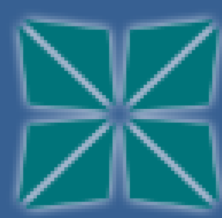

Dimensions Healthcare System

Suppressing the Hepatitis C Virus, Barriers to Care

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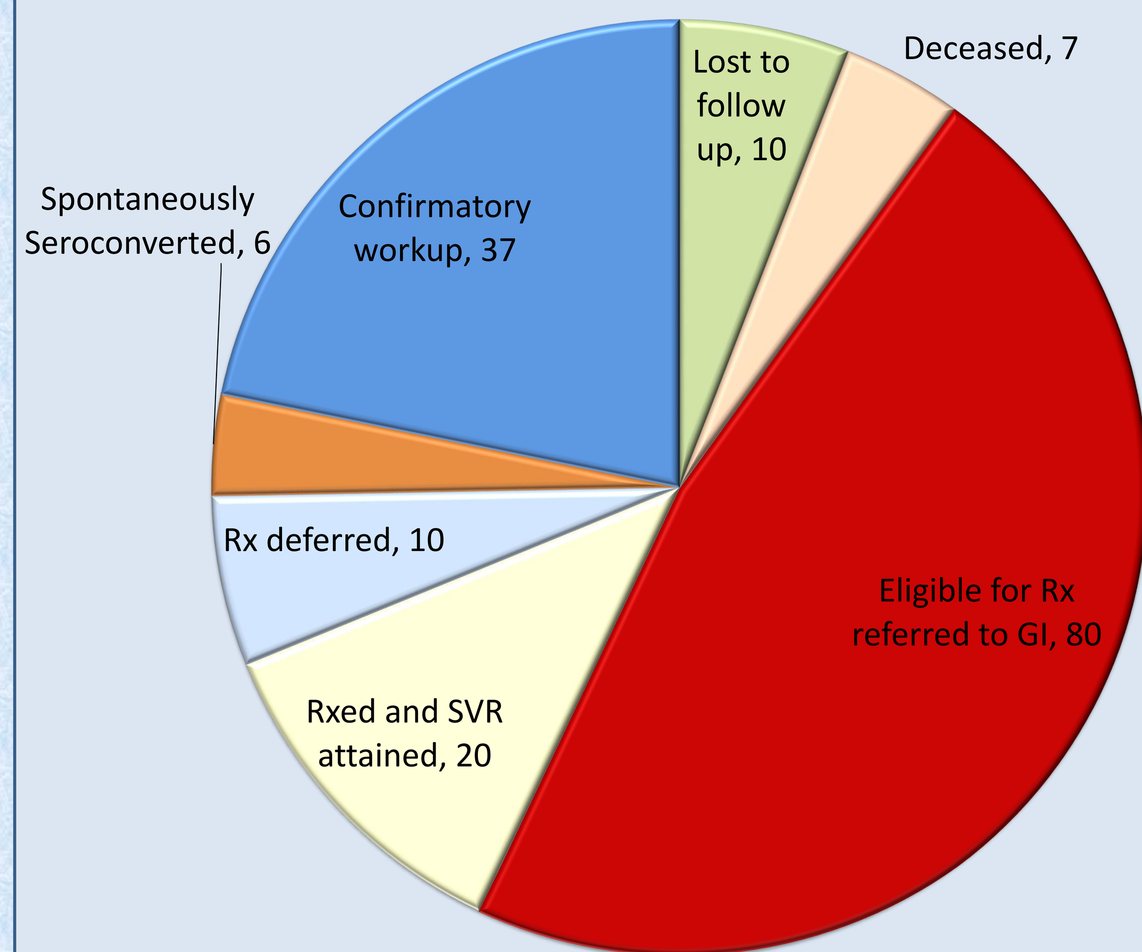
Introduction

- In the United States, an estimated 2.7–3.9 million persons (1.0%–1.5%) are living with hepatitis C virus (HCV) infection of which 75% are "baby boomers".
- In 2014 FDA approved effective and less toxic oral medications to eradicate Hepatitis C. This is now challenging physicians to identify and treat patients.
- Since July 2012 faculty and residents at an internal medicine community clinic have screened patients and developed a registry of 170 patients with Hepatitis C. The baby boomer prevalence of 8.1% is three times the national average.
- The patients are tracked for access to treatment and progression to cirrhosis and hepatocellular carcinoma.

