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Feasibility, acceptability and safety of a nurse led hepatitis B clinic based in the community

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Summary
Aim: The aim of this study was to investigate if a community based hepatitis B (HBV) nurse clinic is a feasible, acceptable and safe strategy to improve access to best practice chronic hepatitis B care (CHB) in Sydney Local Health District.
Methods: The weekly clinic commenced in an Inner West Sydney Health Centre in November 2012. The CNC responsibilities included patient assessment, management, education, triage, the development of care plans for GPs and GP support. Nursing practice was guided by recommendations from internationally and nationally endorsed CHB Guidelines. Information on patient demographics, clinical findings, triage decisions and sources of referral were collected and used to assess the feasibility, acceptability and safety of the nurse clinic. Patients were also invited to complete a self-administered survey. The survey included questions on attitudes towards the clinic and opinions on barriers to accessing treatment and care. Data was collated and analysed in both Excel and SPPS.
Results: In the first 18 months of the clinic 66 people attended, 56 (80%) had CHB, 51 (77%) were born in an Asian country. An equal number of males and females attended. 11 (17%) required further management at a hospital based liver clinic and were referred. 5 (8%) have commenced anti-viral treatment. 24 (36%) met the criteria for six monthly HCC screening and were commenced on HCC surveillance. Twenty-two GPs referred patients. 11 (17%) patients returned the survey and they reported a high level of satisfaction with the clinic and willingness to engage in future CHB care.

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Conclusions: This study of a community based CHB nurse clinic shows it is a feasible, acceptable, and safe initiative. The nurse improved access to best practice care and supported patients to effectively manage their CHB. We have confirmed a nurse can have a central role in triage, case management and GP support. Given the high CHB prevalence in our LHD a higher number of GP referrals were expected. Further research on how to increase engagement with GPs and people living with CHB is needed. We plan to expand our model with the CHB nurse conducting assessments and education in GP practices.

1. Background

Globally more than 350 million people have chronic hepatitis B (CHB), with the highest rates of disease in sub-Saharan Africa and East Asia (prevalence between 5% and 10% of the adult population). CHB is the 10th leading cause of death worldwide, and 25—30% of people with CHB will die from cirrhosis or hepatocellular cancer (HCC) (Lavanchy, 2005). HCC is the most common type of primary liver cancer.

In Australia, the increasing prevalence of CHB is predominately related to an increase in migration from high prevalence regions such as Asia, sub-Saharan Africa and the Pacific. In 2011, an estimated 218,000 people in Australia were living with CHB (1% of the population) however only about half of this number were diagnosed (MacLachlan & Cowie, 2012). The increasing CHB prevalence, the large number of people with undiagnosed CHB and poor uptake of treatment and care (in 2010 only 2.5% of the people with CHB were on anti-viral treatment) is contributing to increasing CHB related morbidity and mortality. By 2010, liver cancer had become the ninth most common cause of cancer death in Australia, increasing faster than any other cause of cancer related mortality (MacLachlan & Cowie, 2012). In New South Wales, 46% of HCCs occur among immigrants, particularly those born in countries with high HBV prevalence. Compared with residents born in Australia, immigrants from China, Indonesia, the Republic of Korea and Vietnam have a six to 12-fold greater risk of developing HCC (Supramaniam, Tracey, & Sitas, 2006). Inner West Sydney Medicare Local (IWSML) has the highest HBV prevalence of any Medicare Local in New South Wales, with an estimated 1.67% of the population (9140 people) living with CHB. This has subsequently led to the highest liver cancer incidence, at 7.9 cases per 100,000 per year, which is 30% higher than the New South Wales average (Victorian Infectious Diseases Reference Laboratory & Australasian Society for HIV Medicine, 2013).

Cost effective anti-viral treatments and HBV preventive vaccines are available. Improving access to vaccination, CHB screening, anti-viral treatment and HCC surveillance can significantly reduce morbidity and mortality. In the last 10 years there have been substantial developments in international and national public health responses to improve access to CHB prevention and care. Many countries have developed HBV Programmes or Strategies. In Australia, the first Australian National Hepatitis B Strategy 2010—2013 (Australian Government, 2010) identified the priority action in reducing the burden of HBV was to improve the level of awareness among primary care doctors. The second National Hepatitis B Strategy 2014—2017 identifies the priority actions of ''examining strategies to encourage the development and implementation of models of care that increase involvement of general practitioners'' and ''exploring tools to improve continuity of care''. The NSW Hepatitis B Strategy 2014—2020 has a target to ''increase the number of people living with hepatitis B receiving antiviral treatment (when clinically indicated) by 300%'' (NSW Ministry of Health, 2014).

The Sydney Local Health District (SLHD) and the Inner West Medicare Local cover almost the same geographic area from the Sydney City Centre out to the Canterbury area. It is an ethnically diverse community. The most common countries of birth being China, Vietnam, Greece, Italy and Korea (Sydney Local Health District, 2014). This ethnic and cultural diversity is a precursor to the high CHB prevalence and growing CHB and HCC related morbidity and mortality. Over the last 3 years the SLHD Hepatitis Governance Committee (including IWSML) have identified a range of local CHB strategies to improve access to best practice care, coordinate and support continuity of care, improve the targeting of priority populations, support GPs and increase collaboration between tertiary, primary health care, GPs, health promotion and public health services. One strategy is a new model of community based nurse care which also gives support to GPs. To date, nurses in New South Wales have only had minimal involvement in community based CHB care and we believe nurses could make a significant contribution in reducing CHB related morbidity and mortality. As part of a new model of CHB nursing care we commenced a community based nurse led clinic at Marrickville Community Health Centre in late 2012.

The aim of this study was to investigate if a community based CHB nurse clinic is a feasible, acceptable and safe strategy to improve access to best practice CHB care in the Sydney Local Health District.

2. Method

2.1. Implementation of the clinic

A CHB Clinical Nurse Consultant (CNC) was recruited in September 2012. The CNC is based within the Liver Clinic at Royal Prince Alfred Hospital (RPAH). The CNC had no prior background in CHB but had over 20 years experience in chronic care and patient education. This included several years as a CNC. The CNC upskilled in CHB area by attending training courses, including the Australian Society of HIV Medicine (ASHM)