Opportunities for screening, care and treatment for HCV in a community health center through primary care

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Houston Federally Qualified Health Centers (FQHCs) in association with Project E.C.H.O. and St. Luke's Liver Center

INTRODUCTION

According to estimates from NHANES, there may be nearly 4 million people infected with the Hepatitis C virus, of which over 3 million are likely to be chronically infected. Given the sheer volume of those requiring care and treatment, as well as management and monitoring of those who are asymptomatic or acutely infected, specialty care through hepatologists is out of the reach of many in resource poor, underserved communities.

In partnership with St. Luke's E.C.H.O. Program, CCCHC-Houston area FQHC implemented HCV birth cohort screening in February 2014. Now screening has expanded to all high risk patients, as regular and routine screening.

METHODS

Through a partnership with Project E.C.H.O. and St. Luke's, and local Federally Qualified Health Centers, primary care patients are screened (both the birth cohort and as part of routine STD panel) for HCV. All patients receive RNA confirmatory testing and those testing RNA + are provided follow up diagnostic testing (genotype, ultrasound and biopsy when required) through St. Luke's. Patients are then enrolled in treatment protocol and monitored through primary care services for the duration of their treatment, and all providers meet weekly via teleconference with specialist at St. Luke's for case meetings on individual patient progress.

OBJECTIVES

Provide care, management and treatment of patients with chronic HCV infection through primary care services and providers (physician assistant and nurse practitioners) at a federally qualifies health center. Through a partnership with Project ECHO and St. Luke's Liver Center, provide case management of primary care patients and enroll them in treatment protocols for chronic HCV.

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Baylor St. Luke's Medical Center, in Houston, Texas, launched a tele-health program, Project E.C.H.O. (Extension for Community Healthcare Outcomes) with a team of healthcare professionals, Project E.C.H.O. Medical Director and Hepatologist, Norman Sussman, MD and Project Coordinator, Lizette Escamilla.

The mission of this program is to use teleconferencing to enhance medical resources in communities that currently lack specialized care. This therefore provides patients the opportunity to receive chronic disease treatment and other specialized services that they may otherwise have difficulty accessing.

OBJECTIVES

Community Collaborations

Project ECHO, Baylor St. Luke's Medical Center collaborates with primary care providers within Texas cities and rural communities.

The program uses multipoint teleconferencing to connect with community providers in a peer-to-peer format, and uses case-based learning to teach providers to deliver state-of-the-art medical care. The end result is a sophisticated medical workforce and improved health and health care in communities across the state.

- Primary Care Providers will learn a specialty.
- Earn CME credits for presenting a patient case.
- Connect with Primary Care Providers throughout Texas.
- Enhance Primary Care Provider facilities with increased medical resources.
- Enhance patient care by decreasing referral and appointment wait times.

RESULTS

To date, CCCHC has screened approximately 450 patients for HCV. Of those, 52 tested anti-body positive and of those, 47 have tested RNA positive, indicating chronic HCV infection. Currently, 11 patients are enrolled in treatment and being monitored for viral load and progress. Of the 11 in care, 4 patients have achieved sustained virologic response (SVR).

Project E.C.H.O. estimates that approximately 68 patient cases have been presented to Baylor St. Luke's specialist and 50% have either been treated or currently undergoing treatment.

Due to the successes of the Hepatitis C Clinic, which launched January 2014, several other clinics and specialists have joined the E.C.H.O. team to provide specialty care to rural and urban clinics. These patient either lack access as well as the resources or funds to get specialized care. The goal is to still promote the idea of Patient Centered Medical Home and continuity of care with in these patients' primary family clinic home.

Project ECHO Clinics

Hepatitis C Clinic
Infectious Disease Clinic
Hepatitis B Clinic
Cardiology
Advanced Liver Disease
Behavioral Health Clinic (Spring 2015)
Nephrology Clinic (Summer 2015)
Pulmonary Clinic (Summer 2015)
Rheumatology Clinic (Fall 2015)

CONCLUSIONS

The urban primary care setting is an important venue for providing care and treatment for those with HCV, particularly for those who do not have access to specialists or specialized medical settings. With increasingly simplified treatment regimens, primary care providers, especially physician assistants and nurse practitioners, can provide care, treatment and management of chronic HCV for those patients without complicated, advanced disease. Therefore, primary care settings should be considered a site of opportunity in treating chronic HCV given the growing numbers of those being screened and requiring care.

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ACKNOWLEDGMENTS/CONTACTS

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