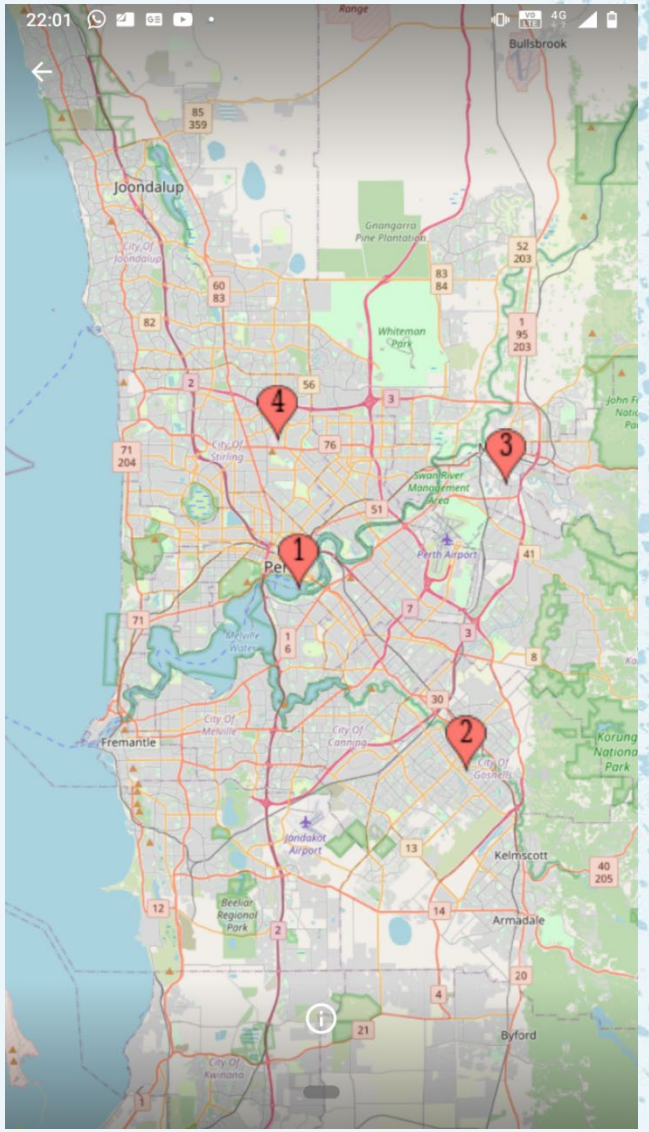
Derbarl Yerrigan: HCV Case Finding

To put our story into context…



Our Patients

Patients	Number
All	59,700
Current	9,485 (5229 regular, 4256 not regular)
Transient	1,545
Past	45,352
Non-patient	3,318

Regular = seen 3 times in last 2 years

SC = Current Client = Lives in DYHS Service Area and has had 1 contact or more in past 2 years

ST = Transient Client = Lives outside of DYHS Service Area but has had 1 contact or more in past 2 years

SP = Past Client = No contacts in past 2 years

SNP = Non-Patient = Has a file but not considered a patient of DYHS

HCV Audit at Derbarl Yerrigan

HCV Audit: patients with a hepatitis C item		
	All patients	Regular patients
Ab pos, RNA check required	64	8
SVR due post treatment	80	23
Current, RNA pos	160 (14%)	37 (8%)
Cleared, RNA neg	873	369
Total	1177	437

Transmission of hepatitis C

Blood borne

Main risk in Australia is intravenous drug use

Transmission via sex is generally low < 5% for long-term partner

Transmission via sex increased between MSM and HIV co-infection

Transmission from infected mother to baby 5%

Natural history of hepatitis C

Acute infection

Only 16% symptomatic: lethargy, myalgia, fever, N+V, pain, jaundice

30% spont clearance Ab pos, RNA neg Occurs within 6 months	70% chronic hepatitis C Ab pos, RNA pos > 6 months Largely asymptomatic Slow progression
	Cirrhosis (15-30% in 20 years) HCC

