# HCV Testing and Linkage to Care

## One-Time Hepatitis C Testing

### Recommendations for One-Time Hepatitis C Testing

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-time, routine, opt out HCV testing is recommended for all individuals aged 18 years and older.</td>
<td>I, B</td>
</tr>
<tr>
<td>One-time HCV testing should be performed for all persons less than 18 years old with behaviors, exposures, or conditions or circumstances associated with an increased risk of HCV infection (see below).</td>
<td>I, B</td>
</tr>
<tr>
<td>Periodic repeat HCV testing should be offered to all persons with behaviors, exposures, or conditions or circumstances associated with an increased risk of HCV exposure (see below).</td>
<td>IIa, C</td>
</tr>
<tr>
<td>Annual HCV testing is recommended for all persons who inject drugs and for HIV-infected men who have unprotected sex with men.</td>
<td>IIa, C</td>
</tr>
</tbody>
</table>

### Risk Behaviors

- Injection drug use (current or ever, including those who injected only once)
- Intranasal illicit drug use
- Men who have sex with men

### Risk Exposures

- Persons on long-term hemodialysis (ever)
- Persons with percutaneous/parenteral exposures in an unregulated setting
- Healthcare, emergency medical, and public safety workers after needlestick, sharps, or mucosal exposure to HCV-infected blood
- Children born to HCV-infected women
- Prior recipients of a transfusion or organ transplant, including persons who:
  - Were notified that they received blood from a donor who later tested positive for HCV
  - Received a transfusion of blood or blood components, or underwent an organ transplant before July 1992
  - Received clotting factor concentrates produced before 1987
- Persons who were ever incarcerated

### Other Conditions and Circumstances

- HIV infection
- Sexually active persons about to start pre-exposure prophylaxis (PrEP) for HIV
- Unexplained chronic liver disease and/or chronic hepatitis, including elevated alanine aminotransferase (ALT) levels
- Solid organ donors (living and deceased) and solid organ transplant recipients
There are an estimated 3.5 million HCV-infected persons in the United States, including 2.7 million in the general noninstitutionalized population (Denniston, 2014) and 800,000 incarcerated, institutionalized, or homeless persons (Edlin, 2015). Approximately 50% of all infected people are unaware that they have HCV (Holberg, 2013); (Denniston, 2012).

HCV screening is recommended because of the known benefits of care and treatment in reducing the risk of hepatocellular carcinoma and all-cause mortality, and the potential public health benefit of reducing transmission through early treatment, viral clearance, and reduced risk behaviors (USPSTF, 2013); (Smith, 2012); (CDC, 1998).

HCV is primarily transmitted through percutaneous exposure to infected blood. Other modes of transmission include mother-to-infant and contaminated devices shared for noninjection drug use. Sexual transmission also occurs but is generally inefficient except among HIV-infected men who have unprotected sex with men (Schmidt, 2014).

Injection drug use (IDU) poses the greatest risk for HCV infection, accounting for at least 60% of acute HCV infections in the United States. Healthcare exposures are important sources of transmission, including the receipt of blood products prior to 1992 (after which routine screening of the blood supply was implemented); receipt of clotting factor concentrates before 1987; long-term hemodialysis; needlestick injuries among healthcare workers; and patient-to-patient transmission resulting from poor infection control practices. Other risk factors include having been born to an HCV-infected mother, having been incarcerated, and percutaneous or parenteral exposures in an unregulated setting. Examples include tattoos received outside of licensed parlors and medical procedures done internationally or domestically where strict infection control procedures may not have been followed (eg, surgery before implementation of universal precautions) (Hellard, 2004).

The importance of these risk factors might differ based on geographic location and population (USPSTF, 2013); (CDC, 1998). An estimated 12% to 39% of incarcerated persons in North America are HCV-antibody–positive, supporting the recommendation to test this population for HCV (Larney, 2013); (Allen, 2003); (Weinbaum, 2003).