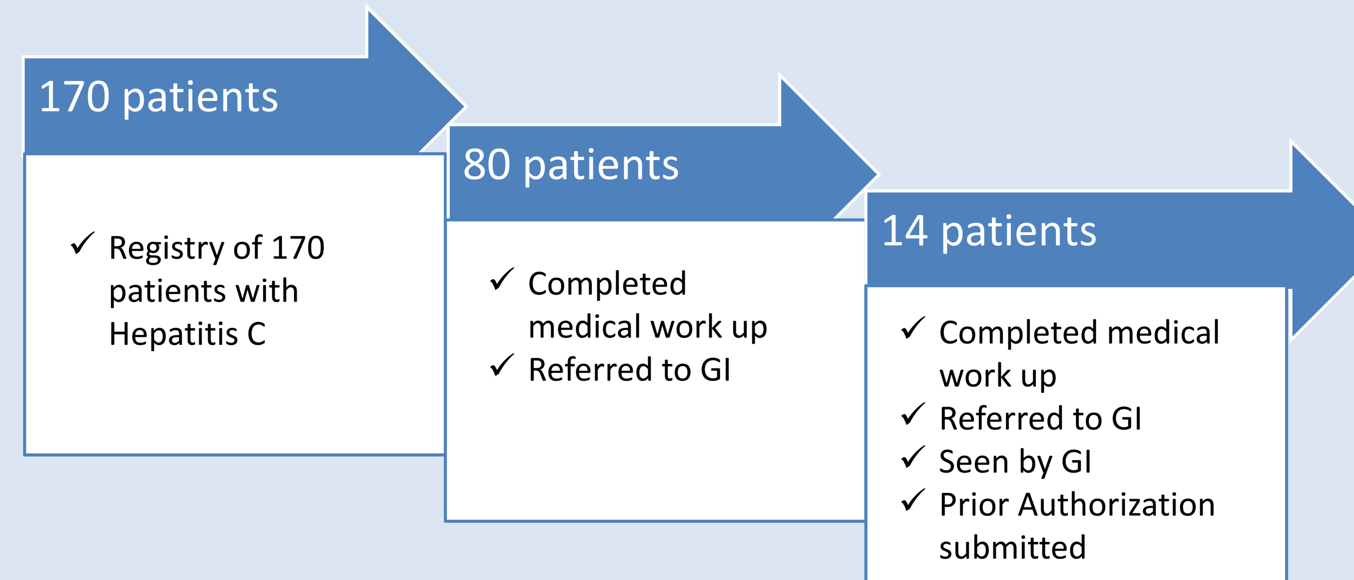
Registry Data

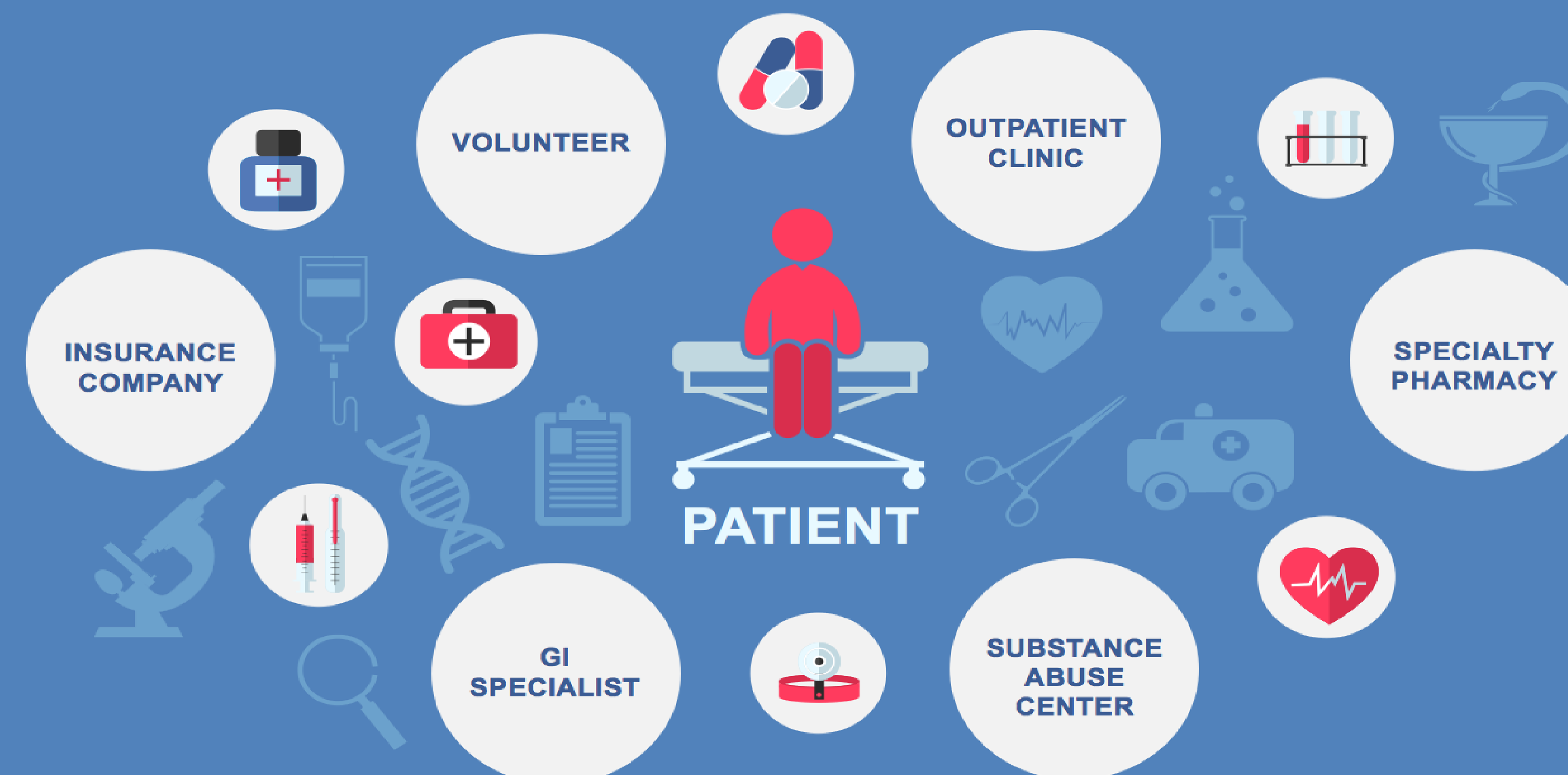


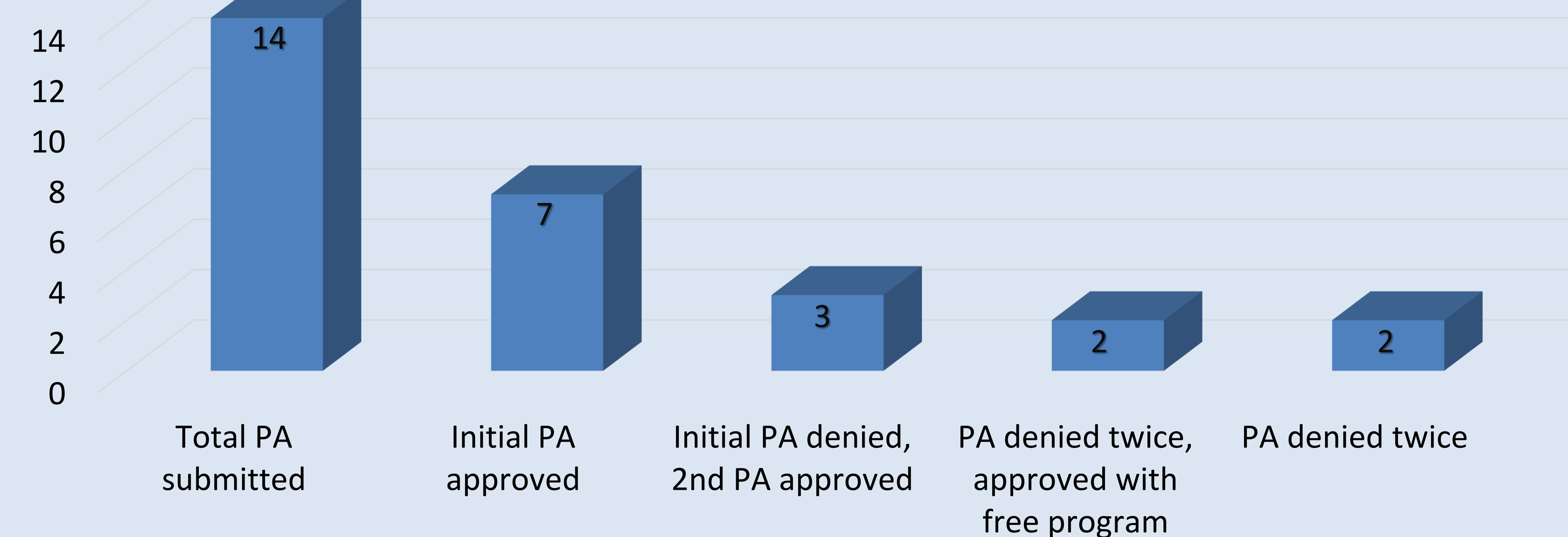
Liver related mortality	Number	Percentage
Liver Cirrhosis	20	11.76%
Deceased	7	4.12%
Liver Transplant	5	2.94%
Hepatocellular carcinoma	4	2.35%

Other- Co Morbidities	Number	Percentage
Hypertension	93	54.70%
Diabetes Mellitus	40	23.53%
Anemia	33	19.41%
Vitamin D deficiency	31	18.23%
Thrombocytopenia	29	17.06%
Chronic Kidney Disease	18	10.59%
HIV	9	5.29%
Hepatitis B	4	2.35%

Methods







Discussion

The experience in working with this cohort has identified barriers to care in the clinic which include:

- Patients are untested or unaware of their diagnosis.
- Fear of toxicity of treatment based on experiences with interferon based regimens.
- Cost of new medications including insurance deductibles and copays.
- Insurance companies' requirements for staging severity by fibrosis scores (F0-4) before approving medications only for advanced disease (F3,4) despite broader recommendations from professional societies.
- Insurance companies' requirements that only subspecialists in Gastroenterology and Infectious Disease can prescribe the medications.
- Completing treatment of comorbid conditions and surgeries prior to committing to 3 months of treatment.
- Need to develop a support network with specialty pharmacies and alcohol and substance abuse programs.