DERBARL YERRIGAN HEALTH SERVICE

Case finding

Key strategies we have found beneficial…

- Check biographics/ contact details at each visit
- Ask explicitly about risk factors
- Order reflex testing
- Collect bloods on-site
- Review clinical items to minimise misinterpretation of results
- Chase external information: pathology results/ prison records/ MHR
- Explicit recalls
- Support of ALO and transport driver to minimise barriers
- Regular audits

Who to screen for hepatitis C

Anyone who requests a test, even if risk not disclosed

People who inject or have ever injected drugs (> 90% new cases)

People who have been incarcerated (30% - 60% prevalence)

People with tattoos or piercings

People who have received blood products before 1990

Migrants from countries of high prevalence (Egypt, Pakistan, Mediterranean, Eastern Europe, Africa and Asia)

Aboriginal and Torres Strait Islander people

Contacts or sexual partners

People with co-infection (HIV or HBV)

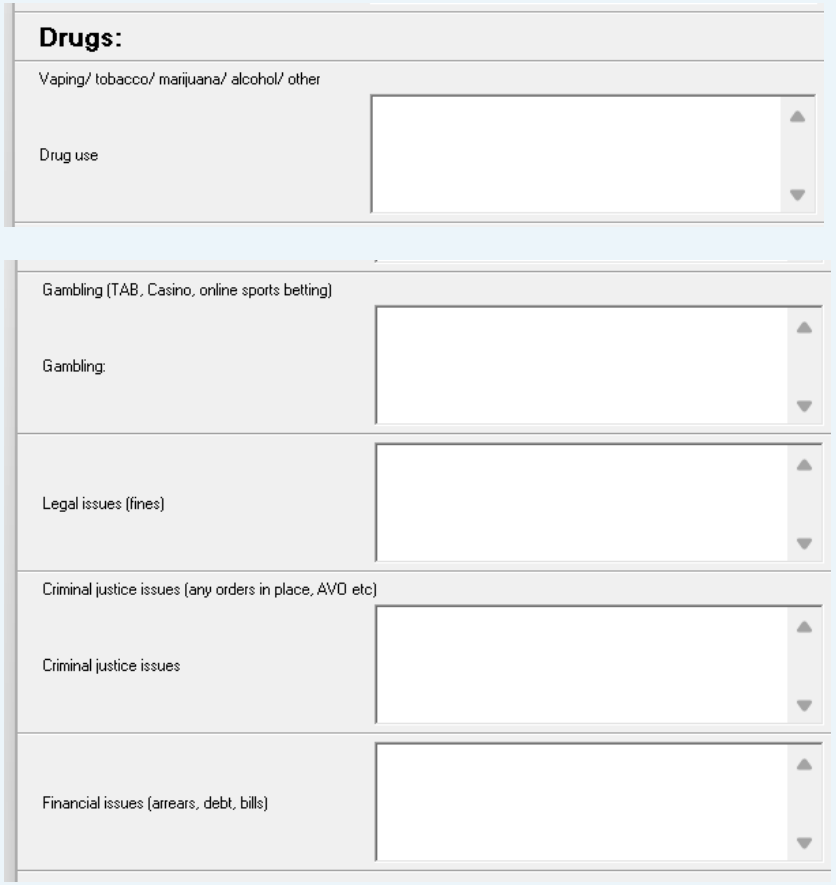
Abnormal liver function test (elevated ALT)