Because of shared transmission modes, persons with HIV infection are at risk for HCV. Annual HCV testing is recommended for sexually active HIV-infected adolescent and adult men who have sex with men. The presence of concomitant ulcerative sexually transmitted infections, proctitis related to sexually transmitted infections, or high-risk sexual or drug use practices may warrant more frequent testing. Sexual transmission is particularly a risk for HIV-infected men who have unprotected sex with men (Hosein, 2013); (van de Laar, 2010). Testing sexually active, non-HIV-infected persons for HCV infection before starting and while receiving pre-exposure prophylaxis (PrEP) for HIV prevention should also be considered (Volk, 2015).

Data also support testing in all deceased and living solid organ donors because of the risk of HCV infection posed to the recipient (Lai, 2013); (Seem, 2013). Although hepatitis C testing guidelines from the US Centers for Disease Control and Prevention (CDC) and the US Preventive Services Task Force (USPSTF) do not specifically recommend testing immigrants from countries with a high HCV prevalence (eg, Egypt and Pakistan), such persons 18 years or older are included in the one-time, opt out HCV testing recommendation.

CDC established risk-based HCV testing guidelines in 1998 (CDC, 1998). These guidelines were expanded in 2012 with a recommendation to offer one-time HCV testing to all persons born from 1945 through 1965 without prior ascertainment of HCV risk factors. This recommendation was supported by evidence demonstrating that a risk-based strategy alone failed to identify more than 50% of HCV infections, due in part to patient underreporting of their risk and provider limitations in ascertaining risk factor information.

USPSTF also recommended a one-time HCV test in asymptomatic persons belonging to the 1945 through 1965 birth cohort, as well as other individuals based on exposures, behaviors, and conditions or circumstances that increase HCV infection risk. Since the birth cohort recommendation was adopted, however, there has been an increase in the number of acute and chronic HCV infections reported in individuals born after 1965 (Zibbell, 2018); (Ly, 2017); (Suryaprasad, 2014). The increase in HCV incidence and prevalence among a younger cohort is a result of the opioid epidemic and increased IDU. This shift in HCV epidemiology and the known failures of risk-based testing warrant an expansion of the recommendation for one-time, routine, opt out testing for adults aged 18 years or older, and continued risk-based testing for those younger than 18 years. Both CDC and USPSTF recently issued draft recommendations that include universal
testing of adults.

Several cost-effectiveness studies demonstrate that routine, one-time HCV testing among all adults in the US would likely identify a substantial number of HCV cases that are currently being missed, and that doing so would be cost-effective. Barocas and colleagues employed simulation modeling to compare several versions of routine guidance, including routine testing for adults aged ≥40 years, ≥30 years, and ≥18 years. The investigators found that routine HCV testing for all adults ≥18 years was cost-effective compared to current guidance, and potentially cost-saving compared to testing only those aged ≥30 years or ≥40 years (Barocas, 2018). The study further demonstrated that routine testing remained cost-effective unless HCV infection had no impact on healthcare utilization and no impact on quality of life. Similarly, Eckman et al found that routine HCV testing for all adults aged ≥18 years is likely cost-effective compared to current guidance, provided the HCV prevalence among those born after 1965 is >0.07% (Eckman, 2019). Notably, these studies reached similar conclusions despite being conducted entirely independently and employing different simulation modeling approaches. Further, a variety of studies have tested the cost-effectiveness of routine HCV testing in specific venues, including correctional settings (He, 2016), prenatal care settings (Chailon, 2019); (Tasillo, 2019), substance use treatment centers (Schackman, 2018); (Schackman, 2015), and federally qualified health centers (Assoumou, 2018). All of these studies demonstrated that routine HCV testing and treatment was cost-effective—even when linkage to HCV treatment after testing was poor and when the rate of HCV reinfection among injection drug users is high.

Generally, routine HCV testing is cost-effective because HCV incidence and prevalence are high among people who inject drugs (PWID), the prevalence of IDU is rising, and many patients at greatest risk for HCV infection and transmission do not readily report their highly stigmatized risk behaviors. Studies conducted in urban emergency departments in the US, for example, reveal that 15% to 25% of patients with previously unidentified HCV infection were born after 1965 and/or have no reported history of IDU and are, therefore, missed by even perfect implementation of current testing guidance (Schechter-Perkins, 2018); (Hsieh, 2016); (Lyons, 2016). Reinfection among those actively using drugs is common, but because HCV testing is a low-cost intervention and therapy is both highly effective and cost-effective, routine testing provides good economic value (ie, cost-effectiveness) even when many people need to be tested and treated more than once over the course of their lives.

