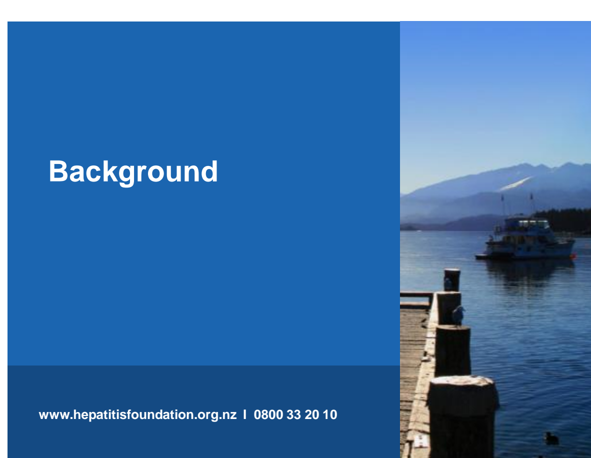
Overview

- **Background**
  - The Hepatitis C Pilot
  - Epidemiology update
  - Priorities
- **Pilot strategies and outcomes**
  - Awareness
  - Targeted testing
  - Community assessment and support
  - Improved surveillance and data collection
  - Coordinated education and support
- **Key impacts of the pilot**
- **Moving forward**



The Hepatitis Foundation of New Zealand

A registered charitable trust whose mission is:

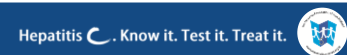
To improve health outcomes for people living with hepatitis B and C in New Zealand

Over 30 years experience in delivering community based services in a shared care environment - facilitation, assessment, follow-up, education and support.

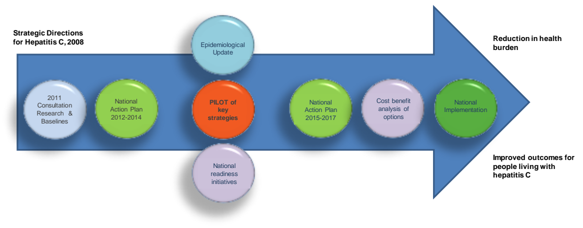
Work extensively with Māori, Pacific and Asian ethnic populations and communities

The NZ hepatitis C pilot programme

- **Two year pilot programme**
  - July 2012 to June 2014
  - Four Health Districts (Bay of Plenty; Capital and Coast., Hutt Valley, Wairarapa)
  - Covers 16% of adult population in NZ
- **Collaborative**
  - involved key providers in the district working in shared care environment to provide a coordinated pathway of care
- **Developmental**
  - Assess a number of strategies and improve or discard those not sustainable or cost effective.
- ***Better Sooner More Convenient***
  - Included delivery of integrated services in the community wherever possible, with goal of improving access, equity and efficiency while reducing cost



The pilot as one step in a larger process



Pilot Objectives

1. Increase awareness of hepatitis C in the community:
2. Improve access to and uptake of hepatitis C testing, assessment, and treatment:
3. Improve health outcomes for people living with hepatitis C:
4. Improve data quality to enable the programme to address the disease burden:

Epidemiological Update

Update on 2000 ESR estimates

- Expert working group including ESR
- Modelling supported by CDA, Colorado and input from Kirby Institute in University of New South Wales

Outcomes:

- Prevalence 50,000 currently infected
- Median age 50 years
- Incidence 1% pa
- Current rate of complications more than 3 times levels predicted in 2000
- Proportion diagnosed increased to 40-50% from 25%

Emerging priorities

- Identify previous diagnoses lost to follow-up
- Promote targeted testing and increase new diagnoses
- Provide effective FibroScan assessment and triage in the community
- Provide community based education and support to improve awareness of treatment options and preparedness for treatment

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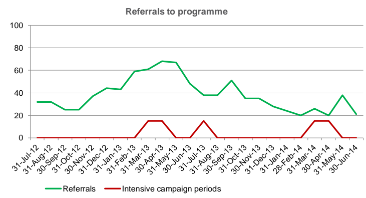
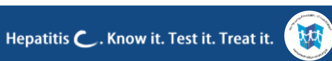
Increasing awareness

1. Increasing awareness of at-risk populations



2. Increasing awareness of health professional
3. Increasing public awareness



Targeted Testing and Identification

Successful strategies in collaboration with PHOs and General Practice

1. Identify those previously diagnosed and lost to follow-up
2. Establish integrated assessment clinics at the point of care
3. Progress to targeted testing linked to an awareness campaign

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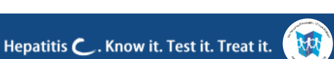
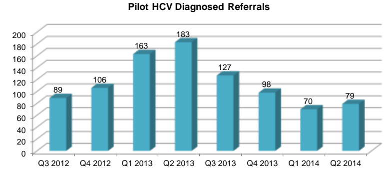
Strategies for improving access for high risk populations (in CADS, NEX, Prisons)

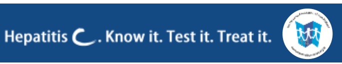
1. Start by establishing long term collaboration with teams and building trust with clients
2. Deploy rapid testing and FibroScan at point of care (still being evaluated)
3. Carefully manage transitions within shared care
4. Develop resources collaboratively to fit with the organisations overall approach including literacy resources



