

# HepCare Europe

Linking with 'Integrate'

Dr John (Jack) Lambert, Mater  
Misericordiae University Hospital and  
UCD School of Medicine, Dublin, Ireland



# HEPCARE: A new Hepatitis C Care service model

## VISION:

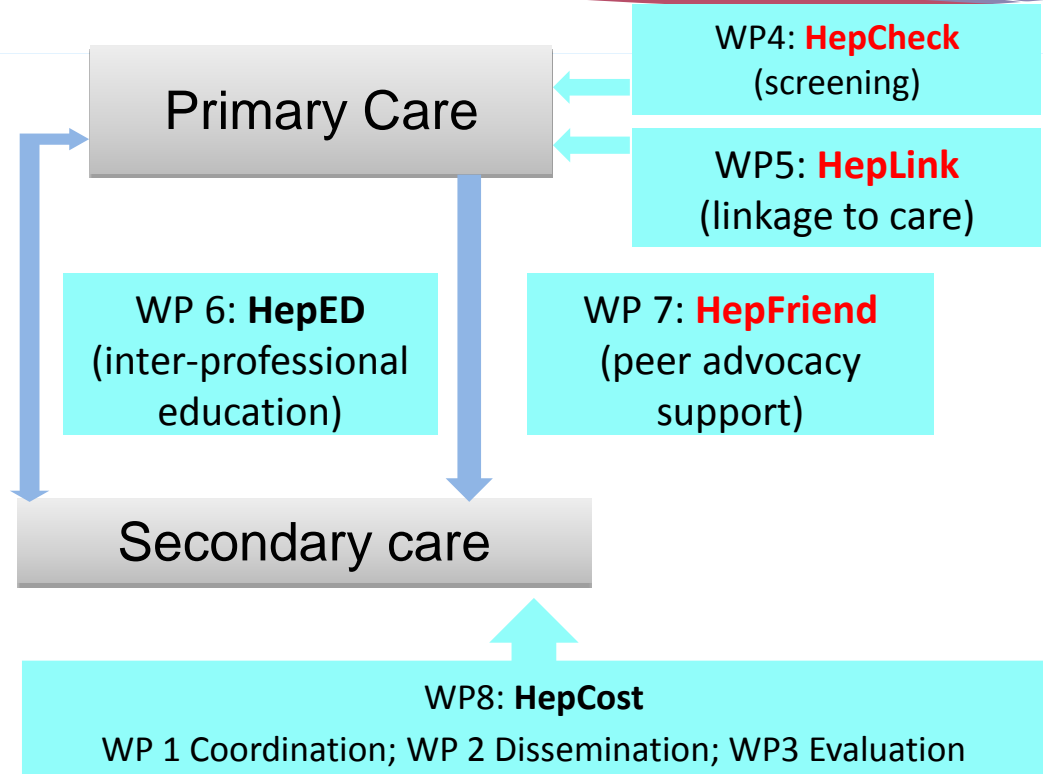
Create an innovative, integrated system for HCV treatment, based on the joint participation of primary and speciality care practitioners

## OBJECTIVE:

Improve access to HCV testing and treatment among key risk groups, including drug users and homeless, through outreach to the community and integration of primary and secondary care services

**HEPCARE EUROPE** is a €1.8M 3-year EU-supported project at 4 member state sites

**Consortium members:** UCD (Ireland); SAS (Spain); SVB (Romania); University of Bristol (UK); University College London (UK)



# How to make HCV a 'rare disease' in the EU

## Community Education

Preparing the at risk population for testing, assessment and treatment)

## Point of Care Testing

Evaluation of point of care testing with HCV oral tests in diverse populations and different countries/settings and assessment of cost effectiveness

## Educational tools and pathways

To help HCV negative people to minimise their risk of HCV infection and other blood borne viruses

## Education of Community Health Care Workers

Improve understanding of new treatments, and prepare them to act as partners in treatment and support in a 'shared care' primary/secondary integrated partnership.

## Community Fibroscan testing strategy

Implementation and evaluation of the strategy, and assessment for advanced disease patients the reasons for non-attendance.

