Expanding hepatitis C testing and treatment through task shifting

PRESENTED BY

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CATIE Canada's source for HIV and hepatitis C information

Webinar Agenda (1.5 hours)

Moderator: Rivka Kushner, Knowledge Specialist, Hepatitis C, CATIE

- Task shifting: What to shift and how to do it
- *Prof John Dillon, Professor of Hepatology and Gastroenterology, University of Dundee*
- Reflections on task shifting in frontline practice in Canada

  Kate Mason, Researcher, Toronto Community Hep C Program

  Jennifer Broad, Community Health Worker, Toronto Community Hep C Program

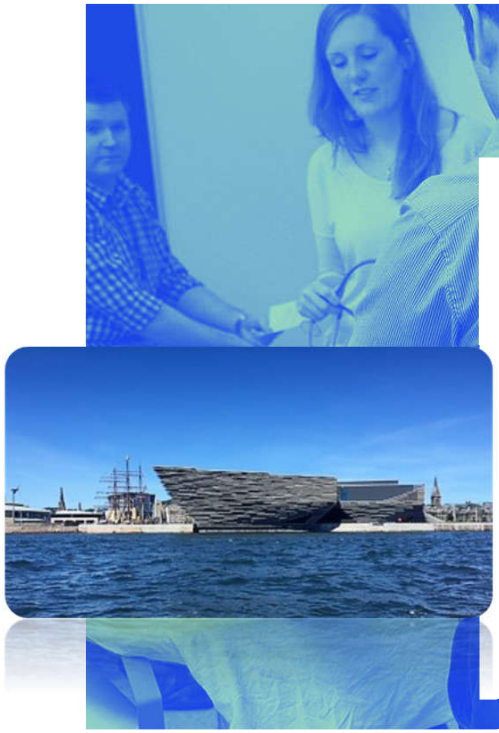
  Jac Atkinson, Outreach Nurse Practitioner, MOSH Halifax
- Q & A

Prof John Dillon

Division of Molecular and Clinical Medicine, School of Medicine, University of Dundee, Ninewells Hospital, Dundee, UK

Prof John Dillon is Professor of Hepatology and Gastroenterology and a principle investigator in the Division of Molecular and Clinical Medicine in School of Medicine at University of Dundee, based at Ninewells hospital in Dundee. He is also an Honorary Consultant with NHS Tayside, leading a busy general hepatology service and a research group. He graduated in medicine from St Georges Hospital Medical School in University of London and subsequently gained his MD based on research performed in the University of Edinburgh while a lecturer in Gastroenterology and Hepatology.

