HepCare Europe

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HepHIV 2019
28-30 JANUARY · BUCHAREST

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Service Integration – Reaching the Homeless Population

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Ireland and Hepatitis C

- Estimated between 20,000-30,000 individuals living with HCV in Ireland
- 80% of these contracted HCV through injecting drug use
- Many of these are engaged in homeless and addiction services but few linked with hospitals and fewer again accessing HCV treatment.

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Homeless HepCheck Study 2016

- Carried out in Homeless Services in Dublin
- 619 Individuals offered screening.
- 216 reported having had a previous HCV test (108 positive, 79 negative & 29 unsure of the result)

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Homeless HepCheck Study 2016

- 547 HCV Antibody Tests were performed
  - 38% (n=206) tested positive
  - 57% (n=310) tested negative
  - 5% (n=31) recorded as no result/awaiting result
- Of the 206 testing positive, 54% (112) were “new” positives while the remaining were “known positives”.
- Following a positive test 51 patients were referred to specialist care BUT 33 did not attend
- Only 2 received treatment with an SVR

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Homeless HepCheck Study 2016

- The most common reasons for non-attendance were
  - active on-going drug use
  - being in prison
  - fear of side effects of treatment
  - forgetfulness

- Asked about barriers to treatment, participants' answers centred around on-going drug use, mental health issues and lack of stable accommodation.

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Shared Care Community Treatment Program

- Collaboration between Mater Hospital Dublin and Granby Methadone Centre (Centre for Homeless/Marginalised persons receiving methadone). GP trainee delivered the service.
- Aims to make DAA (HCV oral only) treatment for HCV more accessible and feasible to patients from marginalised populations.

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Shared Care Community Treatment Programme

- Provide a high quality, clinically effective service within the community
- Receive HCV treatment (DAAs) alongside their opioid substitution therapy in their community pharmacy following initial patient review and work up in the Granby Centre and one initiation visit at the Mater Hospital.

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Shared Care Community Treatment Programme

Roles and Responsibilities of Hospital Consultant

- Hospital Consultant provides overall governance of program
- Engagement in supervisory programme
- Determination of treatment regimen
- Supervision of responses to uncommon side effects/adverse events/significant abnormal blood results.
- Supervision of Peer Support Program

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Shared Care Community Treatment Programme

Roles and Responsibilities of Granby Centre/GP Trainee

- Support for GP Trainee to fulfil responsibilities
- Follow up on patients defaulting by trying to re-engage
- Overall clinical care of the patient
- Setting up meeting with Peer Support Worker
- Collection of data
- Weekly reports to hospital consultant and team
- Weekly contact with community pharmacies to assess compliance

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Shared Care Community Treatment Programme

Roles and Responsibilities of Hospital Pharmacy

- Supervision of pharmacy element of programme
- Ensure correct treatment option is selected as per National HCV Treatment program guidelines
- Ensure a full list of concomitant medicines is obtained from GP trainee
- Provide education to patient
- Ensure community pharmacy are willing to partake in the programme

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Shared Care Community Treatment Programme

Roles and Responsibilities of Hepatitis C Nurse Specialist (Hospital Based)

- Provide advice and support to GP/GP trainee throughout treatment duration

Roles and Responsibilities of Community Pharmacy

- Acknowledgement of receipt of patient medication
- Storage of DAA's
- Ensure patient received take away DAA therapy to cover days when OST not supervised
- Report on adherence to therapy

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Shared Care Community Treatment Programme

To date:

- 25 patients with Chronic HCV infection recruited
- 21 male and 4 female
- Aged between 29-56 years.
- To date all who completed treatment have undetected viral load at EOT, 11 with SVR at 3 months, 5 still on treatment and 7 awaiting 3 month SVR testing.
- 2 defaulted during treatment despite intensive peer support and intervention by community team.

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- 1 defaulted due to severe drug addiction and alcohol issue and refused to complete treatment.
- 1 defaulted due to severe distress as her children were placed in foster care.

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Case Study

- 25yr old Male living in homeless accomodation
- History of Injecting Heroin since he was a teenager
- Alcohol and benzodiazepine addiction
- On Methadone since 2015
- Chronic Hepatitis C
- With intensive Peer Support commenced DAA treatment in May 2018.
- Despite this poor adherence to treatment and stopped prior to end of treatment. Refused to return to clinic for follow up bloods.

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Integrated Care

- Partnership between hospital and community critical to ensure governance and appropriate assessment and support for the patient and the community services engaged in this initiative.
- Ultimately all care needs to be provided in the community, as these patients do not access hospital services
- Despite all support, there will be some ‘failures’.
- Those stable patients coming for hospital care are not ‘high transmitters’. It’s the ‘high transmitters’ we must additionally target to decrease onward transmission.
- In 2018 Ireland treated 1700 patients, but 700 new infections. Slow progress towards ‘elimination’.

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Thank You
Any Question?

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