## Linking Services across Diseases

Address key conditions in vulnerable populations in a linked up fashion (drug and alcohol addiction, primary care, STD, blood borne virus testing, TB, Hepatitis B vaccination)

## Community nurse outreach and peer advocacy support

Community focused assessment for HCV disease in HCV+ as vulnerable communities do not access secondary care services.

# WHO strategy comes with targets, by 2030



## Incidence targets

- 30% reduction in new HCV infections by 2020
- 90% reduction in new HCV infections by 2030



## Mortality targets

- 10% reduction in mortality by 2020
- 65% reduction in mortality by 2030



## Harm reduction

- Increase in sterile needle and syringes provided per PWID/year from 20 in 2015 to: 200 by 2020 and 300 by 2030



## Testing targets

- 90% of people aware of HCV infection by 2030



## Treatment targets

- 80% of people treated by 2030





# **HEPATITIS C; HOMELESSNESS AS A BARRIER TO ENGAGEMENT (HepCheck)**

**Dr Jack Lambert, Mater and UCD**



- During an intensified community HCV screening program operated in 'SafetyNet' Homeless services in Dublin, Ireland, all patients attending services were invited to complete a short questionnaire and offered a rapid oral HCV test, and participation in the HepCheck study if found positive.
- A subset of these participants were selected opportunistically for a qualitative interview (n=49) during screening clinics. Questions asked explored health and social risk factors, including: homelessness experience, health status, health service usage, co-morbidities and the steps that were taken post positive HCV Ab test.



# DATA COLLECTED:

- Number of individuals offered screening
- Proportion of individuals offered screening who already have been diagnosed as having HCV.
- The treatment status of individuals already diagnosed with HCV (cured/treated but not cured/awaiting treatment/defaulted from follow-up/never referred to specialist treatment)
- Number of individuals screened
- Proportion of individuals with positive HCV antibody (HCV Ab +) on screening
- Number of HCV Ab+ individuals (either new or previously diagnosed) attending for HCV assessment.

