Delivering Direct Acting Antiviral Therapy to Highly Marginalised Populations in an Integrated Primary Health Care Setting

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Conflict of interest

- PR- research grant Gilead Sciences, fees for CME/non CME services; Gilead, MSD, Abbvie
- JK- travel scholarships BMS, Gilead
- RG- travel scholarships Abbvie, Gilead
- GD has received consulting fees, fees for non-CME/CE services, and funds for research support from Abbvie, BMS, Gilead Sciences and Merck.
- KC – research grant Gilead Sciences
- RL- no conflicts to declare

Kirketon Road Centre

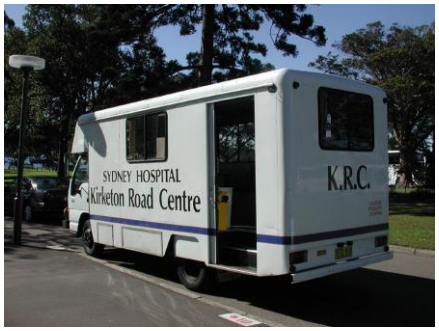
- Established in Kings Cross in 1987
- An integrated primary health care service model which aims to meet the health and social welfare needs of “at risk” youth, PWID and sex workers
- Focus on the prevention, treatment and care of hepatitis, HIV and STIs
- Drop in, late hours, free, confidential
- Provide 14000 episodes of care for >4000 people per annum
- 45% of consults are with PWID
- Up to 50% of regular clients have chronic Hep C

Services at KRC

- General medical care
- HIV, hepatitis A,B, and C testing
- Hepatitis A and B vaccination
- Healthy Liver Clinics
- HIV treatment and care
- STI screening/treatment
- Sex worker check ups
- Pap smears, contraception, pregnancy testing, advice
- Mental health clinic
- Methadone Access Program: ‘low threshold’ with intensive case management approach
- Aboriginal program

Services at KRC

- Client support and activity groups- health promotion and community development activities
- D&A counselling, assessment and referral
- Housing, social security and welfare assistance- Centrelink clinic
- Needle syringe program; needle clean-up service
  - 3 primary NSP sites and 10 secondary sites
  - 8 vending machines, 3 dispensing chutes
- Naloxone training for overdose management
- Safer injecting workshops
- Daily and nightly foot and bus outreach



Health
South Eastern Sydney
Local Health District

Community partnerships and outreach:

- A bus and on-foot outreach 7 nights a week – including joint outreach with peer organisations for drug users and sex workers
- Nurse led clinical outreach
  - Local users peer-based NSP – importance of peer-involvement
  - Medically Supervised Injecting Centre
  - Homeless hostels
  - Local disadvantaged youth services

NUAA
NSW USERS AND AIDS ASSOCIATION

SYDNEY MEDICALLY SUPERVISED INJECTING CENTRE

- University partnerships
- Sentinel surveillance (drug trends and HCV)

Background

- Marginalised populations often excluded from studies of direct acting antivirals (DAAs)
- KRC treating clients with HCV using DAAs since late 2015
  - Patient access programs
  - Clinical trials
  - Direct access through PBS
  - Focus on nurse-led care
- Need to describe real world outcomes in drug users treated in community settings

Aim & Methods

- To describe outcomes from the first cohort of current injecting drug users treated in the era of DAAs at Kirketon Road Centre
- Descriptive statistics for all clients treated with DAAs at KRC from March 2016
  - Demographic variables (age, gender, education, employment)
  - Injecting patterns
  - Clinical history and outcomes

Demographic Characteristics

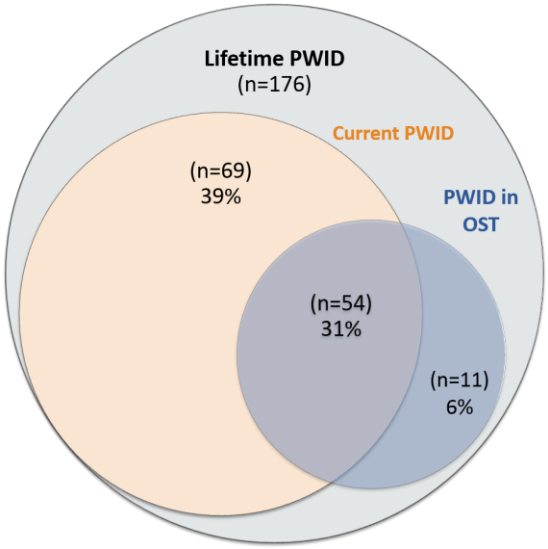
- 233 clients assessed for treatment, of whom 176 commenced treatment by 31st July 2017
- Data includes 133 clients due SVR12 by 31-7-17

- Median age 45, range 24 – 69
- 28% Aboriginal and/or Torres Strait Islander
- 36% homeless in last 12 months
- 67% male
- 88% unemployed

Injecting pattern

- Age first injecting: median 19 years; range 9 - 47
- 95 (73%) currently injecting (last 6 months)
  - 45% injecting weekly, including 13% daily
  - 48% last injected heroin; 39% methamphetamine
  - 15% reported receptive syringe sharing in the preceding year, including 4% within the last month
- 55 (41%) currently taking opioid substitution treatment

