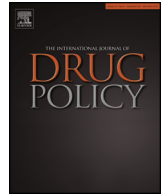




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Contents lists available at ScienceDirect

## International Journal of Drug Policy

journal homepage: [www.elsevier.com/locate/drugpo](http://www.elsevier.com/locate/drugpo)

## Research paper

## From principles to practice: Description of a novel equity-based HCV primary care treatment model for PWID

Rozalyn Milne<sup>a,\*</sup>, Morgan Price<sup>b</sup>, Bruce Wallace<sup>c</sup>, Anne Drost<sup>a</sup>, Irene Haigh-Gidora<sup>a</sup>, Frank A. Nezil<sup>a</sup>, Chris Fraser<sup>b</sup><sup>a</sup> Cool Aid Community Health Centre, 1st Floor 713 Johnson Street, Victoria, BC, Canada V8W 1M8<sup>b</sup> UBC Department of Family Practice, Cool Aid Community Health Centre, 1st Floor 713 Johnson Street, Victoria, BC, Canada V8W 1M8<sup>c</sup> School of Social Work, University of Victoria, Box 1700 STN CSC, Victoria, BC, Canada V8W 2Y2

## ARTICLE INFO

## Article history:

Received 2 January 2015

Received in revised form 9 July 2015

Accepted 13 July 2015

## Keywords:

Hepatitis C

HCV

Drug use

PWID

Community health centre

Primary care

Health

## ABSTRACT

**Background:** Knowledge is increasing regarding effective models of HCV care for people who inject drugs (PWID). However, examples implementing such models in primary care are lacking, leaving a gap in our applied understanding of how practically we best scale-up such care: this is critical and urgent if the benefits of treatment advances are to be realized for PWID.

**A case study:** The Cool Aid Community Health Centre (CHC) provides HCV programming for PWID, putting recent advances into practice. A case study of the CHC's HCV programming describes the practice experience and outcomes of its novel, multidisciplinary, primary care, inner-city HCV treatment program for PWID. This paper describes how this model of care functions to address the many barriers to treatment and successfully facilitate adherence to treatment.

**Conclusion:** Medical advances for HCV will be ineffectual without effective management of complex barriers to care related to substance use, mental health, trauma, poverty, homelessness, criminalization, cultural issues, stigma and marginalization. HCV treatment for PWIDs benefits from low-threshold settings which are culturally appropriate and where trusting relationships between clients and providers are nurtured. Public investment in primary care treatment for PWID living with HCV, including investments in supports that address the social barriers faced by these vulnerable populations would build on existing evidence and improve HCV outcomes for PWID.

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In this paper, we present a case study of a current program for treatment of Hepatitis C in marginalized peoples attending a multidisciplinary, primary care community health centre, the Cool Aid Community Health Center in Victoria, British Columbia, Canada where comprehensive in-house primary care has proven successful in diminishing commonly experienced barriers to treatment in this population.

People impacted by structural inequities, including poverty and homelessness, criminalization, and stigmatization of substance use and mental illness, experience both poorer health and significant barriers in accessing primary healthcare services (Browne et al., 2012). While Hepatitis C (HCV) rates may be decreasing amongst the general population (Myers, Kraijden, & Bilodeau, 2014), certain groups experiencing severe economic hardships, problematic substance use and social exclusion

experience increasing incidence and prevalence of HCV and persistent barriers to care (Grebely, Bruggmann, Backmund, & Dore, 2013; Grebely & Dore, 2014; Klein et al., 2013). People who inject drugs (PWID) specifically have a high risk of infection, a high incidence of HCV and HIV co-infection, and low-uptake, adherence and efficacy of HCV treatment (Grebely, Bruggmann, et al., 2013).

Illicit drug use and other barriers to care are frequently exacerbated by poverty and homelessness. Inner-city populations experiencing unstable housing or homelessness specifically have extremely poor health status (Hwang et al., 2011), and barriers of access to primary care exist despite universal health insurance (Hwang et al., 2010). These populations also have high rates of HIV and HCV infection, low rates of access to testing and care, lower rates of treatment adherence, and poorer treatment outcomes (Gelberg et al., 2012; Milloy, Marshall, Montaner, & Wood, 2012).

New treatment advances hold promise of substantial reductions in morbidity and mortality related to both HIV and HCV (Klein et al., 2014). However, inner-city populations including PWID impacted by HIV have not fully benefited from advances in

\* Corresponding author. Tel.: +1 250 385 1466; fax: +1 250 383 1327.  
E-mail address: [rmilne@coolaid.org](mailto:rmilne@coolaid.org) (R. Milne).

treatment, such as, highly-active antiretroviral therapy (HAART) (Milloy et al., 2012). Similarly, new HCV treatment regimens will not likely realize their potential impact unless HCV treatment uptake and adherence among inner-city populations including PWID is made a public policy priority and successful treatment models enhanced and expanded (Bruggmann & Litwin, 2013; Grebely & Dore, 2014). Indeed, without urgent action to address the well-documented barriers to HCV care for PWID, then uptake of the current medical advances disproportionately benefits those without these barriers (Hepworth, Bain, & van Driel, 2013) and health inequities related to HCV can be expected to increase.