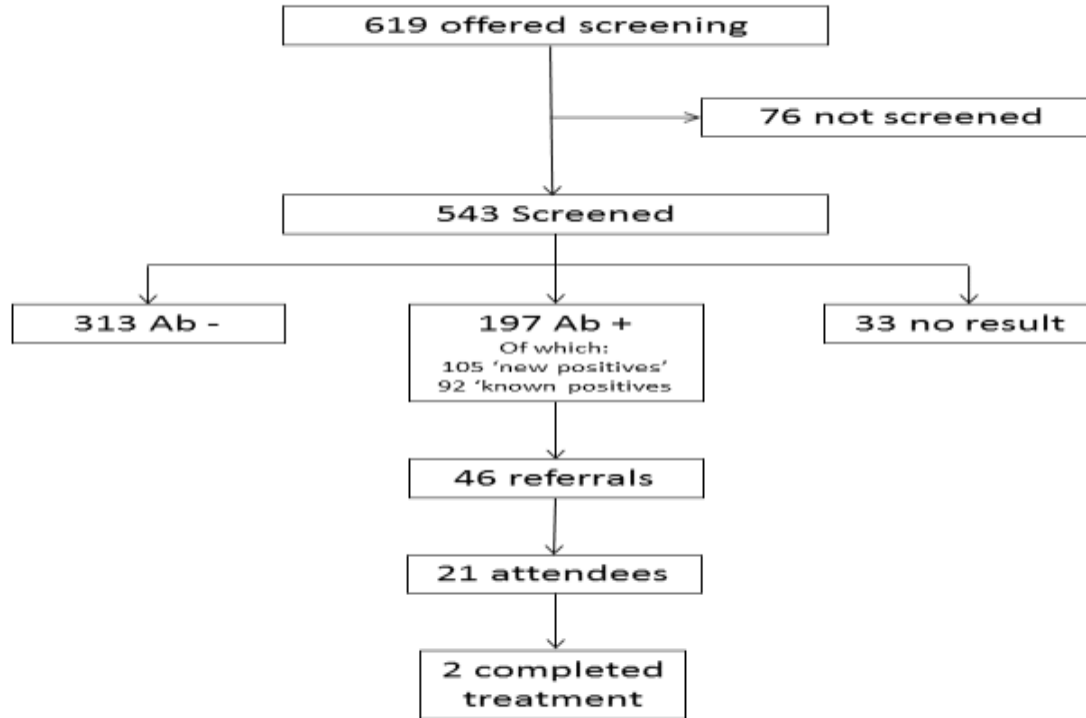


- Patients were tracked along the referral pathway to identify whether they were referred to a specialist clinic, attended the specialist clinic, were assessed for cirrhosis by Fibroscan and were treated for HCV. Where possible, a community key worker was involved in linking the patient to specialist care. Patients were given at least 3 appointments for a specialist clinic.





Figure 1. Screening Flow Chart



# Qualitative Interviews with selected patients

- 49 participants were administered the questionnaire, of which most (78%) were currently living in a hostel. The remaining were sofa surfing, sleeping rough or staying with friends. The average time period of homelessness was 6.2 years, with a range of 2 months to 20 years.
- The most common reasons for homelessness were co-morbidities such as alcohol and/or drugs, and for some, this was combined with family/relationship problems and mental health problems. Most (42%) saw a GP once a week.



- When asked about their HCV antibody result, 63% said they had previously received a specialist appointment. When asked about their HCV healthcare pathway, the most common theme was stable accommodation: participants reported this to be a barrier to attending specialist appointments and accessing treatment.
- The most common other reasons for non-attendance were active drug use, being in prison, fear of side effects of treatment and forgetfulness.



# Conclusion

- Community based screening intervention can determine the prevalence of HCV in homeless populations, however referrals to / attendance at secondary care remains a challenge for this cohort. It is recognised that psychosocial factors were are at the core of why patients do not attend secondary for HCV management and in this study, addiction, mental health and homelessness were especially problematic. Future research should therefore examine interventions (e.g. outreach, counselling, addiction treatment) which address these factors in conjunction with HCV care.



# IPS Research Project

Prison component of European HEPCARE “Seek and Treat” project

Location: Mountjoy Prison Complex (Dublin) (male= 650, female= 105)

Aim: To understand the blocks and enablers to HCV screening and treatment in Irish prisons, to inform how best to maximise HCV screening in Irish prisons

Methodology: 11 focus groups (prisoners, clinical and operational staff and management)

Reporting on the prisoner component of this study: male x3(n=38), female x1 (n=14)



# Findings

## Blocks

Patient: lack of knowledge, fear of HCV treatment and liver biopsy, poor motivation to engage with health services, concerns around confidentiality and stigma

Systemic: poor and inconsistent access to prison health services, delays in having screens and receiving results, confidentiality and the requirement to go to hospital



# Findings

## Enablers

- \* access to health care
- \* in-reach hepatology services
- \* in-reach fibroscanning
- \* peer support
- \* stability of prison life



# Conclusions

Blocks and enablers to HCV screening and treatment can and have been identified from a prisoner perspective

These blocks can be removed ( many have) and recognised enablers can be implemented, including opt-out screening, use of DPS, POC testing, peer support and education and different models of in-reach hepatology services.