Evidence regarding the frequency of HCV testing in persons at risk for ongoing exposures to the virus is lacking. Clinicians should, therefore, determine the periodicity of testing based on the risk of infection or reinfection. Because of the high incidence of HCV infection among PWID and HIV-infected men who have unprotected sex with men, HCV testing at least annually is recommended for these populations (Newsum, 2017); (Aberg, 2014); (Witt, 2013); (Bravo, 2012); (Linas, 2012); (Wandeler, 2012); (Williams, 2011).

Implementation of clinical decision support tools or prompts for HCV testing in electronic health records could facilitate reminding clinicians of HCV testing when indicated (Hsu, 2013); (Litwin, 2012).
## Initial HCV Testing and Follow-Up

### Recommendations for Initial HCV Testing and Follow-Up

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
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<tbody>
<tr>
<td>HCV-antibody testing with reflex HCV RNA polymerase chain reaction (PCR) testing is recommended for initial HCV testing.</td>
<td>I, A</td>
</tr>
<tr>
<td>Among persons with a negative HCV-antibody test who were exposed to HCV within the prior 6 months, HCV-RNA or follow-up HCV-antibody testing 6 months or longer after exposure is recommended. HCV-RNA testing can also be considered for immunocompromised persons.</td>
<td>I, C</td>
</tr>
<tr>
<td>Among persons at risk of reinfection after previous spontaneous or treatment-related viral clearance, HCV-RNA testing is recommended because a positive HCV-antibody test is expected.</td>
<td>I, C</td>
</tr>
<tr>
<td>Quantitative HCV-RNA testing is recommended prior to initiation of antiviral therapy to document the baseline level of viremia (ie, baseline viral load).</td>
<td>I, A</td>
</tr>
<tr>
<td>HCV genotype testing may be considered for those in whom it may alter treatment recommendations.</td>
<td>I, A</td>
</tr>
<tr>
<td>Persons found to have a positive HCV-antibody test and negative results for HCV RNA by PCR should be informed that they do not have evidence of current (active) HCV infection but are not protected from reinfection.</td>
<td>I, A</td>
</tr>
</tbody>
</table>

All persons for whom HCV screening is recommended should initially be tested for HCV antibody (CDC, 2013); (Alter, 2003) using an assay approved by the US Food and Drug Administration (FDA). FDA-approved tests include laboratory-based assays and a point-of-care assay (ie, OraQuick™ HCV Rapid Antibody Test [OraSure Technologies]) (Lee, 2011). The latter is an indirect immunoassay with a sensitivity and specificity similar to those of laboratory-based HCV-antibody assays. Point-of-care assays are valuable in the community setting and allow for sample collection with a finger stick rather than standard phlebotomy. If point-of-care assays are used, reporting of results to the medical record and health authorities should follow protocols used for laboratory-based HCV-antibody tests. When possible, positive point-of-care antibody tests should be followed-up with immediate HCV-RNA confirmatory testing rather than referring the patient to another provider or setting to have the test performed. Table 1 lists FDA-approved, commercially available HCV-antibody screening assays.
Table 1. FDA-Approved HCV-Antibody Screening Assays

