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(on behalf of the Hepcare Europe Consortium)
Hepcare Europe Consortium

- UCD (Ireland: Drs Lambert, Cullen, Stewart, Houlihan, Feeney, Crowley, O’Carroll)
- SAS (Spain)
- SVB (Romania)
- University of Bristol (UK)
- University College London (UK)
Natural history of HCV

Risk factors

Acute infection ➔ Recovery

Chronic liver disease

Cirrhosis ➔ End stage liver disease
IRELAND HCV Disease Burden

20,000-50,000?

IDUs: ~50-80% infected?

A Missed Diagnosis means cirrhosis/cancer
## Evolution of Hepatitis C Care

<table>
<thead>
<tr>
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<th>Old Model</th>
<th>What is new</th>
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<tbody>
<tr>
<td><strong>Screening</strong></td>
<td>Blood test (invasive)</td>
<td>Mouth Swabs (non invasive)</td>
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<tr>
<td><strong>Medication route</strong></td>
<td>Injection</td>
<td>Oral</td>
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<td>administration</td>
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<tr>
<td><strong>Diagnosis of</strong></td>
<td>Liver biopsy (invasive)</td>
<td>Fibroscan (non invasive)</td>
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<td><strong>disease severity</strong></td>
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<tr>
<td><strong>Cost (direct)</strong></td>
<td>+++</td>
<td>++++</td>
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<tr>
<td><strong>Cost effectiveness</strong></td>
<td>Moderate</td>
<td>High</td>
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<td><strong>Efficiency of</strong></td>
<td>Moderate</td>
<td>High</td>
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<tr>
<td><strong>treatment:</strong></td>
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<tr>
<td><strong>Sustained viral</strong></td>
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<tr>
<td><strong>response</strong></td>
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<tr>
<td><strong>Place of care</strong></td>
<td>Hospital Specialist Clinic</td>
<td>Primary care and Specialist clinic</td>
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</table>
Issues that need to be addressed to make HCV a ‘rare disease’ in the EU:

- Community Education (preparing the at risk population for testing, assessment and treatment)
- Community Health Care worker education: to give them a better understanding of the new treatment regimes, and to prepare them to act as partners in treatment and support in a ‘shared care’ primary/secondary integrated partnership.
- Testing of the utility of point of care testing with HCV oral tests in diverse populations and different countries/-settings and assessment of the cost effectiveness of such a strategy.
- Implementation of a community Fibroscan testing strategy and evaluation of the effectiveness of such a strategy; and for those identified with advanced disease, reasons for non-attendance.
Issues that need to be addressed (2)

- Development of a community focused assessment for HCV disease in those identified as HCV positive utilising community nurse outreach and peer advocacy support, as vulnerable communities have not and do not access secondary care services.

- Development of educational tools and pathways for those who test negative for HCV, to ensure that their risk of subsequent risk of acquisition of HCV and other blood borne viruses are minimised.

- Linking up disease services, so that Drug and Alcohol Addiction, Primary Care, STD, blood borne virus testing, TB evaluation and treatment, Hepatitis B vaccination, are all addressed in vulnerable populations in a linked up fashion.
‘HEPCARE’
EU funding will support, over 3 years May 2016-2019

Primary Care

- WP4: HepCheck
- WP5: HepLink

WP 6: HepED
(inter professional education)

WP 7: HepFriend
(peer advocacy support)

Secondary care

WP8: HepCost
WP 1 Coordination; WP 2 Dissemination; WP3 Evaluation
HEPCHECK Study Preliminary Data Dublin

- To establish the *effectiveness* of intensified screening and support for Hepatitis C (HCV) in individuals attending homeless services in Dublin
740 screened

33 new

151 known

184 HCV ab+
51 referred → 8 attended → 2 fibrosanned → 1 treated

33 DNA
10 waiting
1 non-fibrotic
Summary of HepCheck Dublin

- Almost 30% of homeless are HCV positive
- Over 80% were previously diagnosed and not accessing care
- Most do not attend services despite ‘assistance’ and peer support
- These patients are regularly attending homeless services and GP practices in the SafetyNet services in Dublin for medical and social support
OPPORTUNISTIC FIBROSCAN® TESTING IN A DUBLIN GENERAL PRACTICE (GP) MANAGING OPIATE SUBSTITUTION THERAPY: preliminary results of the hepccare study
Results

- 58 Patients had a fibroscan carried out in August 2015 at the Thompson Centre, N Dublin, 2 blocks from the Mater Hospital.