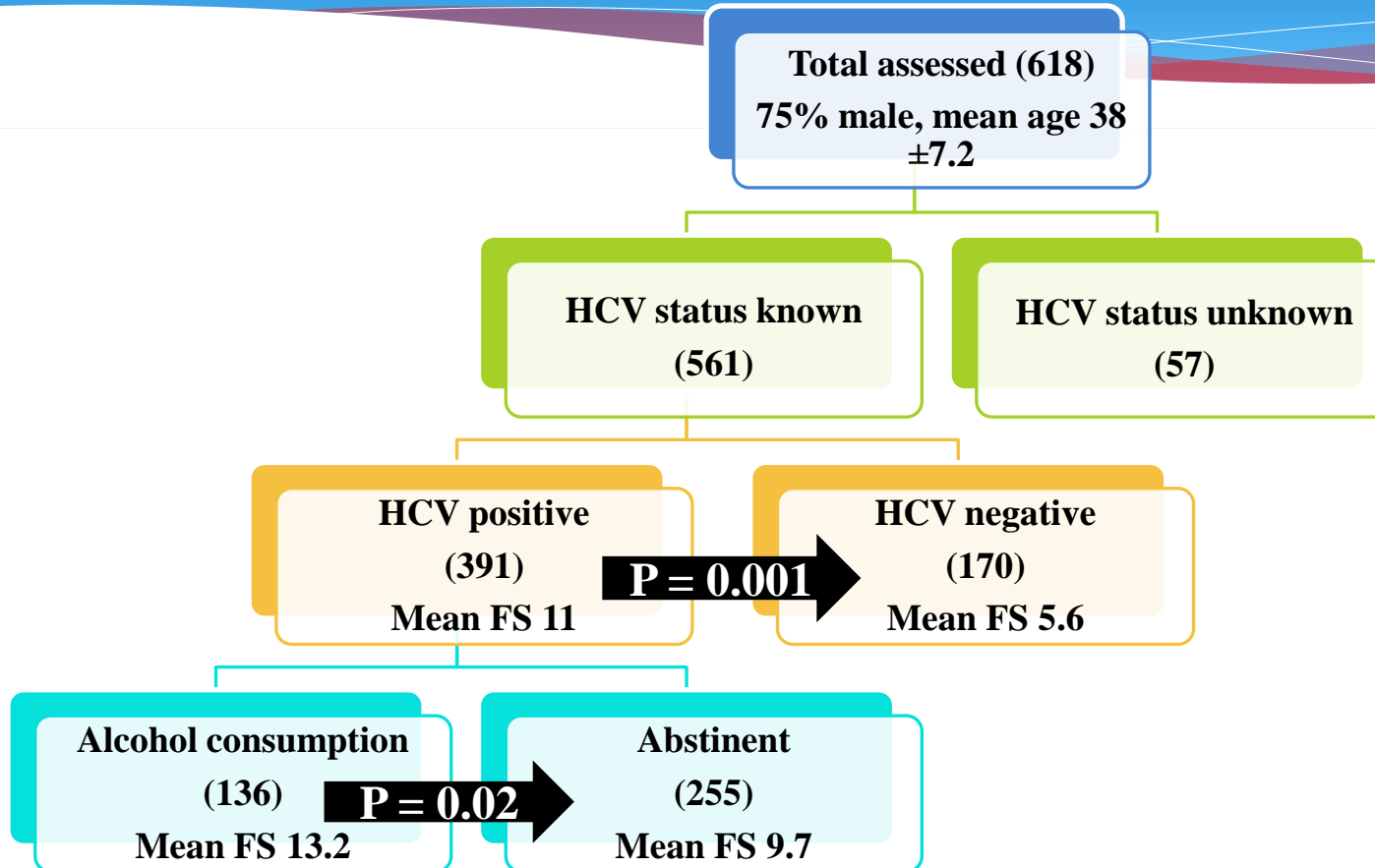




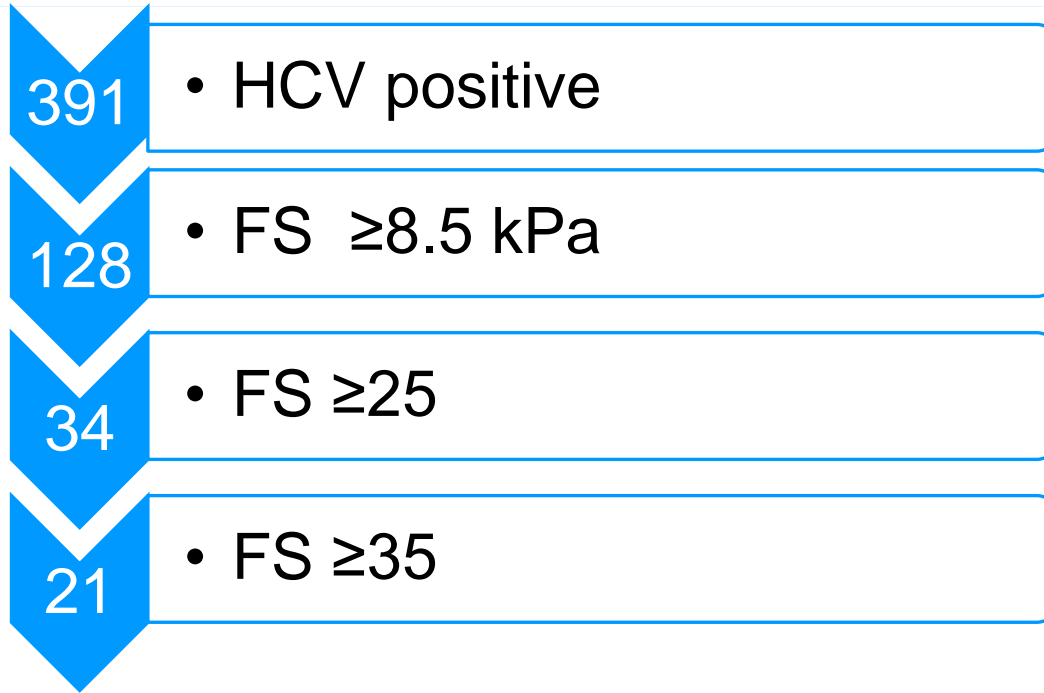
# M+BILE HEALTH CLINIC



# Hidden burden of HCV: Results (1)



# Hidden burden of HCV: Results (2)



# Hidden burden of HCV: Conclusions

- A large number of HCV+ patients did not attend specialist infectious diseases/hepatology services yet qualified for DAA treatment.
- Within this group there were significant numbers of patients at high risk of decompensation.
- On-going alcohol use was associated with a significantly higher FS score.
- While these patients may have significant comorbidities, including addiction, which limits access to specialist hospital services, **it is important to overcome these challenges if we are to make an impact on HCV-related mortality**



# Hepcare Europe: how to 'Integrate' agencies, health services and vulnerable patient populations?

- \* Health Services must follow the patient: from prisons to drug treatment centres to homeless facilities; and provide services there, not in hospitals
- \* Vulnerable populations have multiple co-morbidities: Blood borne viruses, STI's, TB, other chronic illness and substance misuse issues (alcohol is prominent in the HCV arena)
- \* One size does not fit all: the concept of 'personalised medicine' needs consideration
- \* HepCare Europe is working with multiple Irish Agencies: homeless, Irish Red Cross, Civil Community organisations.
- \* We are partnering with E Detect TB, as a first step to 'Integration'



# HCV Elimination agenda : what will it take..?

- \* **Energy, Commitment and Resources**
- \* **A public health approach (simplification, integration, decentralization, equitable access)**
- \* **Innovations: HBV cure, HCV vaccine, pan-genotypic oral treatments**
- \* **Partnerships (governments, civil society, private sector, ...)**
- \* **Concrete and tailored action in countries, guided by national plans**