<table>
<thead>
<tr>
<th>Assay</th>
<th>Manufacturer</th>
<th>Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbott HCV EIA 2.0</td>
<td>Abbott Laboratories</td>
<td>EIA (^a) (manual)</td>
</tr>
<tr>
<td>Advia Centaur™ HCV Assay</td>
<td>Siemens Healthcare</td>
<td>CLIA (^b) (automated)</td>
</tr>
<tr>
<td>Architect Anti-HCV</td>
<td>Abbott Laboratories</td>
<td>CMIA (^c) (automated)</td>
</tr>
<tr>
<td>AxSYM™ Anti-HCV</td>
<td>Abbott Laboratories</td>
<td>MEIA (^d) (automated)</td>
</tr>
<tr>
<td>Elecsys™ Anti-HCV II</td>
<td>Roche Diagnostics</td>
<td>ECLIA (^e) (automated)</td>
</tr>
<tr>
<td>OraQuick™ HCV Rapid Antibody Test</td>
<td>OraSure Technologies, Inc.</td>
<td>Immunochromatographic (manual)</td>
</tr>
<tr>
<td>Ortho HCV Version 3.0 ELISA Test System</td>
<td>Ortho-Clinical Diagnostics, Inc.</td>
<td>EIA (^f) (manual)</td>
</tr>
<tr>
<td>Vitros Anti-HCV</td>
<td>Ortho-Clinical Diagnostics, Inc.</td>
<td>CLIA (^b) (automated)</td>
</tr>
</tbody>
</table>

\(^a\) EIA: enzyme immunoassay  
\(^b\) CLIA: chemiluminescent immunoassay  
\(^c\) CMIA: chemiluminescent microparticle immunoassay  
\(^d\) MEIA: microparticle enzyme immunoassay  
\(^e\) ECLIA: electrochemiluminescent immunoassay

A positive HCV-antibody test indicates current (active) HCV infection (acute or chronic), past infection that has resolved, or rarely a false positive result (Pawlotsky, 2002). A test to detect HCV viremia is therefore necessary to confirm active HCV infection and guide clinical management, including initiation of HCV treatment. Many reference laboratories now offer HCV-antibody testing that automatically reflexes to HCV-RNA PCR testing if the antibody test is positive. This should be considered the optimal testing approach in a clinical setting because it requires only a single blood draw without the need to bring people back to care for confirmatory testing, a major barrier in the continuum of care (Mera, 2016). Collection of dried blood spot (DBS) samples also allows for assessment of HCV antibodies and reflex HCV-RNA testing by testing spots sequentially. DBS samples can be collected using a finger stick rather than phlebotomy and can be transported without an intact cold chain, making it useful in rural areas and in people for whom phlebotomy may be a testing barrier (Lange, 2017).

HCV-RNA testing should also be performed in persons with a negative HCV-antibody test who are either immunocompromised (eg, persons receiving chronic hemodialysis) (KDIGO, 2008) or might have been exposed to HCV within the last 6 months because these persons may be HCV antibody negative. An HCV-RNA test is also needed to detect reinfection in HCV-antibody–positive persons after previous spontaneous or treatment-related viral clearance.

Detection of HCV core antigen in the blood also indicates active HCV infection. Because the sensitivity of HCV core
antigen testing is less than that of HCV-RNA testing, if an HCV core antigen test is used to assess viremia, antibody-positive samples that test negative for HCV core antigen should have a confirmatory HCV-RNA test to exclude a false negative core antigen result (van Tilborg, 2018).

An FDA-approved quantitative or qualitative HCV-RNA test with a detection level of ≤25 IU/mL should be used to detect HCV RNA. Figure 1 shows the CDC-recommended HCV testing algorithm.

**Figure 1. CDC-Recommended Testing Sequence for Identifying Current HCV Infection**

<table>
<thead>
<tr>
<th>HCV Antibody</th>
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<tbody>
<tr>
<td>Reactive</td>
</tr>
<tr>
<td>Nonreactive</td>
</tr>
</tbody>
</table>

- **HCV RNA**
  - Detected
  - **No HCV Antibody Detected**
    - Stop
    - Link to Care
  - **Current HCV Infection**
    - **Additional Testing as Appropriate**
  - **No Current HCV Infection**

a For persons who might have been exposed to HCV within the past 6 months, testing for HCV RNA or follow-up testing for HCV antibody should be performed. For persons who are immunocompromised, testing for HCV RNA should be performed.

b To differentiate past, resolved HCV infection from biologic false positivity for HCV antibody, testing with another HCV-antibody assay can be considered. Repeat HCV-RNA testing if the person tested is suspected to have had HCV exposure within the past 6 months or has clinical evidence of HCV disease, or if there is concern regarding the handling or storage of the test specimen.