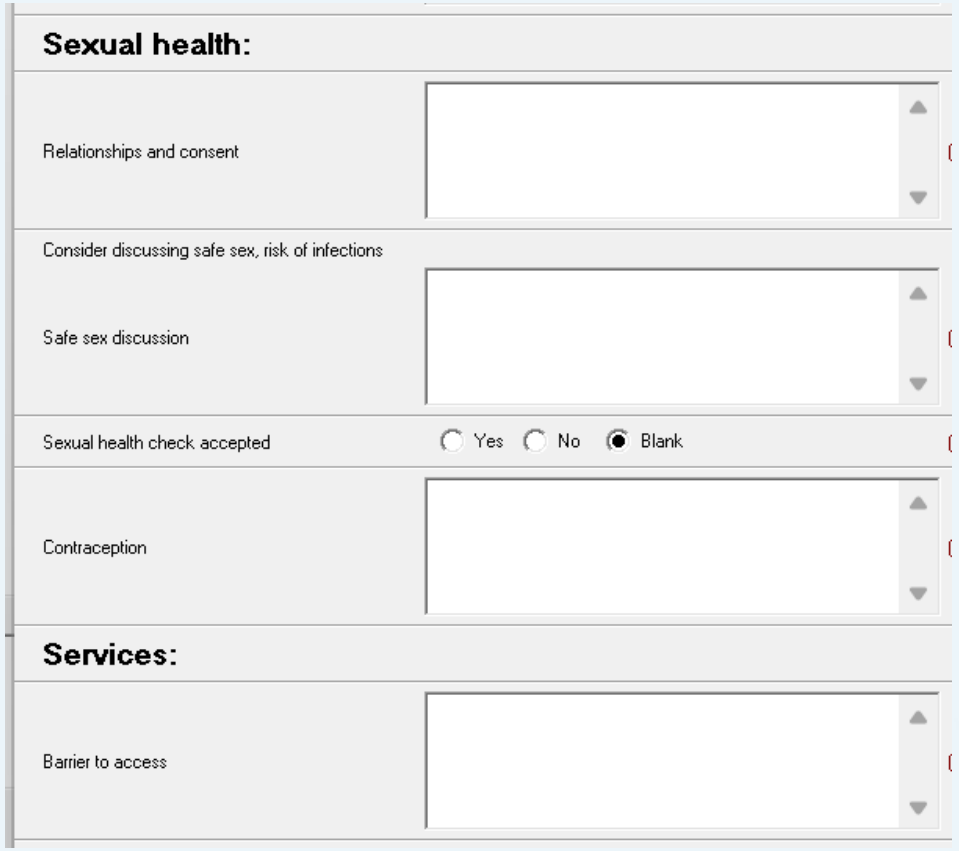
How often to screen

Risk	Frequency
PWID Without sharing needles/ equipment	Annually + after any high-risk injecting episode
PWID Sharing needles/ equipment	3-6 monthly
Sexual partner HCV positive Practicing safe sex	Annually
Sexual partner HCV positive Unprotected anal sex/ other risks	6 monthly
Children of HCV-positive mothers	HCV Ab at 18 months Consider HCV RNA > 8 weeks age
Haemodialysis patients	6 monthly

