: Lessons from the ED**
- **Public Health Implications**
- **Q and A**

I. Hepatitis C Virus (HCV) Infection

- **What it is?**
 - **Contagious infectious disease caused by an RNA virus**
- **How is it acquired / transmitted?**
 - **Most commonly by direct contact with blood from an infected person**

I. Hepatitis C Virus (HCV) Infection

- **Pre ~1990s: Primarily via blood transfusions or organ transplantation**
- **Currently: Primarily via sharing needles / equipment (intravenous drug users)**
- **Other routes (less common): Sexual contacts, Maternal-fetal, Sharing personal items (e.g. razor blades), Tattooing**

HCV – World and US Burden

- **Worldwide**
 - **130–150 million chronic HCV**
 - **~350,000 HCV related deaths/year**
- **United States**
 - **3.5 million with chronic HCV**
 - **~15,000+ HCV related deaths/year**
 - **Two distinct waves of HCV in U.S.**
 - **Baby Boomers (~75% of infections)**
 - **Growing number of younger IDUs**

HCV - Morbidity

- Acute Hepatitis C Virus infection:
 - Short-term illness \leq 6 months of exposure
 - Acute leads to chronic infection for most people
- Chronic Hepatitis C Virus infection:
 - Long-term illness which can last a lifetime
 - Potential for serious liver problems, including cirrhosis (scarring of the liver) liver cancer and death

HCV - US Mortality

- The number of deaths due to hepatitis C is at an all-time high in the U.S. and exceeds those attributable to 60 other infectious diseases including HIV and tuberculosis

What's Possible for Control and Treatment?

- The good news
 - Antiviral medicines can CURE approximately 90% of persons with hepatitis C reducing risk of death from liver cancer and cirrhosis

What's Possible for Control and Treatment?

- The challenge
 - Typically indolent (clinically silent)
 - Optimal systems for screening, linkage to care and treatment remain under-developed
 - Resource constraints

Who Should Be Tested for HCV?

- 2012 CDC Screening Recommendations AUGMENTED prior targeted screening recommendations
 - IVDU
 - Recipients of clotting factors*, solid organ transplant
 - Hemodialysis patients
 - HIV
 - Persons with signs/symptoms of liver disease**
 - Children born to HCV positive mothers
- *before 1987; before 1992;
**e.g. elevated AST

Who Should Be Tested for HCV?

- Addition of 'birth cohort':
 - Adults born between 1945-1965
 - (75% of those infected with HCV fall in this cohort)

Dilemma: Where Should We Test for HCV?

- Primary care is ideal, but sometimes lower yield
 - Simpler referral
 - Identify and treat other contributing co-morbidities
 - HCV treatment in primary care

Dilemma: Where Should We Test for HCV?

- Secondary care may identify a greater proportion of persons infected, but many challenges
 - Testing reimbursement issues
 - Workflow issues
 - Follow-up counseling / referral difficulty

EDs are Well Positioned to Heighten HCV Awareness

- Front door to health system
- Open 24/7
- “Anyone, Anywhere, Anytime...”
- Critical component of the public health infra-structure
 - > 140 million visits / year

EDs are Well Positioned to Heighten HCV Awareness

- ~ 50% US population use ED at least one visit / year
- High volume of unique visitors
- EDs have track record experience / success public health interventions*

*Woollard, et al AEM 2009 Nov;16(11):1138-42.

Rationale for ED HIV / HCV Screening

- Populations Known to Be Disparate Users of U.S. ED Services: Uninsured, Medicaid Recipients, Non-Whites, Persons Living Below U.S. Poverty Level
 - Known to Be disproportionately affected with HIV / HCV
 - Often Lack Access to Primary Care-Based Preventative Screening (i.e., HIV/HCV testing)

Pragmatic Targeted Screening Missed the Mark



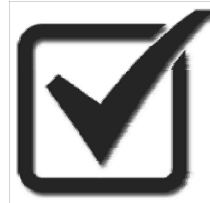
- Identifying non-baby boomer targets (IDUs) is challenging
 - 85% of persons tested were baby boomers or older at UAB
 - UAB tests for IDU risk accounted for <5% of all test orders
 - Incidental (non-risk based) tests of persons born after 1965 revealed 10% HCV-Ab prevalence at UAB

Pragmatic Targeted Screening Missed the Mark



- Stigma barriers
 - Provider - discomfort asking IDU questions, hard to operationalize asking, fear of affecting rapport with patient
 - Patient – recall bias, privacy, concern of affecting rapport with provider

Universal HCV Testing Eligibility



- Born after 1944
- Age > 18 years
- Medically stable for HCV questionnaire
- Self-reports no prior HCV diagnosis
- No prior test result in the EHR

Challenges: Environment

- Competing Priorities of the ED
 - Time Constraints
 - ED Crowding
 - Privacy
 - Medical / Surgical Emergencies

Challenges – Testing Costs / Reimbursement

- Centers for Medicare & Medicaid Services. Proposed Decision Memo for Screening for Hepatitis C Virus in Adults March 2014.
 - “CMS will cover screening for HCV...when ordered by the beneficiary’s primary care physician or practitioner within the context of a primary care setting”

www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=272

Challenges – Testing Costs / Reimbursement

- “Emergency departments, inpatient hospital settings... are examples of settings not considered primary care...”
- Available from: www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=272

Implications of ED Universal Testing - Surveillance

- High volume of unique visitors
- Well-positioned to engage PWID
- Wide geographic reach
- Sizable HCV yield that allows for identification of high prevalence geographic clusters

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