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https://reachmd.com/programs/cme/enhancing-medication-adherence-retention-and-care-for-hepatitis-b-patients/11935/

Released: 11/11/2020
Valid until: 12/20/2021
Time needed to complete: 15 minutes

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Enhancing Medication Adherence, Retention, and Care for Hepatitis B Patients

Announcer:
Welcome to CME on ReachMD. This activity, entitled "*Enhancing Medication Adherence, Retention, and Care for Hepatitis B Patients*." is provided by Global Education Group and the Asian Health Foundation and is supported by an unrestricted educational grant from Gilead Sciences, Inc.

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Dr. Nguyen:
Hello. Welcome to our MedTalk on "Enhancing Medication Adherence, Retention, and Care for Hepatitis B Patients." In the next 15 minutes, we will discuss the challenges on how we can keep the patient in care, and hope to share with you some tips on how to engage the patient. This is relevant, particularly now with the current situation with COVID. And with great pleasure, I would like to introduce my two colleagues, Dr. Raymond Chung and Dr. Douglas Dieterich.

Dr. Chung:
Hi. My name is Ray Chung. I am Director of Hepatology and The Liver Center at the Massachusetts General Hospital in Boston.

Dr. Dieterich:
This is Doug Dieterich. I'm the Director of the Institute for Liver Medicine at the Mount Sinai Health System in New York.

Dr. Nguyen:
Great, thanks so much Dr. Chung and Dr. Dieterich for joining us today. I would like to go directly in and ask Dr. Chung first what your experience is in terms of percent of patients in your practice you think would follow up with you regularly, like every six months or so, and what do you think the national real-world estimate is for this situation?

Dr. Chung:
It's a great question. Well, fortunately, I would say in chronic hepatitis B, we are blessed to have a once-daily therapy that is extremely well tolerated and requires minimal monitoring in the big picture. So, with that in mind, and an educated group of patients, I think my adherence to medications has been in the range of 90%, adherence to both medications and, generally speaking, follow-up appointments. I'd say the national real-world estimate is probably a little bit closer to say 75% or so. One systematic review of about 20,000 chronic hepatitis B patients on NUC analog therapy suggested a figure right in that range. Interestingly, the adherence between high-income and then middle and low-income patients appear to be quite similar in this regard.

Dr. Nguyen:
That's great. Now, what do you think… could you reveal for us what are some of the consequences of non-adherence to medication, as well as non-adherence to liver cancer surveillance or monitoring of disease activity?

Dr. Chung:
Yeah, it's a many-fold set of consequences. The first and perhaps most immediate threat, at least with regard to non-adherence to

medications, would be the real risk for the development of a virologic flair. The loss of control could lead to a significant rise in liver enzymes and in a worst-case scenario, the development of significant hepatitis or even liver failure. Additional potential consequences would include the promotion of virologic resistance, particularly with intermittent adherence and then non-adherence back and forth raises potentially the stakes for the development of that complication.

And then, in terms of failure to adhere to visits and monitoring and screening, there are certainly as well the concerns for clinical outcomes like hepatocellular carcinoma, which of course most of our patients are going to be at elevated risk for and these individuals, if they don't adhere to a screening schedule, do run the risk for detection of these kinds of complications late in the course of the disease. This is why recommendations for typically every six-month screening are in place, so that we can actually maximize the likelihood of early detection of these lesions. So, one fear of non-adherence is late, or later, detection of HCC, for instance.

Dr. Nguyen:
So, now I think that in our practice, I think most physicians would tell the patient they need to do these every 6 months, and advise the benefits and the potential problems. But despite that, the adherence issue remains a problem. What are some of the causes or barriers to patients being able to come do tests every six months or stay on treatment long-term, do you think?

Dr. Chung:
Well, there are several of them, and certainly the fact that there are disruptions in one's life, planned and unplanned, that get in the way of either visits, monitoring, laboratories, or even refills of medications. And unfortunately, this happens on a sporadic but fairly predictable basis. Travel certainly can wedge itself into the picture. The fact the patients are asymptomatic and sometimes, I think, forget that they have a condition that needs to be monitored and surveyed is sometimes a reason for folks getting out of sync with their schedules. And cost certainly can be a factor when it comes to the refilling of medications and large, in some instances, copays for prescriptions, which end up being a deterrent to refilling these essential medications. So really, a number of factors.

Dr. Dieterich:
Actually, may I jump in here, Dr. Nguyen?

Dr. Nguyen:
Yes.