Adapted from Centers for Disease Control and Prevention (CDC, 2013).
Persons who have a positive HCV-antibody test and negative results for HCV RNA by PCR should be informed that they do not have laboratory evidence of current HCV infection. Additional HCV testing is typically unnecessary. The HCV-RNA test can be repeated when there is a high index of suspicion for recent infection or in patients with ongoing HCV infection risk.

Clinicians (or patients) may seek additional testing to determine whether a positive HCV-antibody test represents a remote, resolved HCV infection or a false positive. For patients with no apparent risk for HCV infection, the likelihood of a false positive HCV-antibody test is directly related to the HCV prevalence in the tested population. False positive HCV-antibody tests most commonly occur in populations with a low prevalence of HCV infection (Alter, 2003). If further testing is desired to distinguish between a true positive vs biologic false positivity for HCV antibody, repeat testing may be done with a different FDA-approved, HCV-antibody assay. A biologic false result should not occur with 2 different assays (CDC, 2013; Vermeersch, 2008).

Prior to initiation of antiviral therapy, quantitative HCV-RNA testing may be used to determine the baseline level of viremia (ie, viral load), which may affect treatment duration with certain regimens. The degree of viral load decline after initiation of treatment is less predictive of sustained virologic response (SVR) in the era of direct-acting antiviral (DAA) therapy compared to previous interferon-based treatment (see Pretreatment and On-Treatment Monitoring).

With the advent of pangenotypic HCV treatment regimens, HCV genotyping is no longer required prior to treatment initiation for all individuals. In those with evidence of cirrhosis and/or past unsuccessful HCV treatment, treatment regimens may differ by genotype and thus pretreatment genotyping is recommended (see Treatment-Naive and Treatment-Experienced sections). For noncirrhotic treatment-naive patients, although genotyping may impact the preferred treatment approach, it is not required if pangenotypic regimens are used (see Simplified Treatment Algorithm).

### Counseling Persons With Active HCV Infection

<table>
<thead>
<tr>
<th>Recommendations for Counseling Persons With Active HCV Infection</th>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with current HCV infection should receive education and interventions aimed at reducing liver disease progression and preventing HCV transmission.</td>
<td>Ila, B</td>
<td></td>
</tr>
<tr>
<td>Abstinence from alcohol and, when appropriate, interventions to facilitate cessation of alcohol consumption should be advised for all persons with HCV infection.</td>
<td>Ila, B</td>
<td></td>
</tr>
<tr>
<td>Evaluation for other conditions that may accelerate liver fibrosis, including hepatitis B and HIV infections, is recommended for all persons with active HCV infection.</td>
<td>Iib, B</td>
<td></td>
</tr>
<tr>
<td>Evaluation for advanced fibrosis using noninvasive markers or liver biopsy, if required, is recommended for all persons with HCV infection to facilitate an appropriate decision regarding HCV treatment strategy, and to determine the need for initiating additional measures for cirrhosis management (eg, hepatocellular carcinoma screening) (see Monitoring section).</td>
<td>I, A</td>
<td></td>
</tr>
<tr>
<td>Vaccination against hepatitis A and hepatitis B is recommended for all susceptible persons with HCV infection.</td>
<td>Ila, C</td>
<td></td>
</tr>
<tr>
<td>Vaccination against pneumococcal infection is recommended for all patients with cirrhosis.</td>
<td>Ila, C</td>
<td></td>
</tr>
<tr>
<td>All persons with HCV infection should be provided education about how to prevent HCV transmission to others.</td>
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</table>
Recommendations for Counseling Persons With Active HCV Infection

In addition to receiving antiviral therapy, HCV-infected persons should be educated about how to prevent further liver damage. Most important is prevention of the potential deleterious effect of alcohol. Numerous studies have found a strong association between excess alcohol use and the development or progression of liver fibrosis, and the development of hepatocellular carcinoma (Safdar, 2004); (Harris, 2001); (Bellentani, 1999); (Corrao, 1998); (Wiley, 1998); (Poynard, 1997); (Noda, 1996).