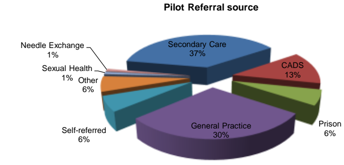
Pilot Referrals

- 915 referrals diagnosed with hepatitis C

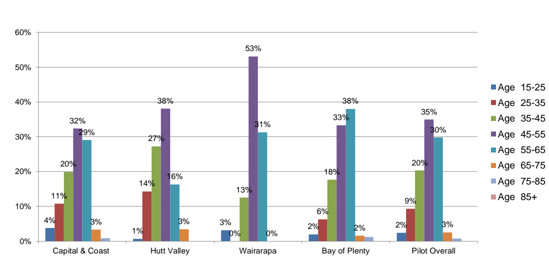




Sources of Referral to Pilot



Enrolments by Age



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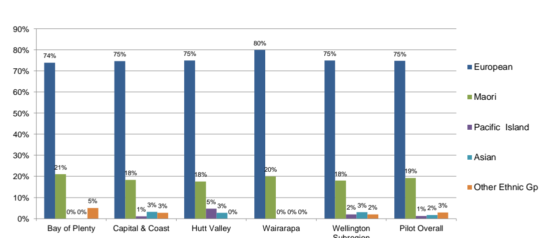
Enrolments by Ethnicity



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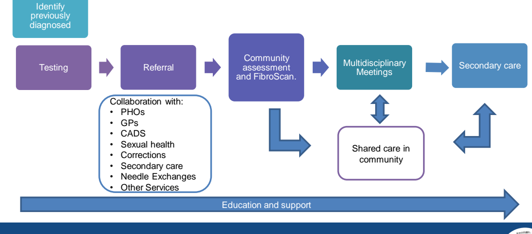
Community assessment and support programme (CAS)

- Integrated shared care
- Community hepatitis nurse
- FibroScan assessment and triage
- Multidisciplinary meetings



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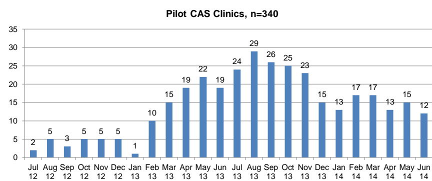
CAS– Community clinics



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CAS – Portable FibroScan

- 788 FibroScans completed
- 128 Cirrhosis
- 69 Severe fibrosis

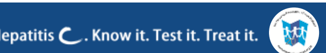
Pilot FibroScan results

Moderate to No Fibrosis 63%

Unsuccessful 12%

Cirrhosis 16%

Severe Fibrosis 9%



Improved surveillance and data collection

- Epidemiological update and modelling
- A SQL database platform delivering:
  - clinical management with shared care decision tracking
  - remote access by clinicians in community
  - data to inform continuous improvement cycle at a local level
  - national anonymised data to assess progress at national level
  - source of epidemiological data

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Coordinated educational resources and support

- Hard copy resources
- Quarterly Magazine
- Peer Support
- Helpline
- Website

Key Impacts for People living with HCV

1. **Increasing access to specialist assessment and care in the community close to where people live.**
   In 2 years the programme has increased the total number of people with hepatitis C currently accessing specialist assessment and care from a baseline of 167 in 2010 to 859, an increase of over 500%.

   544 people from the community who were undiagnosed or lost to follow-up are now accessing assessment and care.
2. **Informing people of their options earlier**
   People have access to clinical assessments, options for treatment and what lifestyle education at a much earlier stage.
3. **Providing a clear pathway to access care**
   The pilot has significantly improved access for those needing to advance to specialist care.
4. **Increasing equitably**
   Programme provides increased support where existing services are overburdened or don't exist.
5. **Reducing wait times**
   Wait time for an initial assessment is 5 weeks compared to the baseline median of 13 weeks at secondary care.
6. **Reducing stigma**
   Patient feedback suggests the community nurses are effective in increasing trust and reducing stigma among patients

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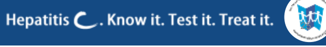
Key Impacts for Primary Care

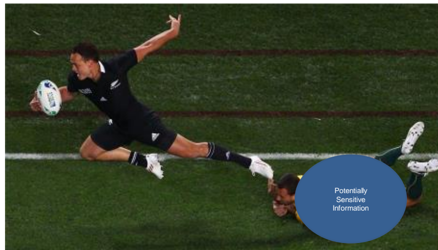
- **Providing enhancements to existing clinical services**
  Significantly increases the clinical information available to GPs to assess and manage patients in a shared care setting
- **Increasing access to specialist care for clients who need it.**
- **Increasing testing and education of at-risk clients**
- **Assisting to find people previously diagnosed but lost to follow-up.**
  Expert assistance using Medtech query builders and laboratory collaboration have proved effective
- **Providing quality educational resources**
  The programme delivers high quality resources available to use with patients, many available in a number of languages.



Key Impacts for Secondary Care

- **Providing FibroScan for Secondary Care patients**
  346 patients from secondary care received FibroScan
- **Moving management of non-urgent patients into the community**
  Of these 46% are now being managed the in community
- **Providing effective triage for secondary care services**
  Improved ability to assess and manage demand for secondary care services
- **Improving readiness for treatment of patients referred to secondary care**
  Patients better educated and aware of options and making lifestyle changes
- **Reducing waiting times at secondary care**
  Better prepared patients require less appointments and help reduce waiting times
- **Lowering attrition rates**
  Programme has an attrition rate of 1.6% compared to 32.4% for secondary care hepatitis C services in 2010

Moving forward



Together we can confront hepatitis C.

Know it. Test it. Treat it.

The Hepatitis Foundation of New Zealand

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