Improving access to Hepatitis C treatment for people currently injecting drugs, a sexual health clinic model of care

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Background

Universal access to directly acting anti-viral agents (DAAs) for Hepatitis C become available in Australia in 2016. In the first 12 months over 40,000 people commenced treatment however the rate of treatment slowed down significantly in more recent times.[1]

Despite the universal funding of DAAs continued efforts are required to expand the range of settings offering treatment to better serve marginalized populations who may fail to access mainstream primary and tertiary care services.

To stay on track for **hepatitis C elimination by 2030 treatment uptake needs to remain high,** including among those highest risk of hepatitis C transmission, such as people who inject drugs (PWIDs)[2].

Sexual Health Clinics in NSW are ideally placed to expand hepatitis C treatment access because they:

- target priority populations for sexually transmitted infections and HIV, including PWID,
- offer a low-threshold walk-in service model
- are staffed by a multidisciplinary team

In order to expand DAA access Pacific Clinic began offering hepatitis C treatment in April 2016. We analysed uptake and outcome from March 2016 to July 2017.

Model of care

Pacific Clinic is a publicly funded sexual health clinic in Newcastle, Australia. We aim to provide testing and treatment for sexually transmitted infections (STIs) and HIV to those most at risk of infection and/or marginalised populations facing barriers to accessing mainstream services.

When introducing hepatitis C treatment Pacific Clinic decided to **actively target our treatment model to best care for people who may struggle to engaged with mainstream services,** especially people who are currently injecting drugs.

Existing strengths of the clinic

- staffed by multidisciplinary team of doctors, nurses and a social worker.
- located in a community health facility
- co-located with the main needle syringe program and public opioid substitution therapy service for the city
- offer a mix of appointment and walk-in service.
- incentivised testing program whereby people accessing the needle syringe program are offer a $20 voucher to attend for an assessment of blood borne virus screening.

Model of care

New strategies implemented

- integrated hepatitis C assessment and treatment into the general walk-in clinics
- used the existing incentivised testing program to perform opportunistic treatment and post-treatment assessments
- tailored treatment and follow-up plans to individual needs
- implemented a universal offer of individualised treatment and adherence support, including SMS reminders, medication ordering and supply, social work support
- worked with partner services to locate and offer support to those lost to follow-up
- worked with referral services to promote our focus on those having difficulty accessing mainstream services
- encouraged clients to promote treatment to partners and friends.
- used the existing electronic medical record to review outstanding issues for flagging or recall that may have been missed for patients choosing not to schedule their care

Effectiveness

Between 1 March 2016 and 31 July 2018 Pacific Clinic treated 79 people for hepatitis C infection.

Despite treatment being open to anyone our targeting strategies were effective with 62% of people treated currently injecting drugs.

Treatment completion rates (by self-report, loss to followed assumed incomplete) were high with 90% of people prescribed treatment completing the full course.

Treatment outcomes were similar to other real world studies with the sustained viral response rate at 12 weeks (SVR12) being 76%. The majority of those without SVR12 were lost to follow-up after treatment completion and hence unlikely to have actually failed treatment.

Only 2 people were found to have detectable virus at SVR12, one with very poor adherence to treatment and one with a new genotype indicating likely reinfection.

Treatment completion and success was no different in those currently injecting drug and other clients.

Overall 56% of clients took up the offer of social work support. PWID were significantly more likely to take up this service compared to other clients.

While the majority of clients required very little social work support a small number of clients required high levels of support highlighting the need to individualise treatment and support plans. The use of SMS and other mobile technology was vital in enable this need to be met within existing recourses.

Effectiveness

Treatment completion rate

	Overall (n=79)	PWID (n=49)	Non-PWID (n=30)	p-value
Completed	71 (90%)	43 (88%)	28 (93%)	0.43
Incomplete	8 (10%)	6 (12%)	2 (7%)	
Ongoing	1	0	1	
Did not start	1	1	0	
Ceased early	1	1	0	
Unknown	5	4	1	

SVR12 rate*

	Overall (n=79)	PWID (n=49)	Non-PWID (n=30)	p-value
SVR12	54 (76%)	36 (78%)	18 (72%)	0.56
No SVR	17	10	7	
Missing SVR result	15	9	6	
Failed SVR	2	1	1	

limited to those eligible for SVR12 at the time of analysis

Conclusion

Sexual health clinics can build on their existing model of accessible care to successfully provide targeted hepatitis C treatment to people who inject drugs and other marginalised populations.

References

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