Daily consumption of >50 g of alcohol has a high likelihood of worsening fibrosis. Some studies indicate that daily consumption of smaller amounts of alcohol also exerts a deleterious effect on the liver; these data, however, are controversial (Hagström, 2017); (Younossi, 2013b); (Westin, 2002). Persons who abuse alcohol and have alcohol dependence require treatment and consideration for referral to an addiction specialist.

Hepatitis B virus (HBV) and HIV coinfection have been associated with a poorer HCV prognosis in cohort studies (Puoti, 2017b); (Kruse, 2014); (Thein, 2008a); (Zarski, 1998). Because of overlapping risk factors for these infections and benefits associated with their identification and treatment, HCV-infected persons should be tested for HIV antibody and hepatitis B surface antigen (HBsAg) using standard screening assays (Moyer, 2013); (CDC, 2008). (See USPSTF HIV screening recommendations and CDC hepatitis B screening recommendations.) Persons who test positive for HBsAg require monitoring during HCV treatment because of HBV reactivation risk (Lee, 2018). Anti-HBV therapy may also be considered (see reactivation of HBV in the Monitoring section). For persons who test negative for HBsAg but positive for hepatitis B core antibodies (anti-HBc), with or without hepatitis B surface antibodies (anti-HBs), have resolved HBV infection; the risk of clinically significant HBV reactivation with HCV therapy is very low and no further workup is required (Mücke, 2018). Patients should be counseled about how to reduce their risk of acquiring these infections and HBV vaccination is recommended when appropriate.

Assessment of Liver Disease Severity

The severity of liver disease associated with chronic HCV infection is a key factor in determining the initial and follow-up evaluation of patients. Noninvasive tests using serum biomarkers or imaging allow for accurate diagnosis of cirrhosis in most individuals (see pretreatment workup in When and in Whom to Initiate HCV Therapy). Liver biopsy is rarely required but may be considered if other causes of liver disease are suspected.

Noninvasive methods frequently used to estimate liver disease severity include:

- Liver-directed physical exam (normal in most patients)
- Routine blood tests (eg, ALT, AST, albumin, bilirubin, international normalized ratio [INR], and CBC with platelet count)
- Serum fibrosis marker panels
- Transient elastography
- Liver imaging (eg, ultrasound or CT scan)

Simple calculations derived from routine blood tests—such as the serum AST-to-platelet ratio index (APRI) (Wai, 2003) and FIB-4 score (Sterling, 2006)—as well as assessment of liver surface nodularity and spleen size by liver ultrasound or other cross-sectional imaging modalities can help determine if patients with HCV have cirrhosis and associated portal hypertension. The presence of portal hypertension is associated with a greater likelihood of developing future hepatic complications in untreated patients (Chou, 2013); (Rockey, 2006). Vibration-controlled transient elastography provides instant information regarding liver stiffness at the point of care and can reliably distinguish patients with a high vs low likelihood of cirrhosis (Bonder, 2014); (Castera, 2012). A more detailed discussion regarding fibrosis assessment is found in the When and In Whom to Initiate Therapy section.
Persons with known or suspected bridging fibrosis and cirrhosis are at increased risk for developing complications of advanced liver disease and require frequent follow-up. They should also avoid hepatotoxic drugs, such as excessive acetaminophen (>2 g/d) and certain herbal supplements. Nephrotoxic drugs, such as nonsteroidal anti-inflammatory drugs, should also be avoided. Ongoing imaging surveillance for liver cancer and gastroesophageal varices is also recommended for these patients (Fontana, 2010; Sangiovanni, 2006). Persons with cirrhosis are more susceptible to invasive pneumococcal infection (Marrie, 2011) and should receive pneumococcal vaccination (CDC, 2012).

Exposure to infected blood is the primary mode of HCV transmission. HCV-infected persons must be informed of the precautions needed to avoid exposing others to infected blood. This is particularly important for PWID given that HCV transmission in this population primarily results from sharing needles and other contaminated drug injection equipment. Epidemics of acute HCV due to sexual transmission in HIV-infected men who have sex with men have also been described (Urbanus, 2009); (van de Laar, 2009); (Fierer, 2008). Table 2 outlines measures to avoid HCV transmission. HCV is not spread by sneezing, hugging, holding hands, coughing, or sharing eating utensils or drinking glasses, nor is it transmitted through food or water.