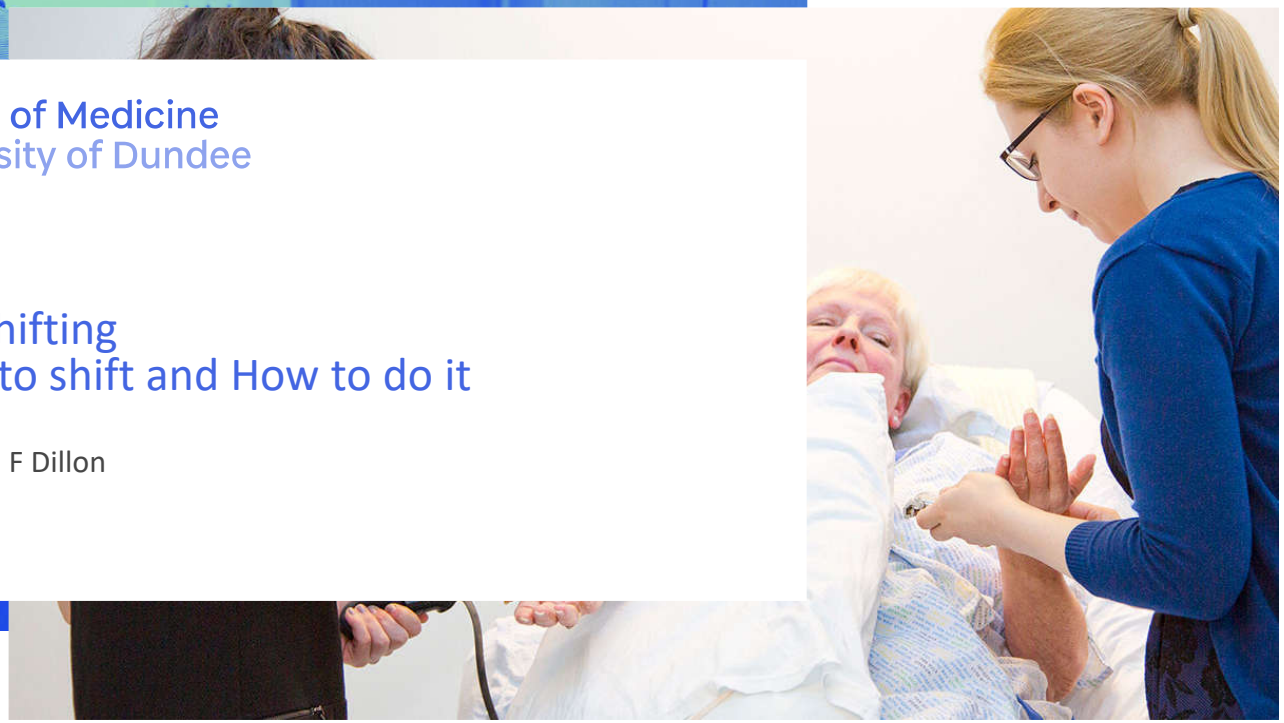
His award winning research interests include new pathways of care for patients with abnormal liver function tests, for people infected with HCV, new therapies for HCV infection, as well as novel diagnostics and treatments for NAFLD. His research activities stretch from the bench to the bedside and out into the community.



School of Medicine
University of Dundee

Task shifting
What to shift and How to do it

Prof John F Dillon



What is a Task

A Task is a required job/process along the pathway to HCV cure

What are they?

→ Making the diagnosis

→ Assessing for treatment

→ Assessing liver fibrosis

→ Prescribing the treatment

→ Delivering the treatment

All tasks are potential barriers

Not all barriers are tasks

Why shift tasks

Making HCV therapy and cure more widely available

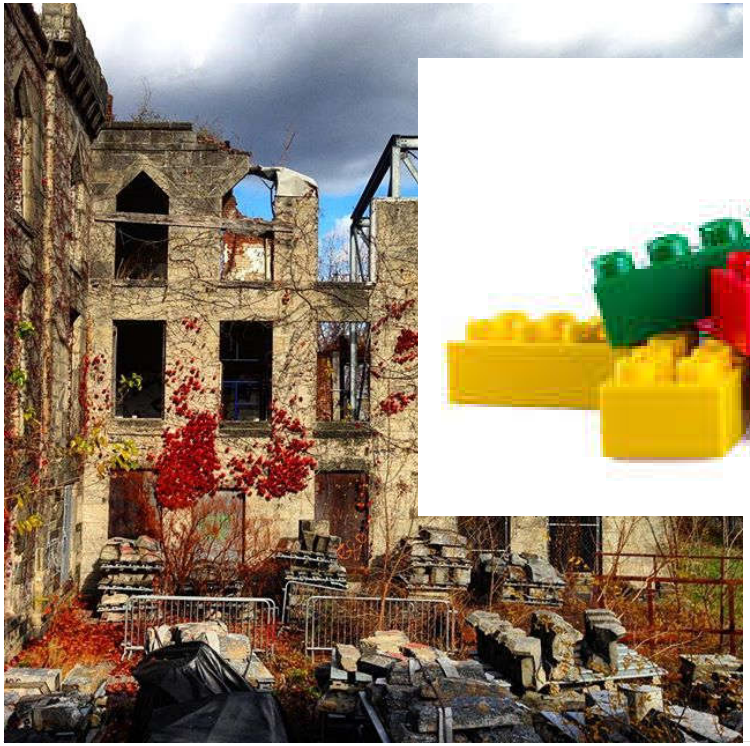
Empowering the workers

Empowering the people and their peers

Making it more cost effective

MAKING IT EASIER

Just because we always did it that way!



Where do you shift Tasks to?

