Optimizing Hepatitis C Treatment: Hepatitis C Center of Excellence

Sara Gaines, PharmD, BCPS
CarePath Road Map

- Who has the condition to treat?
- What is the right thing to do?
- Putting the clinical pathway in to action
- How did we perform?
- Where should we improve?
Hep C: Proven Care Backbone

• Program
  – Clinical efficacy is the key driver
  – Monitor cost, eliminate waste
  – Increased adherence
  – Site of care
  – Matching genomic attributes to prescribing & outcomes
  – Aligning benefits with clinical decisions/efficacy

• Contracting
  – Formulary alignment

– Development of multidisciplinary team
– CarePath development
– Education
Hep C: Putting the clinical pathway in to action

Positive
- Office appointment
- Refer to drug & alcohol counseling if needed
- Identify high risk behaviors (provide resources if needed)
- Counsel on transmission prevention
- Check liver staging (Fibroscan/liver biopsy)

Complete pre-treatment education

Pre-treatment telephone encounter

Initiate treatment

Telephone reminders for labs and treatment adherence

Monitor response
- SVR not achieved: Monitor and consider retreatment
- SVR achieved
  - Fibrosis stage 4: Monitoring for complications of cirrhosis
  - Fibrosis stage 0-3

Discharge to follow-up with PCP

https://catalyst.nejm.org/geisinger-provencare-hcv-cure/
Hep C: How did we perform?

**PATIENT SUMMARY**

<table>
<thead>
<tr>
<th>Earliest Possible SVR Date</th>
<th>Known SVR Achieved</th>
<th>MRN</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Ghs Pop</th>
<th>Genotype</th>
<th>Fibrosis Stage</th>
<th>Coinfections</th>
<th>REGEMIN</th>
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<th>Latest Viral Load Date</th>
<th>Latest Viral Load Result</th>
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**PROBLEM COMMENTS re SVR (if available)**

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**EVENTS DETAIL**

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</table>
Hep C: How did we perform?

- SVR rates GHP/GHS COE: 98.5%
- SVR national comparison rates: 85%-90%
- SVR rate for GHP/nonGHS: manually collated data due to low recoverable results
- QA/QI process monitors physician compliance of Care Path
- Dashboard
- The large volume of cases within the COE has allowed us to determine/tailor:
  - The optimal drugs for treatment
  - The optimal duration of treatment

SVR = Sustained Virologic Response aka “cure”
Hep C: Where should we improve?

• As new/better agents have come to market, we’ve adjusted the Carepath

• This has resulted in improvements to cost and even better effectiveness – in terms of SVR rates and the utility of the agents across genotypes

• Harvoni → Zepatier → Mavyret
  • Versatility across genotypes
  • Does not require NS5A resistance testing
Hep C: Where should we improve?

• HCV NAT positive kidney & liver transplantation

• 2014 annual report from the Scientific Registry of Transplant Recipients, newly listed liver transplant patients increased by 11%, while the number of transplants only increased by 4.4%
  - HCV positive kidneys/livers are otherwise under-utilized donor pools that have the potential to significantly impact survival in well selected candidates

• Program started October 2018
  - 2018: 3 kidney transplants & 1 liver transplant
  - 2019 (to date): 13 kidney transplants & 3 liver transplants

Verna EC. We can cure hepatitis C virus after transplant, but what is the best regimen? Liver Transpl 2016;22:1463-5
Hep C Lessons Learned

• A collaborative approach brings higher value

• Patients receive higher quality care
• The total cost of care is decreased
• The goal is to provide this level of care to all Geisinger patients
  • Scale Center of Excellence by adding capacity and sites
  • Design benefits to drive members to Center of Excellence
Thank you to Sandeep Khurana, Kristi Clarke, Julienne Hanley, Mike Evans, Bret Yarczower, John Bulger, Joe Chronowski, Eric Wright, and Michael Gionfriddo for their contribution to the development of the ProvenCare® Hepatitis C program.