Sharing Hepatitis C Care can it work between primary and secondary services?

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INTRODUCTION:

In Lothian, Scotland all Hepatitis C (HCV) assessment and treatment is delivered via the secondary services. These services have a large "did not attend" (DNA) rate - studies have found that less than half of those diagnosed are referred to appropriate specialist services, with even fewer attending appointments and beginning treatment [(1)] . The numerous barriers that existed previously to HCV treatment have now gone, treatment is shorter in duration with minimal side effects and a better treatment outcome. The majority of patients do not have severe liver disease and can be managed safely and effectively in the community.

In order to reduce this access and treatment gap we liaised with the HCV Managed Care Network (MCN) to work alongside and support a local General Practitioner (GP) practice. Together we identified a GP practice where we knew a number of clients who had not attended HCV services were attending for Opiate Substitution Therapy (OST). Embedding HCV management in a GP practice could help identify harder to reach patients, facilitate initiation onto HCV treatment , improve adherence and provide opportunity for brief interventions on other health issues.

AIMS:

- Ensure HCV treatment was accessible to previous poor attendees of secondary services
- Develop a shared care protocol with a GP with a special interest in HCV
- Increase treatment numbers
- Continuity of care in a local setting
- Minimise treatment drop out rates
- Reduce the pool of infection of the harder to reach and potentially more chaotic patients thus reducing onward infection and helping towards elimination

Shared Care Protocol

•Established by GP & Blood Borne Virus (BBV) Clinical Nurse Specialist (CNS)

•GP identifies individuals known HCV antigen positive who had not engaged with HCV services at secondary care treatment centre

•GP arranges appointment for holistic assessment and exclusion of cirrhosis/hepato cellular carcinoma (HCC)

•GP liaises with secondary services for Fibro Scan® (and Abdominal USS if required). Fibro Scan® machine can be taken to GP

•GP presents individual to multi disciplinary team (MDT) meeting

•Decision at MDT re treatment and/or further investigations

•Secondary care provides prescriptions and liaises with community pharmacist

•GP reviews individual prior to commencing treatment and at week 4, end of treatment and 3 months post treatment

RESULTS:

30 HCV antigen +ve individuals known to GP
3 Patients GP had contact with but not started treatment (due to multiple DNAs)
4 Moved out of area
4 Unable to contact
4 Not interested in treatment
1 Alcohol excess means unable to attend appointments
1 In custody or awaiting sentencing
3 Attending secondary care treatment services

9 treated February 2018 – August 2018 (2 Epclusa®, 6 Maviret®, 1 Harvoni®)
1 approved for treatment, start date September 2018
Of those treated: 1 cirrhotic requiring HCC surveillance post treatment.
1 HCC identified and referred to hepato biliary MDT for ablation pre treatment
Of the 9 treated :
DNA rate of 77% at HCV secondary services 2015-2017
DNA rate of 49% at GP practice HCV service 2017

CONCLUSIONS:

- Increase in HCV treatment in a client group that were previously not accessing HCV services
- Increased awareness of HCV treatments for patients and GP practices/primary services and where/how to access
- Opportunity to provide brief interventions on other aspects of health that may be related to HCV – drug and alcohol use
- Increased awareness of support services available
- Model could be replicated in other GP centres with the support of specialist HCV services
- Strong relationships with key stakeholders, GPs and local voluntary services are essential to the success of a clinic to support the implementation and management of those with HCV

DISCUSSION:

Until now , HCV treatment in Scotland has been delivered from secondary care which may be a barrier to patients accessing treatment. Moving treatment to GP practices where patients already attend and have an established relationship with the GP could improve access to treatment, adherence and closer monitoring. This project demonstrates a successful model of GP led HCV- care.

Treatment in a GP surgery can reduce the stigma often attached to attending a "known HCV" centre.

HCV treatment is straightforward but many of our patients have complex issues, such as chronic disease, mental health or socio economic issues which would be appropriate for GPs to deal with as these could impact other aspects of patient health.

The advent of pan genotypic treatment means GPs would no longer have to negotiate different treatment regimens and if linked with a specialist centre can liaise directly.

As we look to 2030 and HCV Elimination the movement of HCV treatment into the community allows for easy and equitable access to treatment in an individuals choice of centre.

Reference: 1 W. L. Irving; S. Smith; R. Carter; S. Pugh; et al.,(2006) 'Clinical pathways for patients with newly diagnosed hepatitis C – What actually happens' Journal of Viral Hepatitis. 13 (4): 264-271, doi:10.1016?j.jhep.2016.09.004