THE EC NURSE-LED MODEL OF CARE AND THE IMPACT ON HEPATITIS C TESTING COVERAGE IN A NETWORK OF HIGH CASELOAD PRIMARY CARE CLINICS IN VICTORIA, AUSTRALIA.

Layton C[1,2], Traeger M[1,3], Chan K[1], Bryant M[1,2], Draper B[1,3], Cooper M[4], Kozminsky M[5], Andrada E[6], Thatcher R[7], Membrey, D[10], Bramwell, F[10], Stoove M[1, 3], Doyle J[1,2], Thompson A[8,9], Hellard M[1,2,3], Pedrana A[1,3].

[1]Disease Elimination Program, Burnet Institute, Melbourne, Australia; [2]Department of Infectious Diseases, The Alfred and Monash University, Melbourne, Australia; [3]Department of Epidemiology and Preventive Medicine, Monash University, Melbourne, Australia; [4]Lygon Court Medical Centre, Melbourne, Australia; [5]Genesis Medical Clinic, Melbourne, Australia; [6]Mediclinic Clayton, Melbourne, Australia; [7]Access Health The Salvation Army, Melbourne, Australia; [8]Department of Gastroenterology, St Vincent's Hospital Melbourne, Melbourne, Australia; [9]Department of Medicine, University of Melbourne, Melbourne, Australia.; [10]cohealth, Melbourne, Australia.

Background: Since March 2016 in Australia, ~82,000 people (~40%) have been treated for HCV. After an initial spike during 2016-2017, testing and treatment has been declining. The Eliminate Hepatitis C (EC) Partnership is a 5-year program aimed at increasing HCV testing and treatment among people who inject drugs in primary care clinics in Victoria, Australia.

Methods: The model delivers nurse-led interventions to high-caseload clinics. Co-designed with clinic staff and informed by baseline assessments; interventions include education, mentoring, patient recalls, nurse-led clinics, on-site phlebotomy and Fibroscans. We assessed changes in testing uptake 12 months pre- and post-intervention using clinical data extracted from practice software through the ACCESS surveillance system.

Results: The EC Partnership recruited 11 high-caseload clinics between 2017-2020. Twelve months of pre- and post-implementation clinical data is available for seven of those clinics. The number of antibody tests increased pre- and post-intervention in six of seven clinics: (A-G); A (427 vs. 327), B (168 vs. 179), C (113 vs. 137), D (129 vs. 170), E (61 vs. 66), F (62 vs. 71), G (12 vs. 34). Similar increases in the number of RNA tests were observed: A (593 vs. 403), B (103 vs. 106), C (80 vs. 94), D (168 vs. 171), E (106 vs. 120), F (100 vs. 113), G (16 vs 48). The proportion of antibody-positive patients that received a follow-up RNA test within three months increased in five of seven clinics: A (92% vs. 95%), B (43% vs. 55%), C (84% vs. 94%), D (88% vs. 96%), E (97% vs. 91%), F (93% vs. 100%), G (75% vs 67%).

Conclusion: This model assists primary healthcare clinics to address barriers and improve uptake of HCV testing and diagnosis of chronic infection. When considered against the background of declining testing and treatment in Australia, this model could assist others in changing the trend.

Disclosure of Interest Statement: The authors acknowledge funding support from Gilead Sciences and National Health and Medical Research Council for this project through an investigator-initiated research grant from. The Burnet also receives funding support from Abbvie, BMS and Merck for investigator-initiated research. Ms Layton has applied for an ASHM scholarship to attend this conference. AP has received consultancy fees from Gilead Sciences.