# NO ONE LEFT BEHIND

## Hepcare Team:

**Dublin: PI's Drs Lambert and Cullen (Co Investigators Drs Stewart, Feeney, Houlihan)**

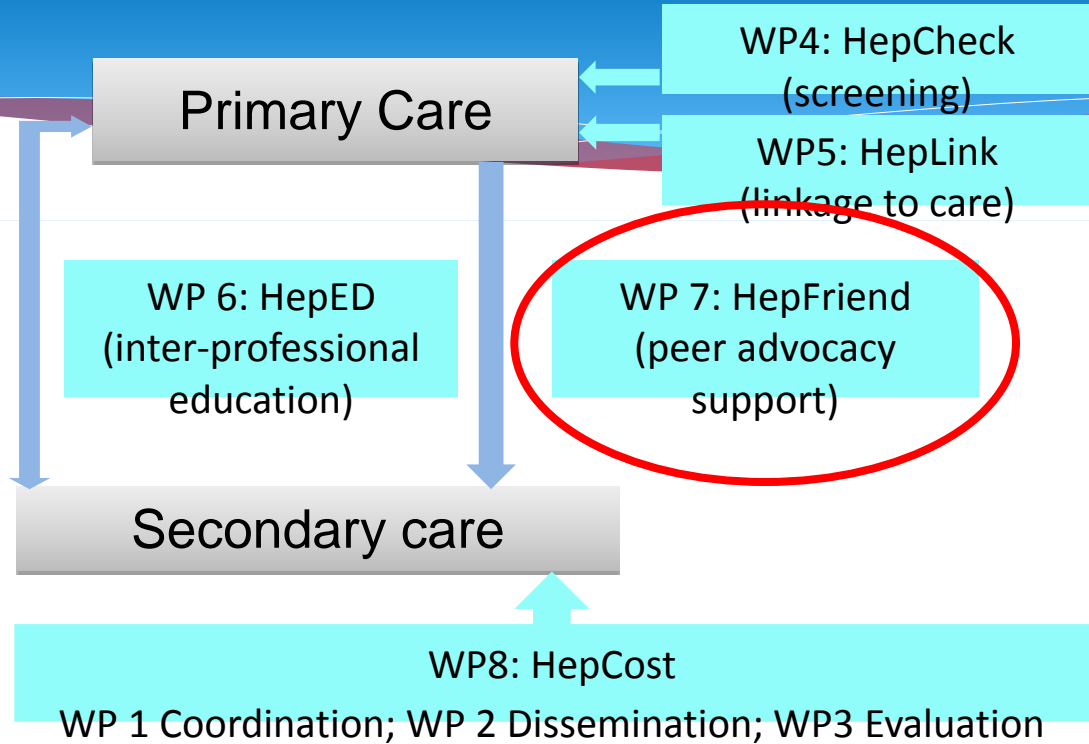
**London: Drs Alistair Story and Julian Surrey**

**Bucharest: Dr Cristiana Oprea**

**Spain: Dr Juan Macias Sanchez**

**Bristol: Drs Peter Vickerman and Matthew Hartman**

**‘HEPCARE’: A new user-friendly Hepatitis C Care service model**



# SDGs set the global agenda



**By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases**

SDG #3 calls for “Ensure healthy lives and promote well-being for all at all ages” and includes several health targets.





# HCV elimination is on the global agenda



Sept.  
2015

**Glasgow Declaration**  
*"It is possible and essential to set as a goal the elimination of both hepatitis B and C as public health concerns"*



Feb.  
2016

**Elimination Manifesto**  
*"Our vision for a Hepatitis C-free Europe"*



May  
2016

**Global Health Sector Strategy on Viral Hepatitis**  
*"Eliminating viral hepatitis as a major public health threat by 2030"*



