Comments about barriers to HCV treatment

- GI docs in my area are now my biggest referral source for hep C. The big barrier to interferon rx is the poor adherence (missed appts and lab) of a substantial # of hep C patients. [CA]
- Awaiting costs for new therapy implementation [MD]
- The major risk factor now is injection drug use. Many/most of these referrals do not have a source of funding for IF/RBV (~$1500/mo) and now the newer, more effective non-IF treatments are even more $$ but shorter. [NC]
- It will greatly increase our outpatient office use while we're already very busy in the hospital. Also concerned that financial reimbursement will not cover the time commitment required. [NV]
- If you asked me last year about barriers, the answer would have included all choices except limited access to providers and medical contraindications. Major problem now is time/effort needed for prior authorization for meds, better since guidelines came out. [NY]
- Most of the patients I see have HIV; we need clear guidelines on how to manage these patients. I think our practice could certainly take on more pure HCV management once short term oral regimens are FDA approved, but it would require more physicians or potentially "physician extenders". [OR]
- There is no financial support for hepatitis treatment presently in Pennsylvania regardless of payor (gov, MA, pvt insurance, other). Paying for medicines (which is every pvt ins for us now) is nowhere near enough. [PA]
- Trying not to be judgmental, but many of these patients come with a host of social, emotional, and related medical and financial issues. The "management" aspect requires more than an MD. [MS]
- Issues relating to the very high cost and limited coverage (very high co-pays) of HCV DAAs are a major disincentive to providing therapy due to the infrastructure (social workers/pharmacists) needed to assure provision of DAAs once a ID physician accepts responsibility for managing a patient's HCV. It requires the type of "medical home" structure that many IDs' offices/clinics do not yet provide. [MO]
- Prior authorizations are a nightmare & a major dampening influence on my enthusiasm for this care. [IL]
- HCV treatment is in the outpatient setting and can be labor intense. My work is primarily inpatient. Treatment has become more simplified and successful. A team approach to therapy seems justified. Psych, financial, and drug interaction issues abound. Concomitant HIV et al is common. [AZ]
- Most Hep C patients have Medicaid. State requires complicated pre-approval as $$$$.[MA]
- Medicaid has historically not paid enough for the time intensive management of HCV to be practical in an office setting. [NJ]
- I am undecided as to whether or not I want to treat hepatitis C patients. I've done so in the past, but became "burned out" by the many psychosocial difficulties. [OR]
- Almost every patient I see has at least one if not up to 5 barriers to HCV treatment. [SC]
• Management of patients with mental health problems week to week monitoring of labs is challenging and time consuming. [CA]

• I treated over 1000 persons with hep C, most mono infected. I was put out of business by CMS attack on private practice specialty medicine and became a hospital administrator. I strongly feel that ID should treat Hep C, and that it is complex, demanding and time intensive for both the physician and the staff. Compensation is inadequate. In my current community, neither GI nor ID will treat, so all patients are sent to Indianapolis. [IN]

• Found survey confusing. I have had no formal training in HCV. Occasionally see pts in coverage/consultation. Time consuming sink hole so frustrating when so many other pts to be seen. No good infrastructure or reimbursement, either. Would be willing to do more if educated. [PA]

• Solo ID practitioners with no staff or ancillary support cannot handle the demands of current interferon-ribavirin based HCV treatments. Without psychologist, social worker, pharmacist and hepatologist close support, treatment is extremely time consuming. The difficulties of managing insurance coverage, side effect monitoring, etc preclude me from treating patients. Hopefully, interferon and ribavirin free regimens will make treatment more accessible to patients. [SC]

• I think that ID specialists should be on the front lines of HCV treatment, but in my own practice my infrastructure isn't good enough to support someone through interferon-based therapy in terms of symptom management. I look forward to interferon-free regimens so that I can be the primary manager of this, especially in my HIV co-infected patients. [MD]

• I do not have and will not likely ever have the outpatient infrastructure needed to safely provide interferon based therapies and/or to manage patients who may develop complications of advanced liver disease. In a resource rich setting where genotype 1 infection predominates. I anticipate hepatologists will continue to manage most hepatitis c infections in my area for quite some time. [PA]

• The treatment of hepatitis C requires team approach, much like HIV. Therapies are quite expensive. Not worth my time to beg insurance companies for reimbursement. Patients require too much clinical support, all non-reimbursable. [ID]

• Most non-academic medical centers do not have established HCV treatment programs, and the burden of the patient population is overwhelming. ID physicians are generally swamped with patients as it is - it is hard to imagine taking on the HCV monotherapy treatment population, especially if it means treatment with interferon. [SC]

Comments about who treats HCV in respondents’ facilities/communities

• Gastroenterology currently does HCV treatment in my community. I will evaluate the need for evaluating/treating in the future if they are not eager to treat HIV/HCV coinfected patients. [CT]

