ERRATUM

Capsule Commentary on Mukhtar et al., Assessment of HBV Preventive Services in a Medically Underserved Asian and Pacific Islander Population Using Provider and Patient Data

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Editor's note: This capsule commentary was to accompany "Assessment of HBV Preventive Services in a Medically-Underserved Asian and Pacific Islander Population Using Provider and Patient Data," which was published in the January 2015 issue. The Editors apologize for this error.

Death from cirrhosis and hepatocellular carcinoma related to chronic hepatitis B and C is preventable with current therapies. Recommendations by the US Preventative Services Task Force (USPSTF) include testing for hepatitis C in persons born between 1945 and 1965 and for hepatitis B in persons at high risk of infection, including those born in all of Asia, Eastern Europe, and most of Africa. Currently, fewer than half of the estimated 2 million cases of hepatitis B have been diagnosed and only a fraction of those infected are being adequately managed.[1,2]

The study by Mukhtar and colleagues highlights some of the barriers to hepatitis B screening.[3] Not surprisingly, testing rates for hepatitis B were positively associated with provider attitudes and negatively associated with providers' perceived barriers to testing. Notably, provider knowledge was not associated with testing. Thus, shifting provider attitudes and reducing barriers to care might be more effective than improving provider knowledge. With new USPSTF recommendations supporting testing, we might anticipate improvement in the provider factors that limit testing of hepatitis B.

However, practical issues in primary care may overshadow these improvements. As noted by Mukhtar et al., patient load had a strong negative effect on hepatitis B testing. An additional preventative test is likely to have low uptake by busy clinicians in practices where high-risk patients are the minority. Alternative approaches addressing patient barriers, leveraging of electronic medical records (EMR), and utilizing case management strategies are more likely to lead to higher rates of testing. Though the absolute effect was small, culturally appropriate patient education administered by bicultural lay health workers significantly increased testing for hepatitis B in an underserved Asian community.[4] Of greater impact was the use of an electronic messaging system to alert providers of the testing recommendations prior to a visit by a high-risk patient.[5] This intervention increased hepatitis B test ordering from less than 2 % to 40 % for a single visit.

Importantly, testing alone will not prevent hepatitis B-related deaths. Evaluation, monitoring, and treatment of infected individuals is needed and well suited for a collaborative case management strategy overseen by primary care providers and specialists.

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Conflict of Interest: *The authors have no conflict with any of the material in this manuscript.*

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