Sept.  
2016

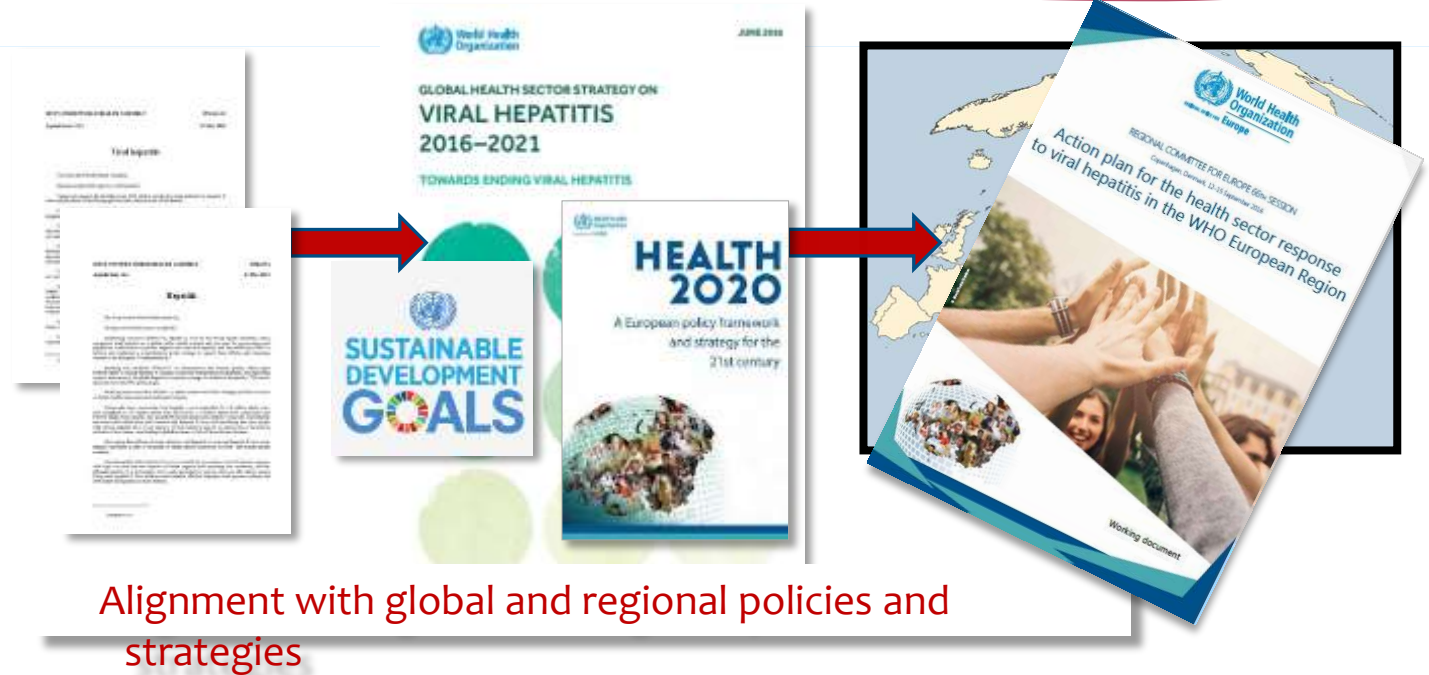
**Action plan for the prevention and control of Viral Hepatitis**  
*"A WHO European Region that is free of new hepatitis infections"*



# Action plan for the health sector response to viral hepatitis in the WHO European Region

## Action plan development:

- \* Building on lessons learned
- \* Broad Region-wide participatory process



# WHO EURO Action Plan accelerates the pace



## Testing and treatment targets, by 2020:

- 50% of people diagnosed and aware
- 75% treatment coverage for hepatitis B and C among diagnosed and eligible



# Action plan for the health sector response to viral hepatitis

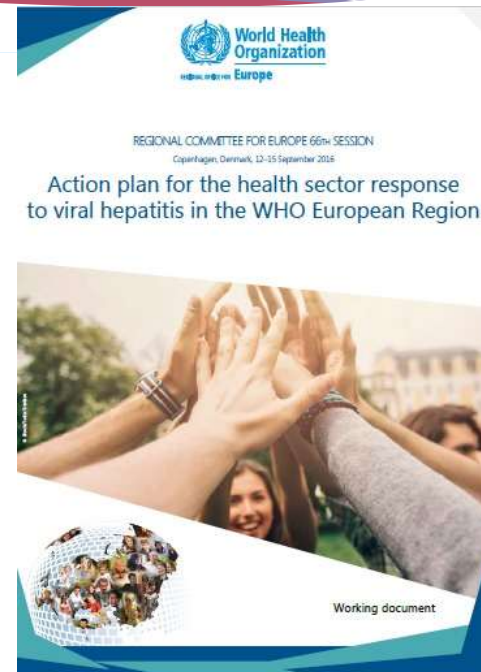
2030  
Vision

- Transmission of new viral hepatitis infections is halted, testing is accessible, and people living with chronic viral hepatitis have access to care and affordable and effective treatment

2030  
Goal

- Elimination of viral hepatitis as a public health threat by 2030 through:
  - reduction of transmission
  - reduction in morbidity and mortality
  - ensuring equitable access

Frameworks for action: universal health coverage, the continuum of services, a public health approach



# Today, countries need to set their goals and design their policy accordingly