The Best place

Types of Tasks

Convention

Guidelines

Standard practice

Required (legally binding)

Do it or you don't get paid

Do it or you get fired/struck off

Do it or it's dangerous

It is quicker to ask forgiveness than permission

But make sure you really check that it is required, look for latitude

Who to shift tasks to?
People who are in contact with people with HCV

Hospital Nurses, interferon support
Shifted to interferon management

Drugs workers

Pharmacists

Cessation of interferon and imminent uner
Shifted to community out reach

Synergise

Community outreach
Diagnosis, treatment

Peers

GPs

Why would they do it

Altruism

Improvement in primary role/ easier patient client relationship

Improved patient outcome

Reward

Specialist Nurses

GPs

Addiction workers

Peers

Pharmacists

What do they need

Training

Clear rules

→ A protocol

→ Access to multi-disciplinary advice/team

Empowerment

Shifting The Tasks
Making the diagnosis

Technology

- → How can you get a PCR
  - → Venepuncture blood
    - → To lab
  - → Dried blood spot
    - → To lab
  - → Point of care test
    - → Whole blood
    - → Capillary blood

Skill

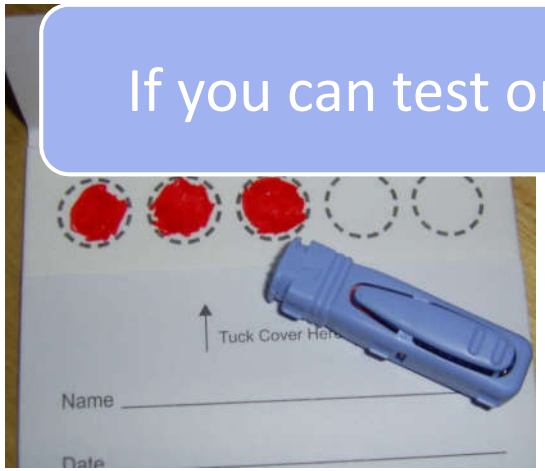
- → Venepuncture
  - → Highly selected skill set,
    - → usually associated with other high value skills
    - → Rare and expensive

Have easy diagnostic tests

Conventional testing with elution step

HCV antibody, HIV antibody, HCV PCR and HBsAg

Works where venepuncture difficult



Over 250 staff trained in blood spot testing, mainly 3rd sector

HCV testing embedded in

→ Drug problem centres

→ Drug Testing and Treatment Order

→ Homeless outreach

→ Needle exchanges

81% of tests are carried out by support workers, without clinical qualifications

If you can test or read a test result you can refer

PEOPLE'S PREFERENCES FOR HEPATITIS C TESTING: A Discrete Choice Experiment in People on OAT

Preference	Willing to Wait
Own rather than other pharmacy	4.25 weeks
Own pharmacy rather than GP	2.11 weeks
Own pharmacy rather than drug worker	0.08 weeks
Treated with respect	7.42 weeks

Shifting The Tasks making referrals

Very dependent on local reimbursement rules

- → Check the fine print of the rules
- → Be inventive
  - → Partial task shifting
    - → Do the work up
  - → Task preparation
    - → Prepare the paperwork

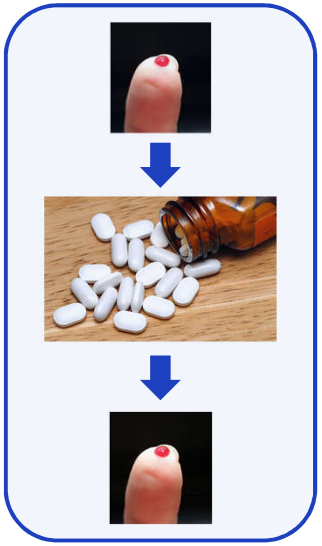
Impact of change in referral practice

SOURCE OF REFERRAL OF ATTENDEES	PRE MCN	%	POST MCN	%	TOTAL	%
GENERAL PRACTITIONER	137	48.7	174	39.2	361	50
DRUG SERVICES	7	2.5	81	18.3	88	12.2
PRISON SERVICE	4	1.4	75	17	79	10.9
HOSPITAL	31	11	29	6.5	60	8.3
SEXUAL HEALTH SERVICES	19	6.7	20	4.4	39	5.4
IMMUNODEFICIENCY SERVICE	9	3.2	21	4.7	30	4.1
HAEMATOLOGY UNIT	10	3.5	10	2.2	20	2.7
OTHER	3	0.9	13	2.9	16	2.2
BLOOD TRANSFUSION SERVICE	5	1.7	10	2.2	15	2
RENAL UNIT	2	0.6	5	1.1	7	0.9
MENTAL HEALTH TEAM	3	1	3	0.6	6	0.8
TOTAL	280		441		721	

Shifting The Tasks
Assessing for treatment

What do we need for treatment to start?

