No "Going back to Normal"

In Hepatitis C (HCV) Care Post-COVID

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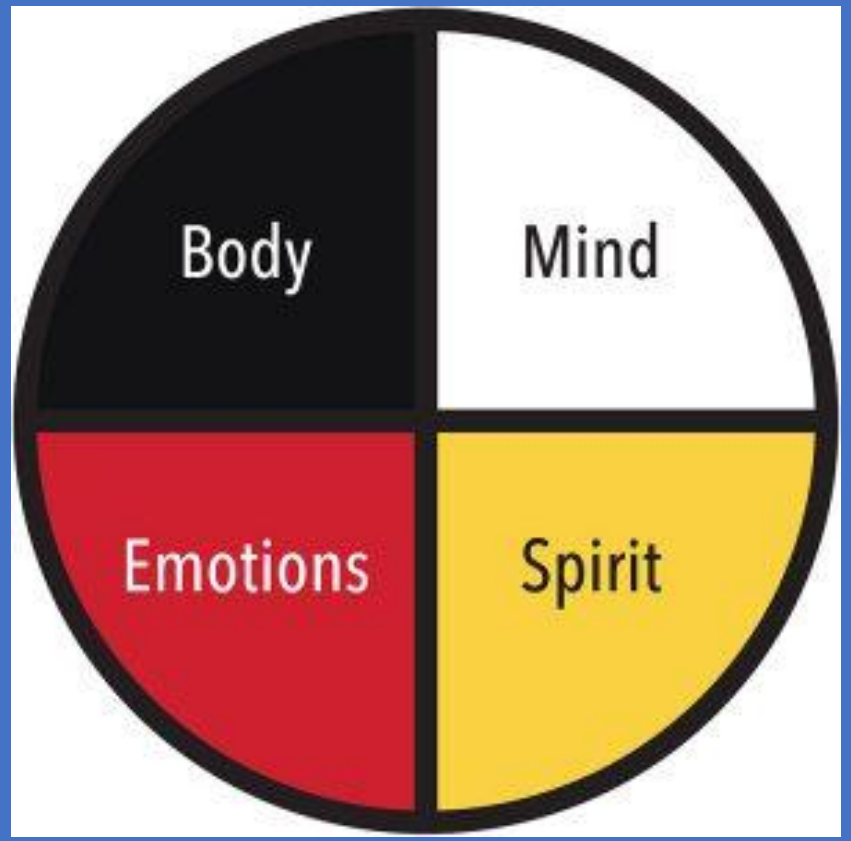

In the spirit of reconciliation, we acknowledge that we live, work and play on the traditional territories of the Blackfoot Confederacy (Siksika, Kainai, Piikani), the Tsuut’ina, the Îyâxe Nakoda Nations, the Métis Nation (Region 3), and all people who make their homes in the Treaty 7 region of Southern Alberta.

CUPS Liver Clinic: Pre COVID-19

Inner-city, multi-disciplinary, low-barrier HCV care for 22 years

Trauma informed

On-site care coordination

Walk-ins, referrals

RN – led

On-site Infectious Diseases MD

Fibroscans as engagement tool

Then Came COVID-19

Non-urgent medical matters were unaddressed for several months

RN diverted to COVID mitigation efforts

Lab tests & In-patient visits severely restricted

New Model of Care

Clients assessed by RN, either in-person or by phone (no internet access for virtual visits)

MD consult based on electronic record alone except high Fib-4 / comorbidities

Treatment starts and support by phone, mailed requisitions

Effectiveness in 1st Twelve Months

RN visits decreased 59 %

MD visits decreased 80 %

MD electronic consults increased over 5 times.

Treatment starts only fell 33 %

Fewer no shows

Increased accessibility to HCV care

Reported satisfaction of clients & primary care team

→decreased satisfaction of Liver Clinic health care team

Allowed treatment of many of our most marginalized patients

- “Rough” sleepers
- Those in shelters
- Those with severe addiction and mental health issues

Conclusions

In-person assessments by the MD are rarely needed.

Electronic consultations remove a significant barrier to HCV care.

Fibroscans are not needed for most clients.

We will continue to use this streamlined model within CUPS and in our outreach programs to other inner-city agencies (eg OAT programs) to increase access to care.