• None of the options in Q 5 and 7 describe my situation. In our academic division, I have colleagues with interest and more expertise with HCV treatment and defer treatment to them. [GA]

• One of our ID faculty is the "expert" and sees nearly all cases in conjunction with GI. [WI]

• Time for ID physicians to stop passing on treatment to the organ based specialists. [LA]

• In our community, gastroenterology has done very little in terms of management of HCV infection other than endoscopy and management of complications of cirrhosis. ID is better suited to manage the infection itself. [MT]

• I am in moderately large ID group. I focus on areas other than Hep C, though did treat in the past when it was much uglier. I now refer to my partners. It looks like it is going to become easier though, if we can get insurance to play. [NM]

• At present GI treats pts, sent by ID. We manage HIV in co-infected pts. ID has no support and not enough training to treat hep C. [NY]

• Our group sees only inpatients. All HCV patients are referred for outpatient treatment to GI office. [TN]
• Prior to moving to our VA affiliate full-time, I treated both HIV-HCV coinfected and HCV monoinfected persons in our University ID clinics, but on a limited basis due to patient financial constraints and inadequate infrastructure. After moving full-time to our VA affiliate, I have treated only HIV-HCV coinfected patients because the large amount of infrastructure personnel support has been directed to the GI section (including funding for mid-level practitioners and clinical psychologist). I foresee the likelihood that more and more HCV monotherapy will fall to the ID practitioner and subsidiary mid-level practitioners as we transition away from interferon-based therapies to DAAs. [OK]

• Most pure HCV patients are seen by GI/hepatology in our community, and their clinic infrastructure is set up for getting these pts through difficult courses of treatment. We have our hands full with current staffing just taking care of our HIV patients. [OR]

• This is an infectious disease and should be treated by ID docs; I do refer decompensated cirrhotics to GI and obtain annual EGD screening for varices in compensated cirrhosis. [SC]

• I have an ID colleague who is also trained in Hepatology, who sees and manages most of the Hepatitis B and C patients who I encounter. We also have a very active Hepatitis Group, who treat patients in an investigative fashion. So there is little need for my input other than to refer patients and to manage their co-infections, especially those who I see in consultation in hospital. [TX]

• Limiting treatment to GI has resulted in only 20% of our patients being treated. [VT]

• The survey doesn't address all options. I am in a University setting where other members of the ID division oversee treatment of HCV, and I refer internally to that group - but this is not a situation which would create tension [MA]

• At our institution the hepatologists evaluate and treat viral hepatitis. We collaborate with them on HIV-coinfected patients or those requiring liver transplantation. ID physicians who are knowledgeable and are so inclined to evaluate and treat HBV or HCV should be able to do so. [AZ]

• I'm not really interested. I get their HIV controlled and then ship 'em to hepatology. They have dedicated nurse practitioners that only treat hep C and a hepatologist who keeps up on all the latest info. I can't compete with that nor do I want to. [OH]

• I treat with the assistance of a Gastroenterologist/Hepatologist. I do not feel comfortable yet making the final decision on my own or without the above specialist evaluating and following the patient. [NY]

• I work in a multidisciplinary clinic with hepatologists, infectious disease docs, specialty RN's, and a specialty pharmacist. I feel that this is an ideal setting for these patients. We lack a social worker, which we are hoping to add. [OR]

• I do not personally treat HCV mainly because one of my partners does, and I refer to her. [MS]

• In our area the GI docs refuse to see HCV patients. We are few in number as ID docs and our clinic is inundated by these patients.... there is no money in it for GI so as usual ID picks it up! [ME]

• I think ID specialty should be involved in HCV treatment and support that. [MA]

• Our program has no I. D. Fellowship so I evaluate HCV patients but send them to a hostilities so their fellows can get experience. [NY]

• As a virologist, I believe that we in ID have better perspective about the use of the agents involved in management of these patients. Consult with our GI colleagues is needed at times. [VA]

• We currently have an independent HCV clinic charged with treating these patients given the complications of therapy. As treatment options simplify HCV care will likely come (back) into the general ID practice. [MI]

• Feel that availability of 3rd generation HCV therapy, overloaded hepatology service make it reasonable to treat HIV/HCV pts. [AR]

• I think ID docs should get involved and treat hep C patients to help maintain their incomes in a world of vanishing hosp work [CA]
• If HCV treatment becomes all oral and well tolerated and the course is as short as 12 weeks then we should also consider a primary care provider model of treatment. If resistance and viral dynamic monitoring is needed then infectious diseases should be involved. Thanks! [MA]

• We do screen and treat for HCV in the hospital, and I believe ID docs should be adequately trained and capable of providing such care in conjunction with GI docs as appropriate. [NY]