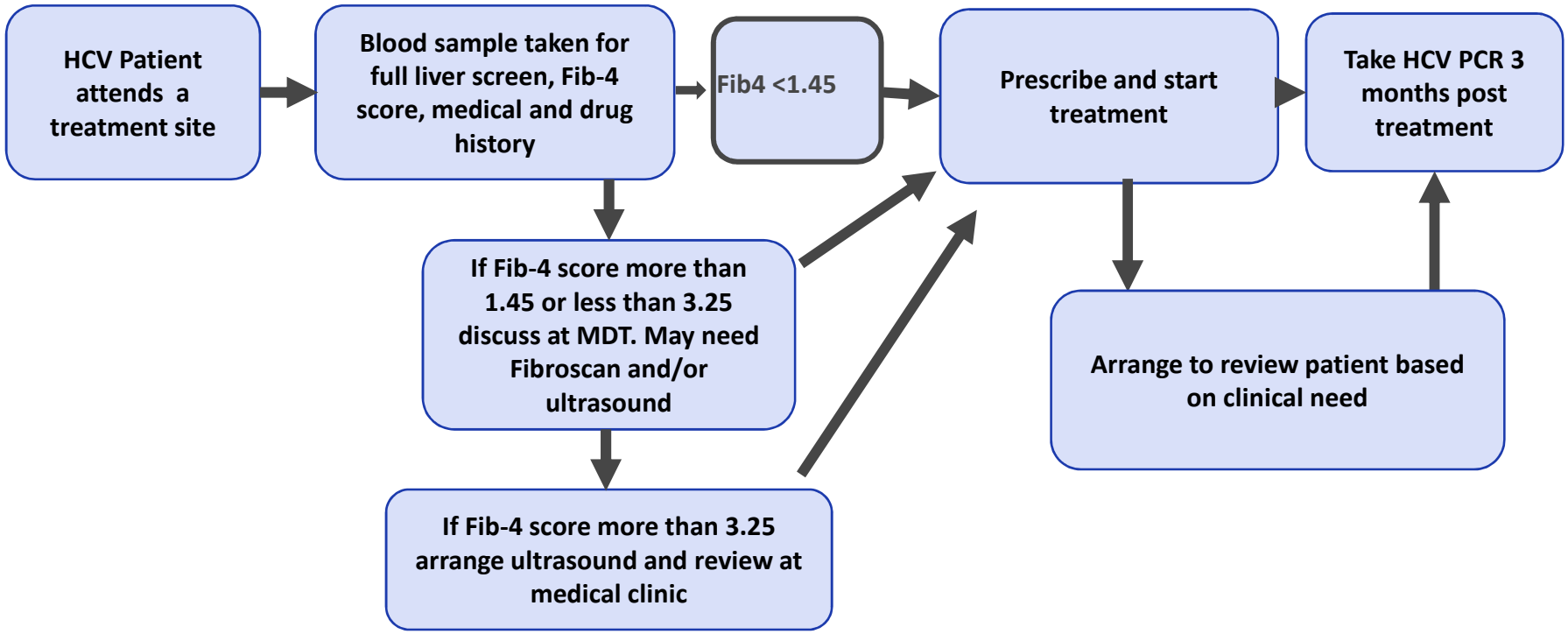
OR



The skinny Nurse led pathway

- Diagnosis made on DBS (HCV ab and PCR, HIV, HBV) or venepuncture by non specialist, referred by who ever did the test
- Visit 1 Seen by Nurse specialist (or the Community Pharmacist who did the DBS)
    1. Protocol history (age and alcohol history)
    2. Bloods for FBC, LFTs, Fib 4, HCV PCR if not possible before,
        1. Genotype (only if cost difference)
        2. Start treatment
- Visit 2 Start Treatment/pick up treatment if not already done so
- Virtual review of results, decide if ultrasound/fibroscan/duration of treatment/follow up
- Visit 2/3 SVR