Canada's public health system does not specify coverage for prescription medications: provincial governments decide which medications are funded resulting in inconsistent access to treatment for HCV across the country. In British Columbia publicly funded HCV medication coverage must be pre-approved for each patient based upon specified criteria for evidence of liver disease stage. Previously, two alanine transaminase values (taken at least 3 months apart) at least 1.5 times the upper level of normal, or evidence of at least F2 fibrosis. In October 2014, this changed to evidence of at least F2 fibrosis, as determined for non-cirrhotic cases by transient elastography, APRI score (aspartate transaminase to platelet ratio index), FIB-4 (fibrosis 4), or liver biopsy. In the case of cirrhosis, the fibrosis must be determined by transient elastography or biopsy, despite the fact that transient elastography is neither publicly funded nor accessible with only one machine on Vancouver Island at the time.

With Hepatitis C direct acting agents made publicly available to patients in British Columbia (BC), Canada, the potential of higher sustained virologic response (SVR) rates became a reality in principle. The challenge remained: how to reach and successfully treat HCV in this population. The treatment cascade is a conceptual model describing access and adherence to services for people living with HIV across the entire continuum of care (Gardner, McLees, Steiner, del Rio, & Burman, 2011). The same model has been applied to HCV (Linás et al., 2014) to inform interventions that seek to prevent leaks in the cascade of care that result in diminished engagement and adherence and reduced efficacy of treatment advances. The Cool Aid Clinic thus embarked to fix the leaky HCV cascade for its clients, initiating a program to review current practices, identify barriers for priority populations and pilot strategies to maximize patient access to treatment. This paper presents a case study of the Cool Aid CHC's novel HCV interdisciplinary primary care based treatment program for PWID in Victoria.

### Models of HCV care for PWID

Elimination of HCV among populations of PWID is currently perceived as feasible (Alavi, Grebely, et al., 2013; Aspinall et al., 2013; Grebely, Bilodeau, et al., 2013; Grebely & Dore, 2014). It is now accepted that good outcomes for PWID are possible and that patients should not be excluded from HCV treatment due to active substance use, opiate substitution therapy, or mental health disorders (Aspinall et al., 2013; Dimova et al., 2013; Grebely et al., 2015). Moreover, there is increasing knowledge about the components of effective models of HCV care for PWID (Alavi, Grebely, et al., 2013; Bruggmann & Litwin, 2013; Mravčík et al., 2013). Still, questions remain about 'how' these models operate and what makes them effective to best support the scaling up of these responses (Grebely, Bilodeau, et al., 2013; Hepworth et al., 2013). Indeed, scaling-up is critical and urgent if the benefits of treatment advances are to be realized for PWID (Alavi et al., 2014; Bruggmann & Litwin, 2013; Grebely, Oser, Taylor, & Dore, 2013; Klein et al., 2013; Robaey et al., 2013).

### Multidisciplinary approach

A review of models of HCV care for PWID observed that an integrated multidisciplinary team approach is the foundation of tailored HCV care for PWID (Bruggmann & Litwin, 2013). Usually, multidisciplinary teams include physicians, nurses, mental health and counselling services, social work and advocacy as well as services related to problematic substance use (Bruggmann & Litwin, 2013). Close collaboration within these models is viewed as essential to success with the multidisciplinary model providing a forum for interaction in which the providers support each other while providing supports to patients (Ho et al., 2013).

### Uninterrupted access to care

Referrals to off-site care is acknowledged as an obstacle to treatment adherence for PWIDs whereas facilities that can provide on-site, uninterrupted services from testing to treatment appear more capable to achieve successful outcomes (Zeremski et al., 2013). Testing outside of hospital settings and specifically within harm reduction services in which PWIDs may already access services or health care are perceived to maximize uptake; we also recognize that this setting requires a non-judgmental approach and recognition of internalized stigma and institutional mistrust among the PWID patient cohort (Harris, McDonald, & Rhodes, 2014).

Frequently, these multidisciplinary teams are integrated primary health care settings. HCV treatment by primary health care providers has been shown effective to treat HCV infection in underserved communities (Arora et al., 2011) with primary care and HCV management provided by the same clinicians. The effectiveness of this model is likely highest in settings such as community health centres providing patient-centred care in accessible locations by culturally competent clinicians for which patients can build a trusting relationship with (Arora et al., 2011). Unfortunately, a literature review on HCV, mental health and antiviral therapy shows that, despite these insights, it is more typical today for access to interferon to be through specialist clinics in a hospital setting. While the reviewers acknowledge that this evidence has yet to be translated into practice, they support HCV testing and treatment within community-based primary care settings to shift care of vulnerable populations (such as PWID) from hospitals, possibly resulting in overall cost savings – and increased equity – for those affected by HCV (Hepworth et al., 2013). Indeed, community-based screening has been identified as the initial step to improving the entire cascade of HCV care for inner-city populations defined by homelessness and problematic substance use (Norton et al., 2014), in recognition of the subsequent benefits of uninterrupted, on-site linkages to care that eliminates referrals to specialists (Trooskin et al., 2015).

Our case thus provides a practical example of a low threshold (Islam, Topp, Conigrave, & Day, 2013) highly accessible multidisciplinary primary care community clinic treating otherwise problematic HCV clients in a setting familiar to them and where trust may already have been established.

### PWID treatment with PWID services

There is ongoing evidence and recommendations for the co-location of HCV treatment and care for PWID within settings dedicated to serving PWID such as harm reduction programs including opiate substitution therapy and needle exchange as well as supports for problematic substance use (Grebely, Knight, & Genoway, 2010; Harris, Arnsten, & Litwin, 2010; Martinez et al., 2012; Treloar, Rance, Grebely, & Dore, 2013; Zeremski et al., 2013). These recommendations further emphasize the need for HCV

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