Hepatitis B and C Care in the Opioid Substitution Setting – an Integrated Nursing Model of Care

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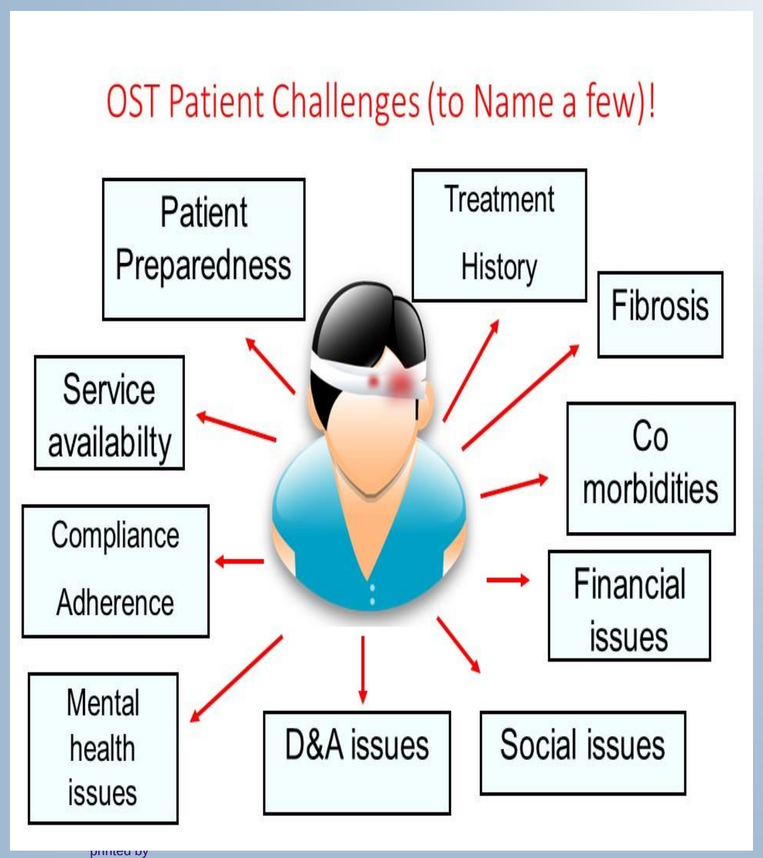
BACKGROUND

Hepatitis B and C are major public health concerns with some 500 and 200 million cases worldwide respectively. Despite the availability of curative therapies for hepatitis C virus (HCV) and viral suppressive therapies for hepatitis B virus (HBV), to date only a minority of infected patients receive treatment throughout the world. [1] In the general population, morbidity and mortality associated with chronic HCV and HBV infection is on the rise. This situation is even further pronounced in the Opioid Substitution Therapy (OST) setting where people living with HBV and/or HCV have been reluctant to access viral hepatitis services. This paper illustrates the creation and functioning of a multidisciplinary, nurse-led model of care for HBV/HCV patients within the OST setting.

PURPOSE AND HYPOTHESIS

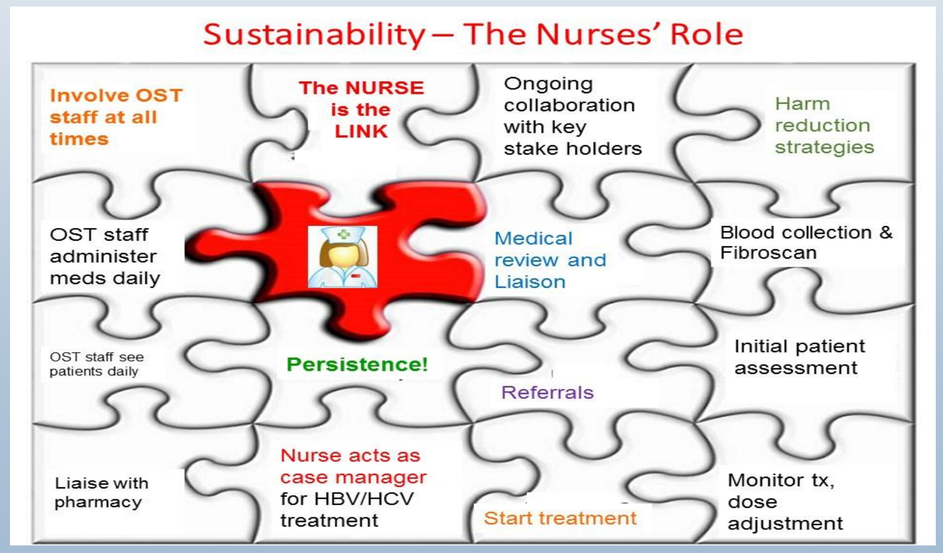
In Australia, an estimated 41%to 68% of people who inject drugs (PWID) are HCV positive [2] and between 28% and 59% of users are estimated to be exposed to HBV.[3] Although current treatment guidelines suggest that active drug use should not preclude people from HCV treatment, uptake of therapy thus far has been low to say the least. In the world of escalating burden of liver disease and healthcare costs, this nursing model of care has been effective in enhancing access to HBV/HCV services among the marginalized injecting drug use population.



MATERIALS AND METHODS

The Rationale:

- OST population is at **higher risk** for HCV/HBV infection due to IVDU
- Conventional tertiary models of care are inappropriate for this cohort
- OST population historically **reluctant** to access medical OR viral hepatitis services
- **Poor diagnosis, assessment and treatment uptake – WHY?**
- Many as yet undiagnosed with HBV/HCV
  - Barriers include:
    - Stigma and discrimination
    - Asymptomatic illness – feel well, no triggers for liver disease
    - Chaotic lifestyle with other competing concerns eg: homelessness, unemployment, ongoing drug and alcohol use, mental health issues and incarceration
    - Fear, negativity and misinformation about HCV/HBV and treatment options
  - HCV/HBV is **not** a healthcare priority
- Limited specialised OST/viral hepatitis services



RESULTS

- ☑ Outreach viral hepatitis services to marginalised group
- ☑ Enhanced awareness of BBV and screening
- ☑ Increase treatment uptake in "safe and familiar" environment
- ☑ OST staff can rapidly alert Liver nurse to concerns = enhanced monitoring, compliance and outcomes
- ☑ Reduce risk of advanced liver disease
- ☑ Improve quality of life in disadvantaged group
- ☑ Reduce waiting times in Liver Clinics
- ☑ Reduce travel time and costs to patients
- ☑ Improved treatment response rates
- ☑ Reduce global burden of liver disease
- ☑ Spreading the word!

CONCLUSIONS

- High rates of HBV / HCV in OST patients
- Assessment and treatment uptake to date remains poor
- OST = Complex group that requires a strategic **nursing model of care**
- Nurse to act as the primary case manager
- **OST clinics provide the ideal setting for the treatment of viral hepatitis**

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2.Nelson, PK, Mathers, BM, Cowie, B, et al. Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. Lancet 2011; 378: 571-583
3.Deacon, RM, Topp L, Wand H, et al. Correlates of susceptibility to hepatitis B among people who inject drugs in Sydney, Australia. Journal of Urban health 2012; 89: 769-778