Shifting The Tasks
Assessing liver fibrosis



Fib-4: Fibrosis-4; MDT: multidisciplinary team

Shifting The Tasks
Prescribing the treatment
Delivering the treatment

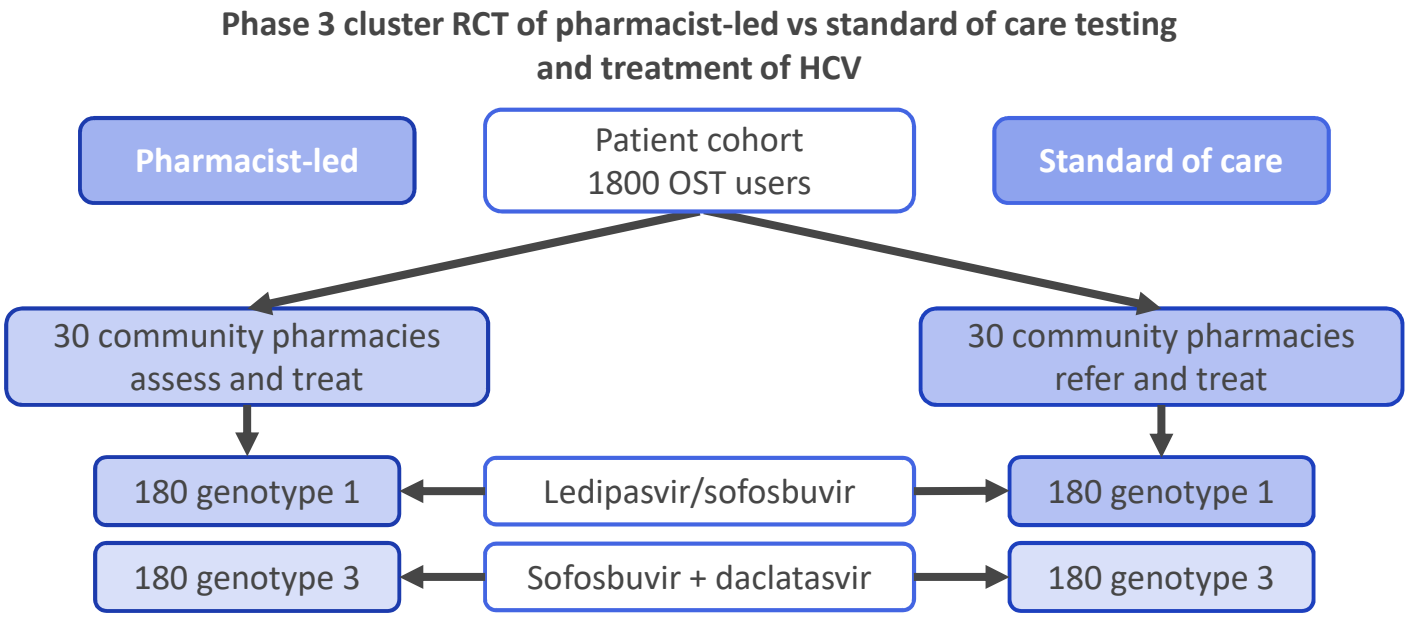
Prescription

- → Medical prescriber
  - → Shifting from hospital consultant to general practioner
- → Delegated/paper check
- → Non-medical prescriber
- → Group patient directive

Delivery

- → Community dispensed
- → Hospital dispensed
  - → The Role of Pharma

Super DOT-C making treatment easy for people on OST



Clinical trial protocol. Available at: https://clinicaltrials.gov/ct2/show/NCT02706223; Radley A, et al. Unpublished data (manuscript under review);

HARVONI (ledipasvir/sofosbuvir) SmPC, July 2018, Gilead; SOVALDI (sofosbuvir) SmPC, Sept 2017; DAKLINZA (daclatasvir) SmPC, June 2018, Bristol-Myers-Squibb