**Table 2. Measures to Prevent HCV Transmission**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>HCV-infected persons should be counseled to avoid sharing toothbrushes and dental or shaving equipment, and be cautioned to cover any bleeding wound to prevent the possibility of others coming into contact with their blood.</td>
<td>Persons should be counseled to stop using illicit drugs and enter substance abuse treatment. Those who continue to inject drugs should be counseled to:</td>
</tr>
<tr>
<td>- Avoid reusing or sharing syringes, needles, water, cotton, and other drug preparation equipment.</td>
<td>- Use new sterile syringes and filters, and disinfected cookers.</td>
</tr>
<tr>
<td>- Clean the injection site with a new alcohol swab.</td>
<td>- Dispose of syringes and needles after 1 use in a safe, puncture-proof container.</td>
</tr>
<tr>
<td>Persons with HCV infection should be advised not to donate blood and to discuss HCV serostatus prior to donation of body organs, other tissue, or semen.</td>
<td>Persons with HIV infection and those with multiple sexual partners or sexually transmitted infections should be encouraged to use barrier precautions to prevent sexual transmission. Other persons with HCV infection should be counseled that the risk of sexual transmission is low and may not warrant barrier protection.</td>
</tr>
<tr>
<td>Household surfaces and implements contaminated with visible blood from an HCV-infected person should be cleaned using a dilution of 1 part household bleach to 9 parts water. Gloves should be worn when cleaning up blood spills.</td>
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**Linkage to Care**

**Recommendation for Linkage to Care**

<table>
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<tr>
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<tbody>
<tr>
<td>All persons with active HCV infection should be linked to a healthcare provider who is prepared to provide comprehensive management.</td>
<td>IIa, C</td>
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Improved identification of active HCV infection and treatment advances will have limited impact on HCV-related morbidity.
and mortality without concomitant improvement in linkage to care. All patients with current HCV infection and a positive HCV-RNA test should be evaluated by a healthcare provider with expertise in assessment of liver disease severity and HCV treatment. Subspecialty care and consultation may be required for persons with HCV infection who have advanced fibrosis or cirrhosis (Metavir stage ≥F3), including possible referral for consideration of liver transplantation in those with evidence of hepatic decompensation.

Only an estimated 13% to 18% of HCV-infected persons in the US had received treatment by 2013 (Holmberg, 2013). Lack of appropriate clinician assessment and delays in linkage to care can result in negative health outcomes. Furthermore, patients who are lost to follow-up fail to benefit from evolving evaluation and treatment options.

Commonly cited patient-related barriers to treatment initiation include contraindications to treatment (eg, medical or psychiatric comorbidities); lack of acceptance of treatment (eg, asymptomatic nature of disease, competing priorities, low treatment efficacy, long treatment duration, and adverse effects); and lack of access to treatment (eg, cost and distance to specialist) (Clark, 2012); (Arora, 2011); (Khokhar, 2007).

Common healthcare provider-related barriers include perceived patient-related barriers (eg, fear of adverse effects, treatment duration, cost, and effectiveness); lack of expertise in HCV treatment; lack of specialty referral resources; resistance to treating persons currently using illicit drugs or alcohol; and concern about HCV treatment cost (McGowan, 2013); (Reilley, 2014); (Morrill, 2005).

Data do not support exclusion of HCV-infected persons from consideration for hepatitis C therapy based on the amount of alcohol intake or use of illicit drugs (see Identification and Management of HCV in People Who Inject Drugs). Some possible strategies to address HCV treatment barriers are listed in Table 3.
### Table 3. Common Barriers to and Misconceptions Regarding HCV Treatment and Potential Strategies

