Takeaways from the 2016 Liver Meeting for Viral Hepatitis Advocates

February 27, 2017 By Emalie Huriaux

The American Association for the Study of Liver Diseases (AASLD) held its annual conference, The Liver Meeting, from November 11-15 in Boston. Traditionally, the Liver Meeting attendees are clinicians and researchers and the program is primarily filled with highly technical scientific content. As a public health policy advocate, much of the content is over my head. (I mean, really, do I need to know about the plasticity of hepatic epithelial cells in liver health and disease?) That said, the 2016 Liver Meeting did have important information with implications for viral hepatitis advocacy. Below are five Liver Meeting takeaways for viral hepatitis advocates in the United States.

1. It really is time to plan for the elimination of viral hepatitis in the United States!

On the final day of the conference, Dr. Anna S. Lok, the incoming AASLD president, gave the Leon Schiff State-of-the-Art Lecture, “Elimination of Hepatitis B: Is It Possible?”. Dr. Lok spoke hopefully about global hepatitis B virus (HBV) elimination as within our reach. To achieve the goal of HBV elimination, we must scale up efforts to prevent transmission (e.g., HBV vaccine programs, efforts to test pregnant women and prevent mother-to-child transmission), increase screening, provide treatment to people living with HBV, and roll out novel HBV therapies.

Throughout the Liver Meeting there were a number of sessions and poster presentations about approaches to eliminating the hepatitis C virus (HCV). For example, Dr. Jason Grebely highlighted the need to focus on scaling up testing for and treating people who inject drugs (PWID), utilizing the idea of HCV “treatment as prevention” – in other words, treating and curing people living with HCV, particularly people who are likely to transmit the virus to others (e.g., PWID who share injection equipment) – as a key element of a strategy for eliminating HCV in communities. He also spoke about the need to offer harm reduction services, like sterile injection supplies and medicated assisted therapy, to prevent new infections and to prevent re-infection in those who have been cured. Susana Llerena et al presented a poster (#916) about efforts to eliminate HCV in a Spanish prison through a pilot program that includes scaled up efforts to test incarcerated individuals and treatment of all individuals identified as viremic. In another poster (#1995), Danny Issa et al presented findings from a single center cohort of U.S. veterans living with HCV, including the finding that sustained virologic response 12 weeks after treatment completion (SVR 12, also considered HCV cure) is similar to clinical trial and “real-world” cohort studies, and that HCV elimination “among all US veterans that are suitable treatment candidates is now a realistic goal.”

We have the tools to eliminate HBV and HCV in the United States and beyond. Scaling up preventive services, screening, and treatment activities to realize the goal of elimination requires the work of advocates, who must demand the necessary resources and policies that will support viral hepatitis elimination efforts.

2. There will likely be a (functional) cure for hepatitis B in the near future.

While much attention has been paid to advances in HCV treatment over the last few years, novel approaches to HBV treatment are on the horizon. We may soon have a “functional cure” for HBV (for more information on advances in this area, see this excellent summary).

The take-home for viral hepatitis advocates is that we must monitor what happens when new, more effective HBV treatments come to market. We must advocate with the pharmaceutical corporations to ensure these treatments are affordable and advocate with health insurers to ensure there are no unnecessary access restrictions. We have learned from the experience of the HCV direct acting antivirals coming to market that high prices and access restrictions make it difficult for people living with HCV to get the medications they need. Let’s take those lessons and apply them to treatment advances in HBV so history does not repeat.

3. Treating hepatitis C in primary care is both necessary and successful.

Hepatologists and infectious disease specialists alone cannot carry the burden of treating the estimated 3.5+ million people living with HCV in the United States. In order to treat as many people with HCV as possible, it is imperative that primary care providers learn how to treat HCV in their practices. At the Liver Meeting various methods for training primary care providers were outlined.