RCT: randomized controlled trial

General Practice
Telemedicine, MCNs, virtual MDTs

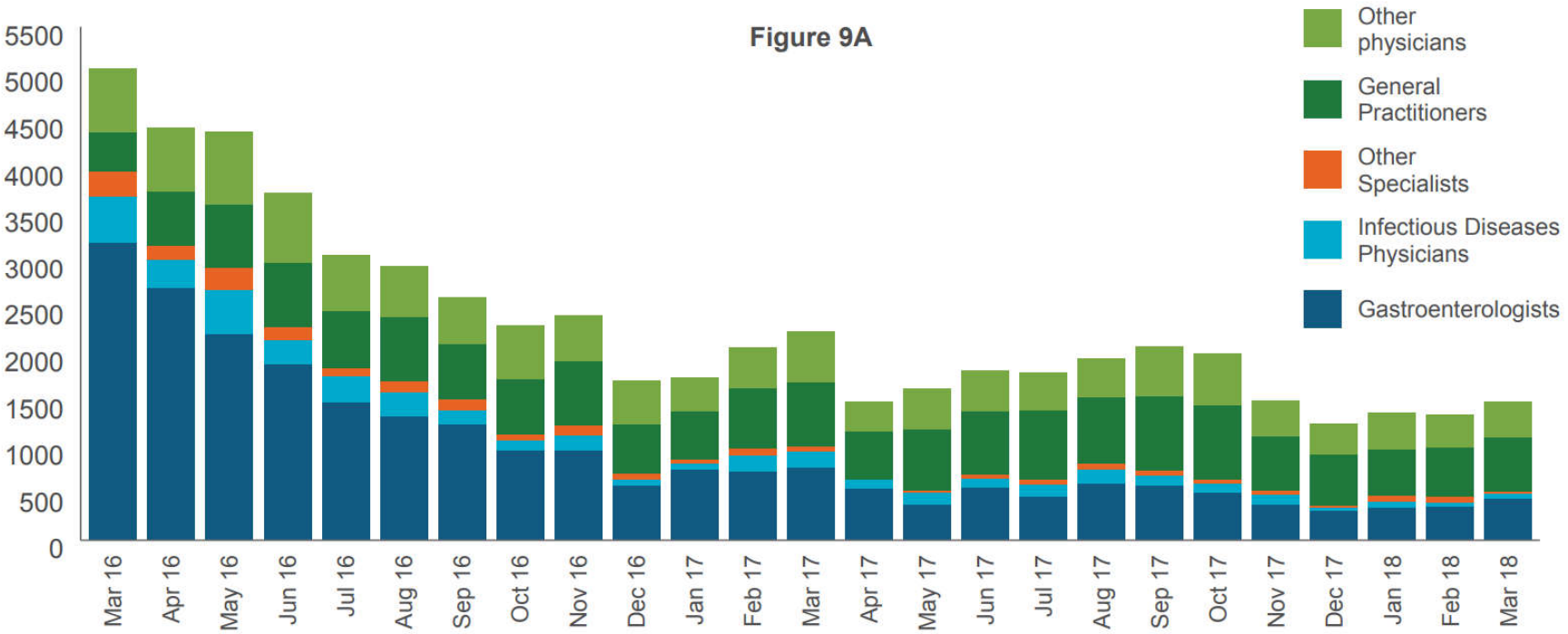
Marked geographical variation in HCV prevalence with deprivation status in a practice area, varying from 0.1 to 3%

Should approaches be tailored to local circumstances?