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Strategy</th>
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| Comorbid conditions (eg, substance use psychiatric disorders, uncontrolled chronic medical conditions) | • Conduct counseling and education.  
• Refer for services (eg, mental health services, medications for opioid use disorder [MOUDs], and syringe service programs).  
• Co-localize services (eg, primary care, medical homes, and drug treatment). |
| Competing priorities and loss to follow-up                             | • Conduct counseling and education.  
• Engage case managers and patient navigators. Consider other strategies such as incentives, peer navigators, and transportation assistance.  
• Co-localize services (eg, primary care, medical homes, and drug treatment). |
| Long treatment duration and adverse effects                            | • Conduct counseling and education.  
• Consider other strategies like incentives, peer navigators, and transportation assistance.  
• Utilize directly observed therapy. |
| Lack of access to treatment (eg, out-of-pocket costs, high copays, lack of insurance, geographic distance, and/or lack of specialist availability) | • Leverage expansion of coverage through the Patient Protection and Affordable Care Act.  
• Participate in models of care involving close collaboration between primary care clinicians and specialists.  
• Liaise with pharmaceutical patient assistance programs and copay assistance programs.  
• Co-localize services (eg, primary care, medical homes, and drug treatment). |
| Lack of practitioner expertise                                         | • Collaborate with specialists (eg, project ECHO-like models and telemedicine).  
• Develop accessible, clear HCV treatment guidelines.  
• Develop electronic health record performance measures and clinical decision support tools (eg, pop-up reminders and standing orders). |

Co-localization of HCV screening, evaluation, and treatment with other medical or social services (ie, integrated care) is a strategy that addresses several treatment barriers. Co-localization has already been applied to settings with high HCV prevalence (eg, correctional facilities, needle exchange programs, substance abuse treatment centers, and harm reduction programs) but this type of care is not uniformly available (Burton, 2019); (Harrison, 2019); (Morey, 2019); (Schulkind, 2019); (Bruggmann, 2013); (Islam, 2012); (Stein, 2012). A study conducted by Ho and colleagues demonstrated that integrated care—consisting of multidisciplinary care coordination and patient case management—increased the proportion of patients with HCV infection and psychiatric illness or substance use who begin antiviral therapy and achieve SVR without serious adverse events (Ho, 2015).
A strategy that addresses lack of access to specialists—a primary barrier to hepatitis C care—is participation in models involving close collaboration between primary care practitioners and subspecialists (Beste, 2017b; Rossaro, 2013; Miller, 2012; Arora, 2011). Such collaborations have used telemedicine and knowledge networks to overcome geographic distances to specialists (Rossaro, 2013; Arora, 2011) or the availability of experienced providers in a methadone or correctional setting (Morey, 2019; Talal, 2019). For example, project ECHO (Extension for Community Healthcare Outcomes) uses videoconferencing to enhance primary care practitioner capacity in rendering HCV care and treatment to New Mexico's large rural and underserved population (Arora, 2011). Through case-based learning and real-time feedback from a multidisciplinary team of specialists (gastroenterology, infectious disease, pharmacology, and psychiatry practitioners), project ECHO has expanded HCV treatment access in populations that might have otherwise remained untreated. The short duration of treatment and few serious adverse events associated with DAA therapy present an opportunity to expand the number of primary care providers engaged in HCV management and treatment. This expansion will support the goals of HCV elimination and overcome barriers associated with the need for subspecialty referrals. The ASCEND trial utilized a real-world cohort of patients at urban federally qualified health centers and found that HCV treatment administered by nonspecialist providers was as safe and effective as that provided by specialists (Kattakuzhy, 2017).

Additional strategies for enhancing linkage to and retention in care could be adapted from other fields, such as tuberculosis and HIV. For example, use of directly observed therapy has enhanced adherence to tuberculosis treatment, and use of case managers and patient navigators has reduced loss of follow-up in HIV care (Govindasamy, 2012). Recent hepatitis C testing and care programs have identified the use of patient navigators or care coordinators as important interventions in overcoming challenges associated with linkage to and retention in care (Ford, 2018; Coyle, 2015; Trooskin, 2015). There are also data suggesting that financial incentives and peer navigation may be useful to support treatment adherence in patients with substance use disorders (Ward, 2019; Wohl, 2017). Ongoing assessment of efficacy and comparative effectiveness of this and additional strategies is a crucial area of future research for patients with HCV infection. Replication and expansion of best practices and new models for linkage to HCV care will also be crucial to maximize the public health impact of newer treatment paradigms.

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**Related References**


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