In a special session sponsored by the Centers for Disease Control & Prevention about improving testing, care, and cure of HCV in the U.S., Dr. Sanjeev Arora spoke about the Project ECHO model, an innovative model that links academic medical centers and specialists with primary care providers through video and tele-conferences that include training, mentoring and patient case presentations. He was joined by representatives from a number of cities who are utilizing the ECHO model or similar models for building primary care providers’ capacity to treat HCV. In a separate session Dr. Sophy Wong presented the work happening in Alameda County, CA to increase access to HCV care in primary care programs (an excellent summary of Dr. Wong et al’s findings is available online).

In the various presentations and posters describing HCV treatment in primary care, all had the same conclusion – that primary care providers do just as good of a job treating and curing HCV as specialists AND they derive professional satisfaction from providing patients with a needed service that leads to a CURE. If you think about it, how often do primary care providers have the opportunity to tell a patient they are cured of anything?

Advocates must demand that health insurers currently imposing prescriber restrictions, by only allowing specialists to prescribe treatments that cure HCV, remove these restrictions immediately (see #5 below). As part of our advocacy we can share the information presented at the Liver

Meeting about the need for and success of HCV treatment in primary care.

4. Everyone with hepatitis C who wants to be treated should be treated!

This is probably not news to any of you, but at the last Liver Meeting this was underscored by numerous presentations and posters that emphasize that all people living with HCV, not just those with advanced fibrosis or cirrhosis, should be treated. During a post-graduate course at the Liver Meeting, Dr. Norah Terrault summarized the data about treating people with early stage HCV by examining three endpoints: clinical, patient reported outcomes and economic. This review is available online (pp. 38-69). Dr. Terrault summarizes that treating all people with HCV is both good for individual patients and good for society at large. She notes:

- Every patient with HCV should be offered the opportunity to be cured.
- While the risk of liver complications in the short-term is low for people with no or little fibrosis, there are benefits to treating early-stage fibrosis, including improved quality of life and work productivity and reduced transmission to others.
- Treating HCV in individuals with no or little fibrosis can be cost effective. In one study, the benefits of treatment equate to a net economic gain of $2.28 billion per year. This includes economic gains due to improvement in work productivity.
- Although more studies are needed, treating individuals with no or little fibrosis does seem to reduce extrahepatic (non-liver) complications of HCV, such as reducing rates of diabetes, renal disease, and cardiovascular disease.

It is important that viral hepatitis advocates continue to beat the drum that everyone living with HCV deserves to be cured, and that treating everyone with HCV Is not only the right thing to do for individuals, it is the right thing to do for our communities and our country.

5. Access to hepatitis C treatments in state Medicaid programs is improving, but more work is needed to ensure everyone with hepatitis C has the opportunity to be treated and cured.

The National Viral Hepatitis Roundtable and Harvard Law School’s Center for Health Law & Policy Innovation presented a preliminary report, Hepatitis C: The State of Medicaid Access, which assesses HCV treatment access restrictions in all 50 states and the District of Columbia (the full report is available online).

The key findings of the report include:

- Since a 2014 assessment, transparency regarding Medicaid programs’ HCV treatment policies has improved;

- Since 2014, access to HCV treatment in Medicaid programs has improved, as some states have reduced or eliminated fibrosis restrictions or disease severity restrictions, but many states continue to employ restrictions based on sobriety and/or limit HCV treatment prescribing to certain specialists which limits providers’ ability to treat HCV in primary care settings; and
- There is variability from state-to-state in terms of how Medicaid managed care organizations adhere to the same policies set forth in the Medicaid fee-for-service programs.

In light of recent threats to the Patient Protection & Affordable Care Act (ACA), the progress that has been made to treat HCV in Medicaid programs is under serious threat. Viral hepatitis advocates must work together with public health and health care advocates to ensure that all Americans have access to the health coverage and health care they need, and we must continue to be vigilant and employ various advocacy and legal strategies to ensure everyone with HCV has access to the medications that can cure them.

It is critical that patients and patient advocates work closely with medical, public health and health economics experts to speak out about our nation’s ability to respond to viral hepatitis. Looking ahead to the next four years and beyond, we must utilize scientific takeaways, like those from the 2016 Liver Meeting, to inform public policy.

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