Explicit prompts /normalising the conversation

715 Aboriginal health check
10987 Follow-up of health check





Reflex testing

Consent

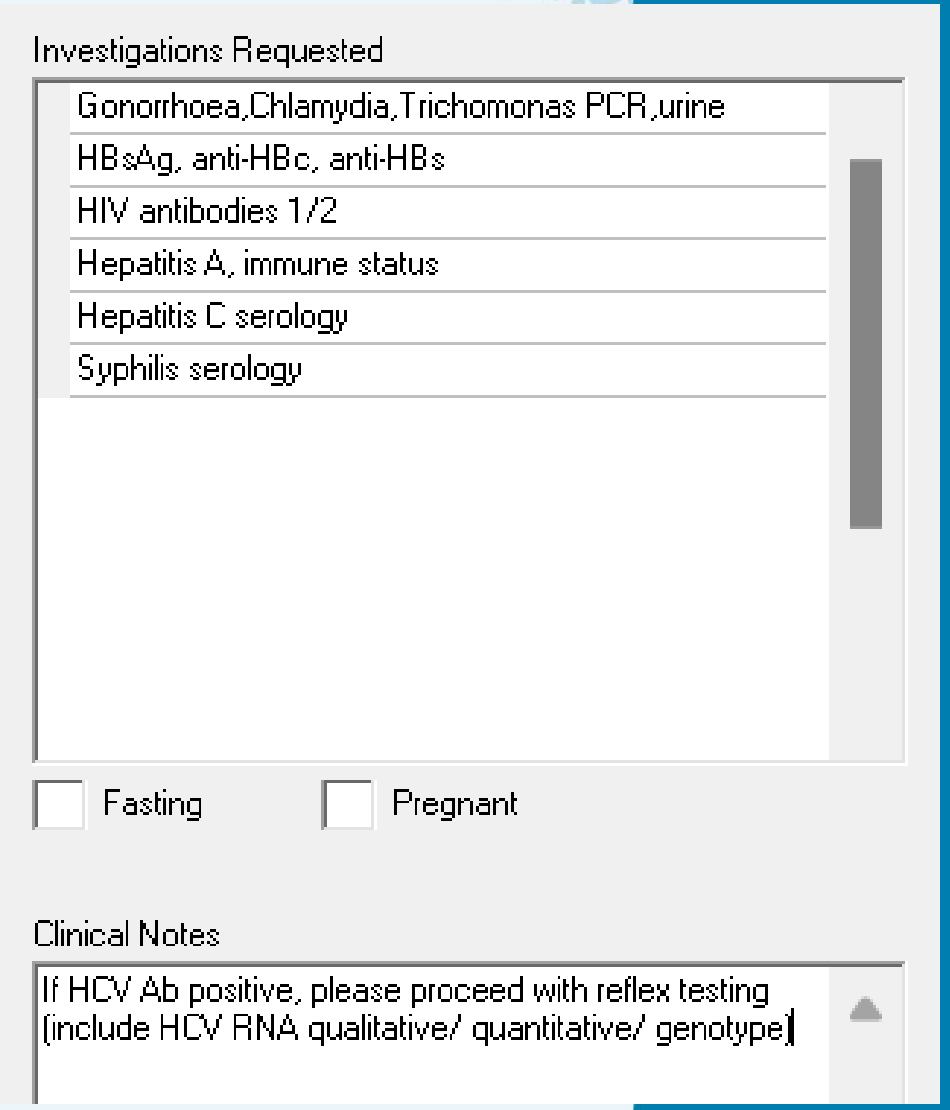
Reflex testing

Explain new treatment options

Ensure dedicated serology tube for RNA

Check biographics

Make a plan to review results



Improving documentation and clinical coding

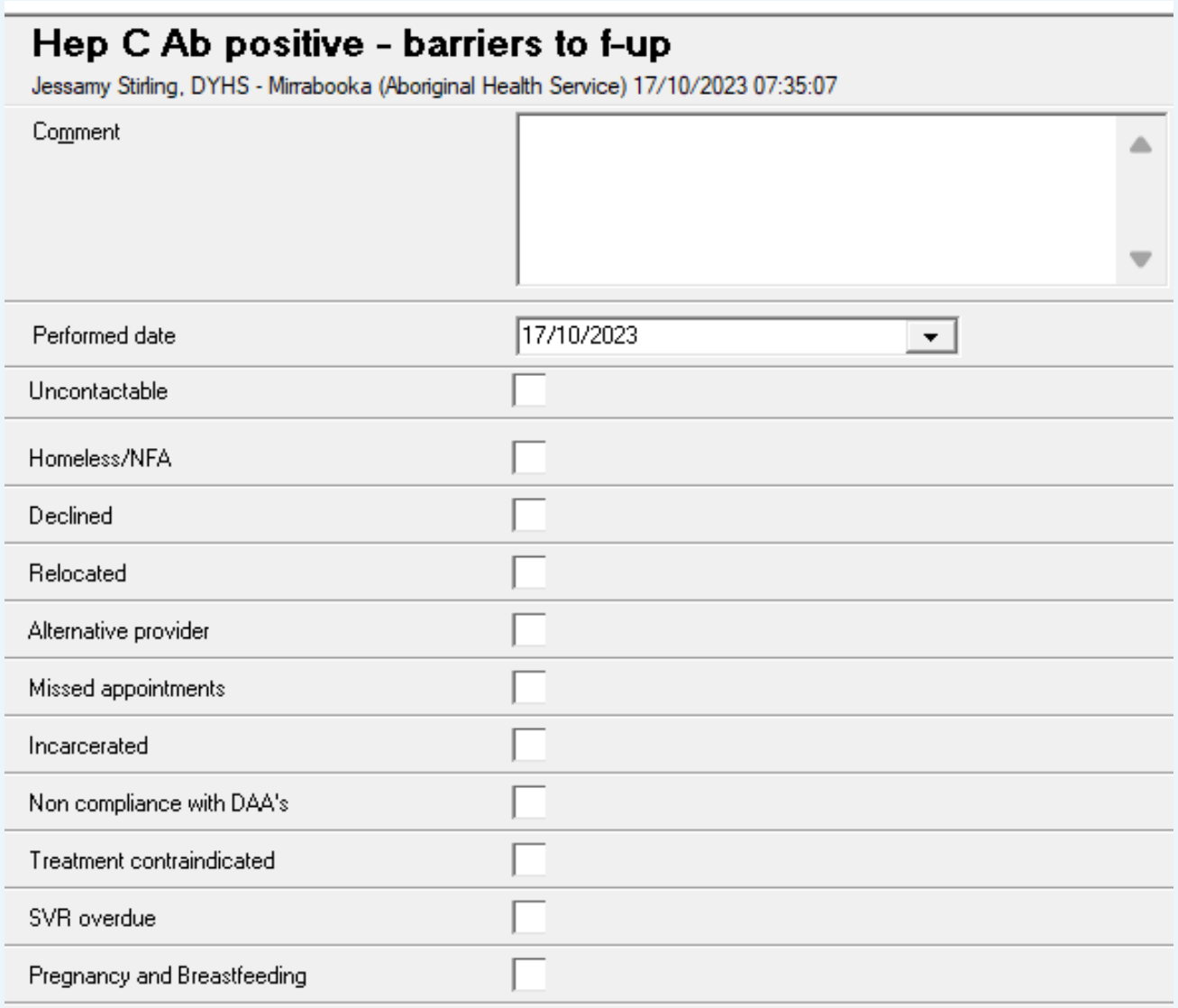
Past items	Current items
Conditions - Hepatitis C positive - Chronic hepatitis - Hep C Ab pos, RNA neg; post treatment - Hep C Ab pos, RNA neg; spontaneous - Hep C Ab pos, RNA neg; ? Spont ? PostRx - Hep C Ab pos, Check RNA	Conditions; Hep C Ab pos, RNA positive; CURRENT Hep C Ab pos, RNA neg; CLEARED Hep C Ab pos, RNA check required Hep C, maternal infection during pregnancy Procedures; Hep C Ab pos, barriers to follow-up

Examination

Look for signs of chronic liver disease;

Spider naevi
Palmar erythema
Jaundice
Encephalopathy
Hepatomegaly
Splenomegaly
Ascites
Peripheral oedema