- 18 patients (31%) had FibroScan® scores within Irish guidelines for treatment (they had previously unrecognised cirrhosis/F4 fibrosis). Scores ranged from 12.2- 63.9 (mean=29.25). Of these patient 16 were referred for specialist treatment, 8 patients did not attend, 6 are undergoing treatment with the new DAA therapies, 1 patient was HCV antigen and DNA negative on repeat testing and 1 patient’s FibroScan® score was below threshold on repeat Fibroscanning after abstinence from alcohol.
Specialist referral and treatment

- 67% (n=39) were previously referred to specialist services.
- 49% (n=19) of those referred attended once.
- 8% (n=3) had completed treatment with interferon/ribavirin but had subsequently relapsed.

1 patient cleared HCV infection.
Reasons for non attendance with specialty services

- Chaotic drug and/alcohol use
- Fear of biopsy and/or interferon side effects
- Mental health/psychiatric diagnoses
- Poor linkage between hospital and community services
- There was no identification by the caregivers that patients had significant liver disease (they had not yet developed signs of decompensation)
Specific objectives of the HEPCARE EUROPE project

1. To enhance screening of vulnerable populations: screening by oral rapid HCV test in each of four clinical sites of 2000 patient and ascertainment of HCV status among those attending primary care centres (drug treatment centres, homeless centres providing support for PWID for addiction treatment)
Objectives (2)

2. To integrate primary and secondary care by
   --developing an integrated model of HCV care
   --delivering this model of care
   --determining the feasibility, acceptability and likely efficacy of this model of care (approach 240 patients attending primary care, 48 healthcare professionals in primary and secondary care)

3. To develop and implement multidisciplinary inter-professional education in HCV care for Health Care professionals across Europe (develop curriculum, running HCV ‘masterclass’ at each site)
Objectives (3)

• 4. Hepfriend: to assist vulnerable populations to access care for HCV, TB, HBV and HIV through peer education and support. To recruit, train and support peers to provide HCV testing and care management. Trained peers to improve care integration and HCV treatment adherence and outcomes following development of a community care model

• 5. HepCost: Health Economics. To examine the cost effectiveness of the Hepcare Europe system of care
Objectives (4)

- 6. To share learnings between consortium members
- 7. To engage policy makers/stakeholders nationally and in the EU
- 8. To disseminate findings to the scientific community
- 9. To disseminate findings to raise awareness in Health Care Professional
Evaluation Tools planned

- Questionnaires (those at risk, those HCV positive, lost to follow-up)
- Surveys of caregivers and affected communities
- Trainings (site specific, webinars, e-learning)
- Monitoring of patients assessed as part of project (number tested, number HCV positive, number with cirrhosis, number accessing care, number completing treatment)
- Country reports
Priorities and future interventions

- Identifying the burden of HCV disease in the EU.
- Ireland reports HCV in the range of 20 to 50,000?
- What is the burden of HCV in the EU?
- How do we engage ‘hard to reach’ populations? 
  ….go to the patients, and not require them to come to ‘us’.
- HCV does not exist in isolation: HCV care needs to be linked to homelessness, health inequalities, ongoing substance abuse, especially alcohol, and other co-morbidities including TB, HIV, Hep B, and others
- Each country in the EU may have unique issues
Partnerships

- National Patient Support Groups/Services (homeless services, prisons, relevant NGOs)
- National Policy Influencers
- European and International Groups including:
  - EASL, Hepatitis B & C Public policy Association, EATG, ELPA, Correlation, ICMHD, VHPB, World Hepatitis Alliance, EU Committees for HIV and Drugs, Think Tank, CSF for HIV/AIDS and Drugs, TB Services, and EU Services (ECDC, EMCDDA and EC- DGSANTE and DG HOME)
HepCare Europe
HepCheck
HepLink
HepFriend
HepEd
HepCost

‘Seek and Treat’

“we, the clinicians, must go to the patient (and not patients to the hospital) if we want to ensure that HCV will become a ‘rare disease’ in the EU”