Patient Outcomes

Initial PA approved

CBC, CMP, VL Fibrosure, U tox	Rx Start date	Week 4 , 6, 8 CBC, CMP, VL	End of Rx CBC, CMP, VL	SVR 12 VL	Insurance/ barriers
Rx exp, F4, VL<6m, 24 wks	05/25/2015	Wk 4- VL<15 Wk 6- VL 0	11/16/2015 Not done	02/08-02/15/16 Pending	UHC-Medicaid EGD, wk 6 re-PA
Rx exp, F4 VL<6m, 24 wks	06/18/2015	Wk 4- VL 0	12/03/2015 Pending	02/25-03/03/16 Pending	Medicare EGD
Rx naïve, F4 VL<6m, 12 wks	07/02/2015	Wk 4 -VL 0	09/02/2015 Not done	12/01-12/08/15 Pending	Medicare EGD, GI app wait
Rx naïve, F4 VL<6m, 12 wks	03/12/2015	Wk 4 – VL 0	05/28/2015 VL 0	08/27-09/03/15 Not done	UHC-Medicaid
Rx naïve, F3 VL<6m, 8 wks	05/21/2015	Wk 4- VL 0	07/16/2015 Not done	10/08-10/15/15 Not done	UHC-Medicaid B-blocker, AICD
Rx naïve, F2 VL>6m, 12 wks	04/09/2015	Wk 4- VL 0	07/02/2015 Not done	09/24-10/01/15 Not done	Medicare
Rx exp, F2, VL<6mln, 12 wks	01/21/2015	Wk 4- VL 0	07/13/2015 VL 0	07/08-07/15/15 <100 copies	BCBS Care First Co-pay

Initial PA denied, second PA approved

CBC, CMP, VL Fibrosure, U tox	Rx Start date	Week 4 , 6, 8 CBC, CMP, VL	End of Rx CBC, CMP, VL	SVR 12 VL	Insurance/ barriers
Rx naive, F3, VL<6m, 8 wks	05/14/15	Wk 4-VL 0	07/09/2015 VL 0	10/01-10/08/15 Not done	Medicare U tox positive
Rx naive, F3, VL<6m, 8 wks	07/03/2015	Wk 4- VL 0	08/28/2015 Not done	01/20-01/27/15 Not done	UHC-Medicaid U tox positive
Rx naive, F2, VL<6m, 8 wks	04/16/2015	Wk 4-VL 0	06/17/2015 VL 0	09/03-09/10/15 Not done	UHC-Medicaid U tox positive

PA denied twice, approved with free drug Program

CBC, CMP, VL Fibrosure, U tox	Rx Start date	Week 4 , 6, 8 CBC, CMP, VL	End of Rx CBC, CMP, VL	SVR 12 VL	Insurance/ barriers
Rx naive, F2, VL>6m, 12 wks	04/08/2015	Wk 4- VL 0	07/01/2015 VL 0	09/23-09/30/15 Not done	BCBS-Care first Low fibrosis
Rx naive, F2, VL<6m, 8 wks	06/25/2015	Wk 4- VL 0	08/20/2015 Not done	11/12-11/19/15 Pending	UCH-Medicaid Low fibrosis

PA denied twice, pending new PA process

CBC, CMP, VL Fibrosure, U tox	Rx Start date	Week 4 , 6, 8 CBC, CMP, VL	End of Rx CBC, CMP, VL	SVR 12 VL	Insurance/ barriers
Rx naive, F3, VL<6m, 8 wks	Pending				UHC-Medicaid U tox
Rx naive, F2, VL<6m, 8 wks	Pending				Priority Partners Lost insurance

Conclusion

- Identifying and assessing a patient for treatment requires a complex assessment of the medical conditions, severity of fibrosis and necrosis and psychosocial issues.
- A patient who is ready for treatment has required 6-10 encounters prior to starting medication.
- Treatment by a specialist further delays the start of treatment. Experts predict that there are not enough specialists to treat the 2-4 million patients expected to be eligible over the next 5-10 years.
- Integrating the management of Hepatitis C into primary care training is thus essential to the future management of uncomplicated cases.
- Designated staff person or committed volunteer with nursing or medical or public health background is needed to guarantee the program.

Acknowledgement

Teshome Tegene, MD, Program Director, Internal Medicine Residency