Documentation of barriers

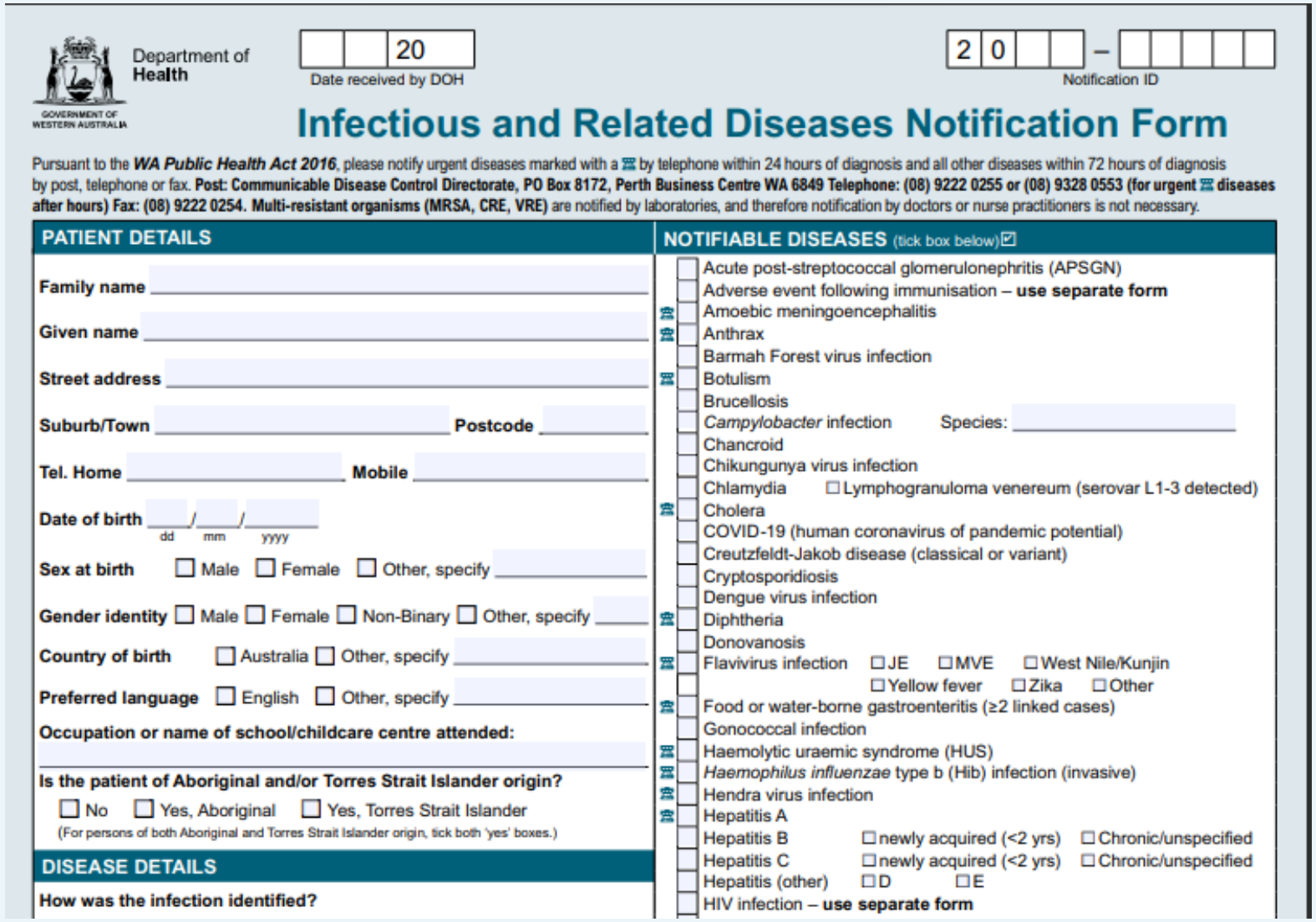


Hep C Ab positive – barriers to f-up

Jessamy Stirling, DYHS - Mirrabooka (Aboriginal Health Service) 17/10/2023 07:35:07

Comment	
Performed date	17/10/2023
Uncontactable	☐
Homeless/NFA	☐
Declined	☐
Relocated	☐
Alternative provider	☐
Missed appointments	☐
Incarcerated	☐
Non compliance with DAA's	☐
Treatment contraindicated	☐
SVR overdue	☐
Pregnancy and Breastfeeding	☐

Notification



Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Date received by DOH: [ ][ ]20

Notification ID: 20[ ][ ] – [ ][ ][ ][ ][ ]

Infectious and Related Diseases Notification Form

Pursuant to the ***WA Public Health Act 2016***, please notify urgent diseases marked with a ☎ by telephone within 24 hours of diagnosis and all other diseases within 72 hours of diagnosis by post, telephone or fax. **Post: Communicable Disease Control Directorate, PO Box 8172, Perth Business Centre WA 6849 Telephone: (08) 9222 0255 or (08) 9328 0553 (for urgent ☎ diseases after hours) Fax: (08) 9222 0254. Multi-resistant organisms (MRSA, CRE, VRE)** are notified by laboratories, and therefore notification by doctors or nurse practitioners is not necessary.