Dr. Dieterich:
I think there's two things that particularly are important to recognize with that. I have many patients that go to Hong Kong for the winter and they will miss appointments, you know, because of that. And thenI had a couple of patients who go to India for the winter, actually one of whom was a cardiologist who just retired with HCC that we had taken care of and was in full remission and he was actually very adherent, really was careful about his visits. But he came back from India with a new HCC and 100,000 IUs of HBV DNA and I was a little upset. I said weren't you taking your tenofovir? And he says yeah, every day. I said where did you get it? He said oh, at the corner drug store in India. And I said well, you were taking M&Ms, because that was counterfeit tenofovir and he said well, it saidthe name of a very reputable generic maker. I said obviously it's really important for our patients who spend the winter or travel overseas to understand that 15% or 20% of medications they might buy over there is counterfeit. So, fortunately, this guy's HCC responded a second time to treatment and now he gets all of his medication in the US, before he leaves for India for the winter. So, another important problem with adherence may not be the patient's fault, actually, if they go overseas.

Dr. Nguyen:
Yes, people buy more and more medications online now, outside of the US. I have had some patients who told me that they do that.

Dr. Nguyen:
So, I am going to move to the COVID issue now. I think that we all have seen patients, clinic volumes and clinic visits to be down during the COVID time overall, and so I want to ask both doctors, especially Dr. Dieterich, because you are from New York, the epicenter of COVID in our country, what…

Dr. Dieterich:
We're not the epicenter anymore, actually.

Dr. Nguyen:
Ah, yes, that's right.

Dr. Dieterich:
It's now Florida.

Dr. Nguyen:

And California, where I am now.

Dr. Dieterich:
And it could be Mississippi soon. Yes, actually COVID has been a huge issue, because we stopped seeing regular patient visits except for basically decompensated cirrhosis and HCC for about three months during the worst of the COVID time in New York. And, we've pretty much restored our clinics, pretty close to normal now, but there's still a lot of reluctance on many patients with hepatitis B to come in for visits. They're less reluctant to go, to outside radiology for ultrasound or MRI screening. But, getting blood drawn is more of a problem. Even though we could send them to LabCorp or Quest or some other commercial labfor labs, they're still kind of reluctant because they're afraid people are going in there for COVID tests, so it's difficult to get lab tests done. Even if we're seeing the patients via telehealth, which is quite common nowadays, most of our docs are doing one or two sessions a week of telehealth and the patients love it. You know, in order to follow our hep B patients, we need imaging and we need labs. So, imaging has been less of an issue but labs have been a big stumbling block for our folks. I don't know, Ray, are you having the same problem?

Dr. Chung:
Absolutely. You know, we've had to become resourceful and creative in how we deal with these issues. I mean, certainly we have had to educate them and use either carrot or stick approaches to try to motivate them to come in for either tests or ultrasounds or other imaging studies. But, it does underscore the importance of coming up with perhaps more durable solutions as we deal with the aftermath of the pandemic, like home blood draws or home point of care testing to perhaps, as we're doing with other viruses, look at, viral loads using a rapid home-based approach, for instance, or at least mailing in a home blood draw into an independent laboratory for reading. We have to explore, I think, a number of possible solutions, at least for long-term monitoring questions.

Dr. Dieterich:
We've been doing the home visits by M.D.s for clinical trial visits, too. And then, of course, they're doing the blood draws at the same time. The clinical trials have been affected greatly by COVID as well, since the patients are staying at home and, you know, we haven't opened up the clinical trials unit yet. So, to keep the patients in the clinical trials, we've had to… or the companies have frequently – or the CROs have been sending docs to the patients' homes to do a physical, do a visit and draw blood. Yeah, it's definitely required some creative solutions.

Dr. Nguyen:
Before we close, I want to bring up one thing that I am pretty sure you may have observed, too, is that the COVID brings out the disparity even more than before. So, from my experience, we do almost all telehealth visits here in California at this time because of other research over here and the home patients, the immigrant patients with less economic resources don't have a reliable computer and internet. And the patients who have limited language abilities, these patients actually have been the hardest hit. They cannot get on the telehealth. We can barely do telephone with some of these patients, and especially the older patients, it's even more difficult. And our hepatitis B patients, 70% of them are immigrants, so I think that as far as hepatitis B is concerned, we may see even more problems or disparity as this goes on.

Dr. Dieterich:
Yeah, particularly older patients don't tend to have smartphones that they can use for telehealth visits.

Dr. Chung:
I wonder at this point in time whether we ought to be, again, applying resources like patient navigators who may again be facile in the languages of origin of many of these patients to actually act as a sort of a group hep B patient navigator, as the case might be. Again, I think all options have to be on the table here for us to try to reach out to a group that may have even less reason to come in to see us and interface with us.

Dr. Dieterich:
Yeah, we don't have those. We frequently have sons or daughters, and more likely daughters to be able to help the patients, either on the telehealth visit or bringing them in, or getting them to radiology, etc.

Dr. Chung:
Great point.

Dr. Nguyen:
Great. Thanks so much, Dr. Chung and Dr. Dieterich. I think that we hope to have provided everyone with some tips and something to think about as we monitor our patients, some of the issues that the patients face that we may be able to help them address and retain and keep the patients in care. Thank you everyone.

Dr. Chung:

Thanks very much.

Dr. Dieterich:
Thank you Dr. Nguyen.

Dr. Nguyen:
Thank you.

Announcer:
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