Hepatitis C Screening and Evaluation: Clinical Decision Tool

Publication of the Clinical Decision Tool (CDT) for Hepatitis C Screening and Evaluation marks a milestone for the American Gastroenterological Association (AGA). This CDT is the first in a series of care pathways created for the “Clinical Service Lines” (CSL) component of AGA’s “Roadmap to the Future of GI” initiative. The Roadmap to the Future of GI is designed to provide gastroenterologists with a single source for clinical tools needed to practice within the emerging value-based reimbursement environment. These tools have been created using a process steeped in the scientific rigor characteristic of AGA publications, combined with immediate access and the applicability needed for clinical practice.

The Roadmap to the Future of GI was originally presented to the AGA Governing Board during its strategy retreat in July 2011. It was first described in a July 2012 article in Clinical Gastroenterology and Hepatology and subsequent sections of the AGA website (www.gastro.org). The AGA initially committed to fully develop 3 CSL including (a) Hepatitis C Screening and Evaluation; (b) Colorectal Cancer Prevention; and (c) Inflammatory Bowel Disease. Beginning components of these 3 CSL can be referenced within the Practice Section of the AGA website.

The following components populate each CSL:

1. Clinical practice guidelines
2. Clinical Decision Tool
3. Performance measures
4. Methods to collect data on performance measures
5. Guides to reimbursement
6. Patient tools
7. Professional education

Hepatitis C virus (HCV) was endorsed as an important first CSL because of the substantial impact of chronic HCV infection on the adult population, the new recommendation for population-based screening and the enormous progress made in its treatment. Chronic HCV infection is a leading cause of liver disease, cirrhosis, hepatocellular cancer, liver transplantation, and death. Newly developed therapies, including direct acting antiviral therapies, have been developed and it is likely that therapies will become entirely oral and of shorter duration compared with traditional interferon-based treatments.

Within the last year, the Centers for Disease Control and the United States Preventative Services Task Force both recommended one time screening for HCV for all people born between 1945 and 1965 in an effort to identify the 2.7–3.9 million Americans who are living with a chronic HCV infection. Seventy-six percent of those infected with HCV are contained within this age group, and an estimated 45%–85% of those people with HCV are unaware they are infected, with 15%–40% expected to eventually develop cirrhosis or cancer.

It is clear that the burden of age cohort-based HCV screening, not to mention subsequent management of screen-positive patients, will overwhelm the capacity of United States hepatologists. General gastroenterologists must engage in HCV management to the highest level of their comfort. As a result of this sobering realization, the AGA, in partnership with the American Association for Study of Liver Disease (AASLD), set out to develop an easy-to-use care pathway with evidence-based recommendations for managing the initial phase of HCV evaluation.

An initial advisory group met in October 2012 in Chicago, IL. The final Task Force (listed at the end of this article) developed the CDT and evaluated each of its 15 decision points as part of a series of meetings and teleconferences from January to June of 2013. We gratefully acknowledge the participation of physician leaders and staff from the AGA, AASLD, and the Infectious Disease Society of America, plus practice leaders from both academic and community gastroenterology practices.

This CDT will aid gastroenterologists in the early management of HCV-positive patients and is intended to become a map for both clinical practice and construction of standard order sets, alerts, and dynamic point of care feedback within electronic medical records. The unique aspect of this CDT is that each decision point was evaluated and graded for its strength of evidence and strength of recommendation. Using the CDT, gastroenterologists can complete an evidence-based, cost-effective initial evaluation of patients whose screening for HCV is positive.

It is important to emphasize that initial HCV screening positivity is not sufficient to begin therapy since further testing should confirm infection and must be coupled with expert evaluation of liver status including inflammation and histologic stage. Treatment of HCV infection was not included in this CDT since therapies are changing rapidly, however, care delivery infrastructure will need to adapt quickly in order to manage the number of expected HCV infected patients and the complexities of emerging therapies. Programs like Extension for Community
Healthcare Outcomes (ECHO), represent a model of treatment that might help with capacity management.6

As the United States moves into a health care delivery world constrained by financial pressures and characterized by accountable care, risk contracting for population management, and reimbursements tied to outcomes, the tools created by the AGA will aid gastroenterologists to redesign their practice to meet these challenges. AGA leadership and staff hope that clinical decision tools like this and other tools within the Roadmap to the Future of GI will support the critical role that gastroenterologists play in providing care for the people that entrust us with their lives and health.

JOHN I. ALLEN
Chair, Hepatitis C Screening and Evaluation Task Force and President-Elect – AGA and Clinical Chief of Digestive Diseases, Yale School of Medicine
New Haven, Connecticut

Appendix. The Hepatitis C Task Force includes: Mark D. Boldt, RN, CNP, Minnesota Gastroenterology; Joel V. Brill, MD, AGAF, Predictive Health; Gary L. Davis, MD, Baylor University Medical Center Dallas(retired); Stuart C. Gordon, MD, AGAF, Henry Ford Health System; Arthur Y. Kim, MD, FIDSA, Massachusetts General Hospital; Lawrence R. Kosinski, MD, MBA, AGAF, Illinois Gastroenterology Group; Arnold G. Levy, MD, Capital Digestive Care; Ronald G. Nahass, MD, MHCM, FIDSA, ID Care; John I. Allen, MD, MBA, AGAF (Chair), Yale School of Medicine.

References

Reprint requests
Address reprint requests to: John I. Allen, MD, MBA, Clinical Chief of Digestive Diseases, Yale School of Medicine, 40 Temple Street, New Haven, Connecticut 06510. e-mail: john.i.allen@yale.edu; fax: (203) 737-1345.

Conflicts of interest
The author discloses no conflicts.