Injecting profile of Kirketon Road Centre clients initiating DAAs

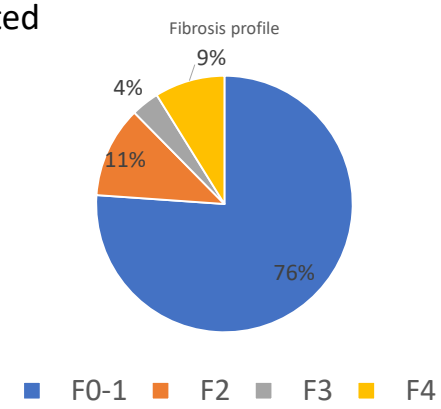


Slide design courtesy Greg Dore

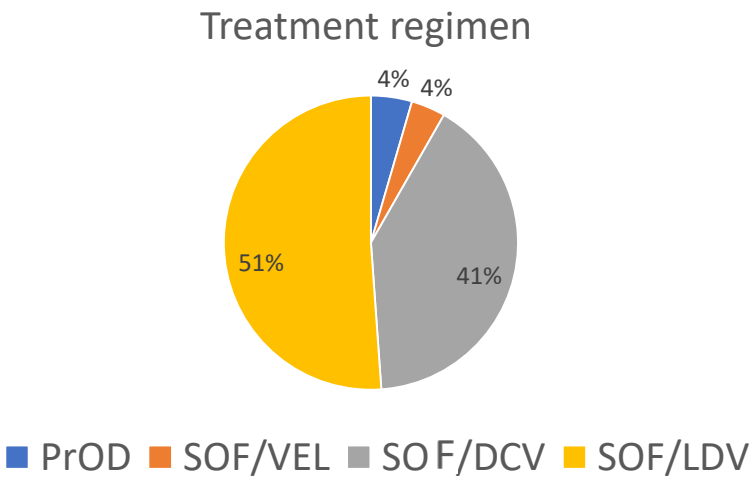
Clinical History

Time since diagnosis:
15 ± 10.1 years
94% treatment naïve
14 (11%) HIV co-infected
Genotypes
Type 1: 78 (58%)
Type 2: 6 (5%)
Type 3: 49 (37%)

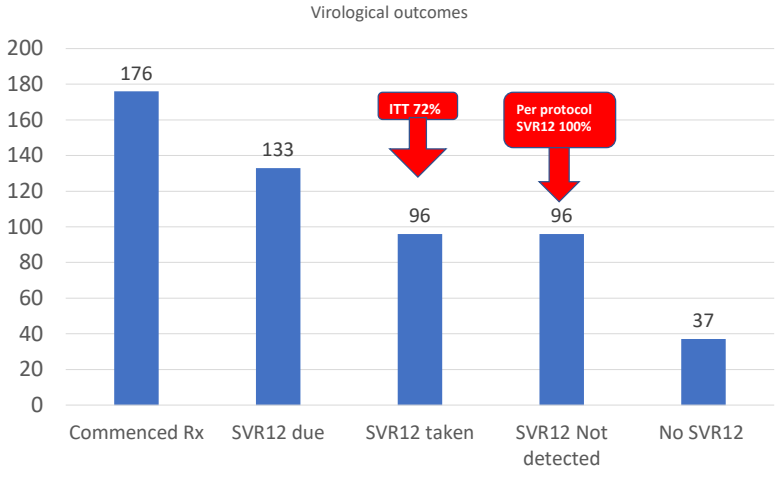
Fibroscan:
- Median = 5.9
- Range 3.0 – 73.5



Treatment Prescribed



Treatment Outcomes



Reasons for no SVR12 test

- 133 due: 37 not tested
  - 4 died during treatment- 3 drug overdose, 1 unknown cause
  - 6 lost to follow-up on treatment
  - 1 deferred treatment and SVR12 date postponed
  - 1 pending (Successful ETR)
  - 25 completed treatment but late for SVR12
    - 6 less than 12 weeks late
  - If exclude those less than 12 weeks late, who died, postponed or pending
    - mITT is 96/121 80%
- Associations with no SVR12 test
  - Homelessness (OR 3.7, 95%CI 1.0-12.9 p=0.042)
  - Poly-drug use (OR 3.3, 95%CI 0.8-13.9 p=0.109)
  - Neither significant in MV analysis
- Homelessness associated with late SVR12
  - aOR 25.4 95%CI 2.8-234.7, p=0.004

Adherence and outreach support

- 61% managed monthly treatment
  - Telephone support
- 39% utilised intensive support
  - Daily dosing at KRC
  - Pick up medication weekly dosette box
  - Arrange dispensing through another facility
  - Delivery of medications to prison, psychiatric units, police cells, homeless hostels
  - Monitoring in outreach settings
  - Picking up medications at pharmacy
- 25% first engaged on outreach
- 36% had some care delivered in an outreach setting
  - NSP
  - Injecting centre
  - User organisations
  - Aboriginal programs
  - Homeless hostels

Discussion

- Initial adherence and treatment outcomes appear favourable in this population of active, often homeless drug users
- Provides further evidence that drug use and social marginalisation should not be an impediment to, nor compromise efficacy of HCV treatment
- Multi-disciplinary client centred approach
- Liaison with other services (mental health/homeless)
- Flexibility, walk in, outreach
- Link to related services – counselling, etc
- Dosing options
- Working with peers
- Overdose risk significant- naloxone; exceeds HCV mortality in short term

Discussion

- Per protocol outcomes excellent (100% SVR12)
- Significant drop off in retention post-treatment
- Many clients tested much later than week 12
- Association with homelessness and delayed SVR12
- Standard of follow-up?
- Duration?
- Importance?
- Is SVR12 too stringent in the real world setting?

Thank you

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