• Folks who think GI will go away in HCV tx have not thought this through. Why would docs who can get a pt through ifn/RBV bail out when treatment is becoming so much easier (albeit more expensive)? ID will come in not because of our expertise (GI has always ignored virology and ID expertise/science - just see HBV guidelines (BTW I am GI and ID trained) but because we have a RW setup with case managers which will be critical for cocktails that will cost about the same as it costs to buy a Lamborghini. [SC]

Need for liver biopsy and serologic studies (Questions 9a and 9b)

• Lots of grey areas here and with likely non-interferon very effective rx licensed in the near future (1 year?), I am practicing watchful waiting for most patients unless documented cirrhosis without decompensation and no other contraindications. [CA]

• Question 9a too vague: decision for biopsy depends on other factors, e.g., age, likely duration of infection, results of non-invasive testing (elastography, FibroSURE ...). [ME]

• Question 9a is not applicable as I do not see any reason to ever use interferon again. With newer regimens I do not order liver biopsies as we will treat regardless of findings. [NY]

• Liver biopsy should be limited to early diagnosis and r/o other steatosis, autoimmune disease. Fibroscan should replace liver biopsy for late diagnosis ie cirrhosis or not. Non-IF regimens open up treatment options even to internists. [VT]

• I have to consider the amount of cirrhosis in determining treatment options, and liver biopsy. Questions 8 and 9 are not so clear cut. [VT]

• Regarding the Vignette. Fibrosure or similar are not perfect but the biopsy as a gold standard is not close to be golden either. The diagnosis of cirrhosis is not quite as important as it used to be maybe except for duration of therapy (as long as not decompensated) and I would venture to say that we will soon treat decompensated patients with a certain priority (and without ifn). [SC]

• Question 9 needs more nuance. APRI, FibroSURE, etc almost completely eliminate need for biopsy if consistent with F0 (no fibrosis) or F4 (cirrhosis); an equivocal result is more complicated. [MD]

• ALT and AST are not liver function studies. Liver function studies include bilirubin, albumin, and Protime. Platelet counts below 100,000 in the presence of hepatitis B or C are markers suggestive of cirrhosis. [LA]

• Question 9a is difficult. If Fibrosure was very favorable, I would not biopsy and would wait for IFN free regime. For Genotype 1a and b, there is no IFN free based regime that has been approved -- although literature says that sofosbuvir ribavirin is effective (though less than when IFN is added). [CA]

• Not sure there is enough data to convince me that fibroasure precludes doing a liver biopsy [DC]

• The vignette above is difficult to answer without knowing 1) the age of the patient and 2) the estimated length of infection. A 20 year old infected for 2 years does not need a biopsy; a 50 year old infected for 30 years probably does, all regardless of interferon/interferon-free treatment. [VT]

• I think it is difficult to give strict yes or no responses to either question in #9 above. Each case is unique and decision regarding liver biopsy is very much dependent on a variety of factors. [OR]

Determination of which patients to treat

• Evaluate HCV only, do not treat yet [GA, MO, SC]

• Still in transition from 1st generation treatment to new drugs in development. Plan to have a more active role later. [UT]
• have gradually gotten out of HIV treatment, more because I feel uncomfortable with primary care than HIV. I am less adverse to treating HCV, because it may be more episodic and not include the primary care piece. But, I would need training and resources. GI has the resources to treat. [MA]

• I have treated monoinfected and HIV/HCV coinfected patients in the past but do not do so presently, as I currently work only in the hospital setting. [TX]

• Will treat compensated cirrhosis [NJ]

• I treat all patients with HCV and would be willing to preceptor anyone who needs more exposure [WA]

• We, like many ID MDs mainly treat coinfected patients but are waiting for regimens known to be effective in this population with fewer drug interactions and less toxicity (preferably IFN-free). [CT]

• Given the upcoming availability of IFN-free treatment options, I often defer patients with minimal fibrosis currently (currently not available in Canada). [NT]

• I only treat HBV in HIV co-infected pts - that wasn't an option [MO]

Education and training
• Treatment has all changed recently, so prior training not relevant [NC]

• I have just begun to evaluate & manage patients with HBV or HCV. This is a natural fit for ID physicians, but few of us have received formal training in these areas. Training programs SPECIFICALLY FOR ID DOCTORS are needed. [AL]

• IDSA Hepatitis Webinar may be helpful. I registered for the webinar series. [MN]

Comments about various treatment choices
• Several insurance companies are steering new patients to sofosbuvir. [IL]

• Needs interferon ribavirin free regimens. [DC]

• Some of these questions are already outdated since interferon-free regimens are available [MD]

• Question 1 forces the answer. I believe none is really thinking about INF-based regimens. IDSA recent Guidelines do not even support INF [CA]

• More data about the new HCV drugs in setting of HIV/HCV coinfection are needed. [DE]