GPs who provide addictions services

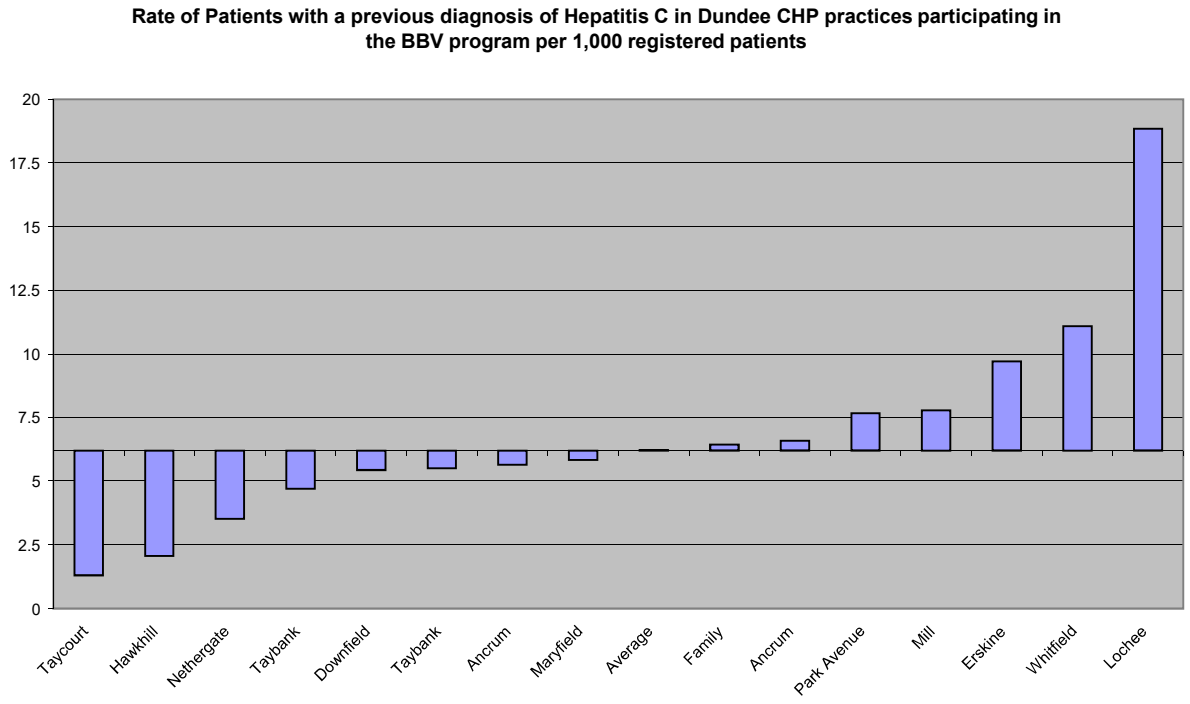
Number of prescriptions per month

Figure 9: Absolute frequency (A) and relative frequency (B) of prescriber types in each month for individuals initiating DAA treatment during March 2016 to March 2018 in Australia



Source https://kirby.unsw.edu.au/sites/default/files/kirby/report/Monitoring-hep-C-treatment-uptake-in-Australia_Iss9-JUL18.pdf

General Practice Identified Rates of Hepatitis C



Systematic Rapid review of Community Care Settings

Population: People with Hepatitis C Infection

Intervention: Treatment uptake rates with Direct Acting Antiviral Drugs (DAAs)

Comparison: Community and Secondary/Tertiary Care settings

Outcome: Sustained Viral Response

Study design: Comparison studies (inc RCTs)

Rapid review of Primary Care Settings

Records identified through database searching
(n = 16483) (9151 after de-duplication)

Cinahl (852)

EMBASE (7992)

Medline (3253)

PsycINFO (340)

PubMed (4046)

101 articles assessed: Nine conference abstracts and nine papers selected for review

Community Care Settings Utilised

Settings Evaluated	Number of Studies	Lead Authors of Studies
Primary Care	6	Bloom; Buchanan; Kattakuzhy; McClure; Miller; Norton.
Integrated Systems	5	Abdulameer; Beste; Cheetham; Francheville; Georgie.
Addictions Centres	3	Butner; Morris; Read
Pharmacy Services	2	David; Radley
Telemedicine	2	Cooper; Hatashita.