PATIENT DETAILS

Family name _____

Given name _____

Street address _____

Suburb/Town _____ **Postcode** _____

Tel. Home _____ **Mobile** _____

Date of birth ____/____/_____ (dd mm yyyy)

Sex at birth ☐ Male ☐ Female ☐ Other, specify _____

Gender identity ☐ Male ☐ Female ☐ Non-Binary ☐ Other, specify _____

Country of birth ☐ Australia ☐ Other, specify _____

Preferred language ☐ English ☐ Other, specify _____

Occupation or name of school/childcare centre attended:

Is the patient of Aboriginal and/or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

(For persons of both Aboriginal and Torres Strait Islander origin, tick both 'yes' boxes.)

DISEASE DETAILS

How was the infection identified?

NOTIFIABLE DISEASES (tick box below) ☑

- ☐ Acute post-streptococcal glomerulonephritis (APSGN)
- ☐ Adverse event following immunisation – **use separate form**
- ☐ Amoebic meningoencephalitis
- ☐ Anthrax
- ☐ Barmah Forest virus infection
- ☐ Botulism
- ☐ Brucellosis
- ☐ *Campylobacter* infection Species: _____
- ☐ Chancroid
- ☐ Chikungunya virus infection
- ☐ Chlamydia ☐ Lymphogranuloma venereum (serovar L1-3 detected)
- ☐ Cholera
- ☐ COVID-19 (human coronavirus of pandemic potential)
- ☐ Creutzfeldt-Jakob disease (classical or variant)
- ☐ Cryptosporidiosis
- ☐ Dengue virus infection
- ☐ Diphtheria
- ☐ Donovanosis
- ☐ Flavivirus infection ☐ JE ☐ MVE ☐ West Nile/Kunjin ☐ Yellow fever ☐ Zika ☐ Other
- ☐ Food or water-borne gastroenteritis (≥2 linked cases)
- ☐ Gonococcal infection
- ☐ Haemolytic uraemic syndrome (HUS)
- ☐ *Haemophilus influenzae* type b (Hib) infection (invasive)
- ☐ Hendra virus infection
- ☐ Hepatitis A
- ☐ Hepatitis B ☐ newly acquired (<2 yrs) ☐ Chronic/unspecified
- ☐ Hepatitis C ☐ newly acquired (<2 yrs) ☐ Chronic/unspecified
- ☐ Hepatitis (other) ☐ D ☐ E
- ☐ HIV infection – **use separate form**

Hepatitis C audit

Hep C Audit

Current pt name	Pt ID	Site	HCV Ab pos: RNA pos: Current	HCV Ab pos: RNA neg: Cleared	HCV Ab pos: RNA check required	HCV Ab pos: Barriers to follow-up	Post treatment SVR: *Recall*	Hep C audit	Hep C treatment	Immune to hep A	Immune to hep B

Reducing barriers

Welcoming

Culturally-safe

Confidential

Normalise the conversation

Include prompts in health checks

Have posters around the clinic

Ask explicitly about risk factors

Minimise number of visits required

Reminders/ recalls / supports

Harm minimisation

Educate re potential for infection or re-infection

Key strategies;

1. Needle syringe programs
2. Naloxone program
3. Immunisation hepatitis A and B

Naloxone take-home program

Obtained for free, no prescription required

Opioid users (prescribed and illicit)

People who may witness an opioid overdose (household members)

Pre-filled syringe (Prenoxad) IMI

Intranasal spray (Nyxoid)

Any questions?