Summary

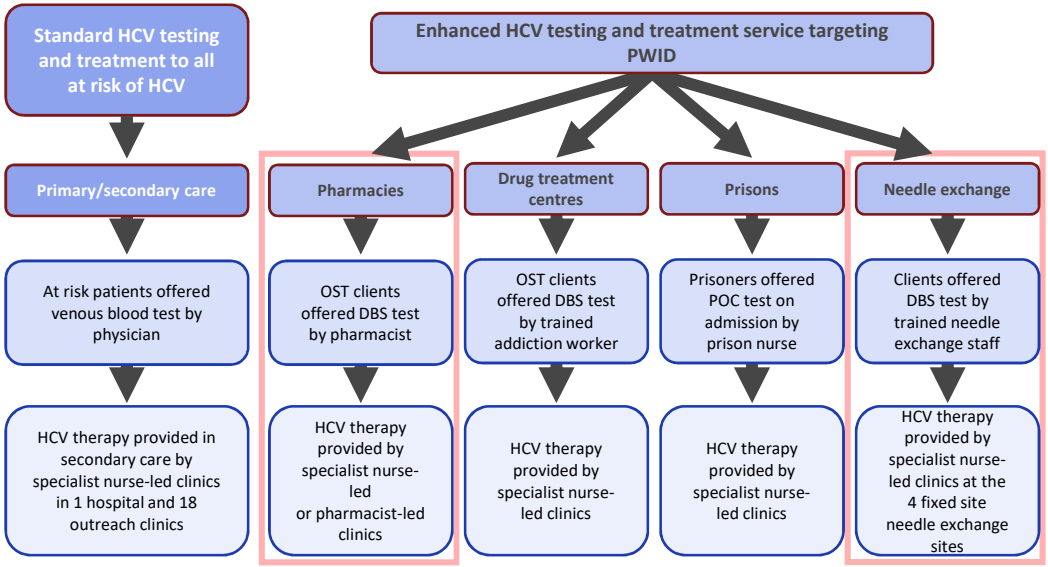
Community-sited services are feasible and can deliver increased uptake of treatment, especially for vulnerable and marginalised populations.

Such clinics are able to demonstrate similar SVR rates to published studies and real-world clinics in secondary care.

Seven studies reported reduced SVR rates when their outcomes were analysed from an intention-to-treat perspective because of loss of patients before the final confirmatory blood test.

Services and systems are very specific to their localities

HCV testing and treatment pathways for the PWID and OST populations



PWID defined as those who either (a) are currently injecting drugs, (b) have ever injected drugs and are currently on opioid substitute therapy, or (c) have ever injected drugs and are currently in prison

DBS: dried blood spot; OST: opioid substitution therapies; POC: point of care

Conclusions

Revolutionise your care pathways

→ Dump the TASKS

Minimise steps

→ be inventive

Keep it local

Keep it known

Keep it simple

We need to get better at sharing practice

Reflections on task shifting in frontline practice in Canada

Kate Mason

Researcher, Toronto Community Hep C Program

Kate Mason is a community-based researcher and evaluator with a focus on projects and programs related to homelessness, substance use, and health. She currently works with the Toronto Community Hep C Program, a partnership between South Riverdale Community Health Centre, Regent Park Community Health Centre and Sherbourne Health in Toronto. The aim of this program is to improve access to treatment and supports for people living with hepatitis C who are unable to access the mainstream health care system.

Jennifer Broad

Community Health Worker, Toronto Community Hepatitis C Program

Jennifer Broad is a Community Health Worker with the Toronto Community Hep C Program. In her current role, she provides case management, outreach and support services for program clients. She is also responsible for supporting people with lived experience to deliver program services. She was the founding Co-Chair of the program's Patient Advisory Board when it began in 2010 and one of the first graduates of the program's peer training program.

Jennifer has presented on the involvement of people with lived experience in hepatitis C treatment and support at numerous conferences hepatitis C workshops in Toronto and internationally. She participates in and has co-coordinated program research projects. Jennifer recently published an article on the transition from client to coworker in the Harm Reduction Journal.

Jacqueline Atkinson

Outreach Nurse Practitioner, MOSH Halifax

Jac Atkinson works as the Nurse Practitioner for MOSH (Mobile Outreach Street Health) in Halifax, Nova Scotia. She strives to provide effective primary health care for people living on the margins of society (homeless, street involved, addictions, sex work). The small team works closely with community agencies to deliver care where the client needs it, with their priorities leading the care plan. Approximately 7 years ago she started a community based Hepatitis C treatment and support program with Dr. John Fraser. Upon becoming a NP in 2016, she was one of the first community prescribers in Atlantic Canada.

Questions?

Please type your question or comment into the chat box.

Thank You

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