Barriers and facilitators to HCV care and treatment among vulnerable populations: a clinic perspective

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Viral hepatitis conference 2018

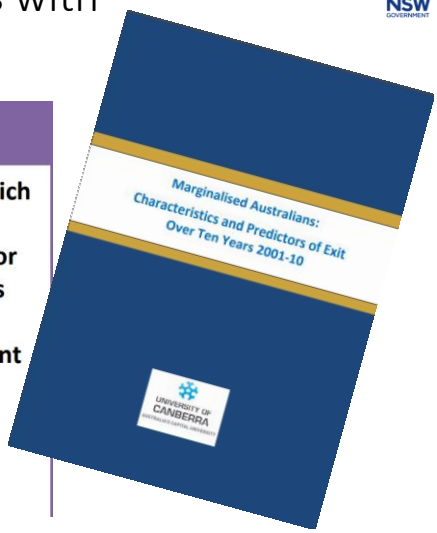
Kirketon Road Centre

- 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, people who inject drugs and sex workers
- Provide 14000 episodes of care for >4000 people per annum
- 45% of consults are with PWID, 30% with sex workers, 20% young people
- Treated around 300 people in DAA era
  - 70% current drug users, 37% homeless, 26% Aboriginal, 36% seen on outreach, 28% adherence assistance, 40% mental health diagnoses

Vulnerability often overlaps with marginalisation

What is marginalisation?

Marginalisation describes a state in which individuals are living on the fringes of society because of their compromised or severely limited access to the resources and opportunities needed to fully participate in society and to live a decent life. Marginalised people experience a complex, mutually reinforcing mix of economic, social, health and early-life disadvantage, as well as stigma.



Cruwys, T., Berry, H.L., Cassells, R., Duncan, A., O'Brien, L.V., Sage, B. and D'Souza, G. (2013). Marginalised Australians: Characteristics and Predictors of Exit over Ten years 2001-2010. University of Canberra, Australia.

Marginalisation: 13% of Australians

Risk factors

Financial hardship
Early life disadvantage
Poor health
Social isolation
Social stigmatisation

F>M, Aboriginality

Protective factors/Resilience

Age
Schooling
Parenting figures
Employment
Home ownership
Good mental health
Social/intimate relation ships

Clinical services for vulnerable populations

Principles

- Accessibility
- Affordability
- Acceptability
- Equitability

- Integrated, holistic services
- Recognise social determinants of health
- Low threshold, low barrier

Populations in context of Hep C

- People who currently or ever inject drugs (+/- opioid treatment)
- Homeless people
- Aboriginal and Torres Strait Islander people
- Released prisoners
- Some CALD populations
- People living with HIV

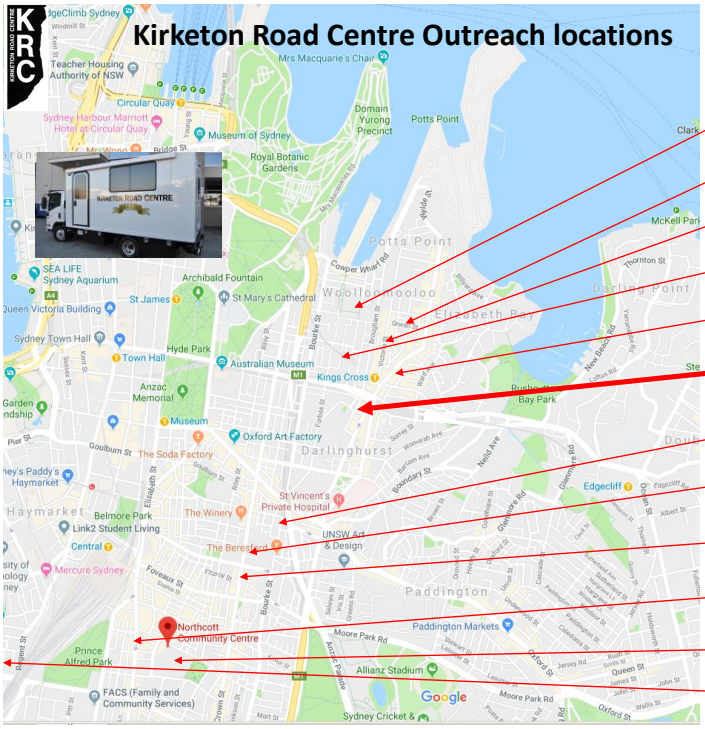
Accessibility

Barriers

- Location
  - Transport
  - Not close to other significant places
- Hours
  - Not focussed on client group
  - Limited times HCV care available
  - Expertise too tightly held
- System access
  - Referral required
  - Focus on medical model
  - Multiple visits required
  - Incomplete identification
- Limited value proposition
  - Few reasons to come to service other than Hep C

Facilitators

- Outreach and partnership models
- Flexible, late hours
- No-wrong-door; seamless services
- Opportunistic/ drop in options
- Need co-ordination, but broaden skill base
- No referral required
- Support access to correct ID e.g. medicare
- Nurse led services
- Inclusion of other staff, HEO/social worker/ peer workers
- Maximise reasons clients would attend rather than go elsewhere
  - Other clinical services
  - Social services
  - Community activities (BBQ, art, music etc..)



Affordability

Barriers

- Cost of transport
- Cost of co-payments
- Cost of time
- Opportunity cost

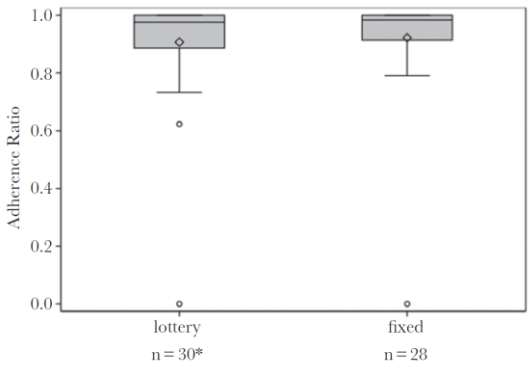
Facilitators

- Support transport
  - Other appts
    - Endoscopy/ imaging
- Use options to reduce co-payment
  - s100 in some states and territories
  - CTG where possible
  - Consider funding co-payment
- Minimise requirements for multiple visits, streamline process, rapid diagnostics
- Value add- food/social events
- Role of incentives in discrete moments of healthcare

Incentives

Financial Incentives for Adherence to Hepatitis C Virus Clinical Care and Treatment: A Randomized Trial of Two Strategies

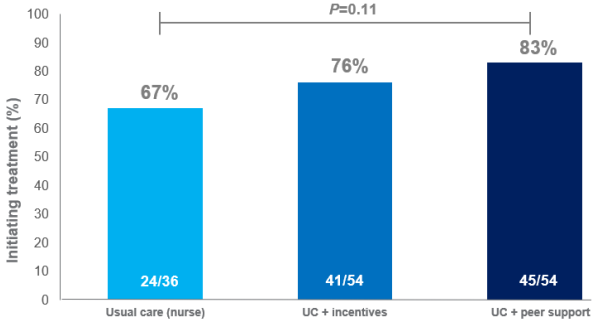
David A. Wohl,[1] Andrew G. Allmon,[2] Donna Evon,[3] Christopher Hurt,[1] Sarah Aileen Reifeis,[2] Harsha Thirumurthy,[3] Becky Straub,[1] Angela Edwards,[1] and Katie R. Mollan[3]



Wohl et al Open Forum Infect Dis. 2017; 4(2): ofx095

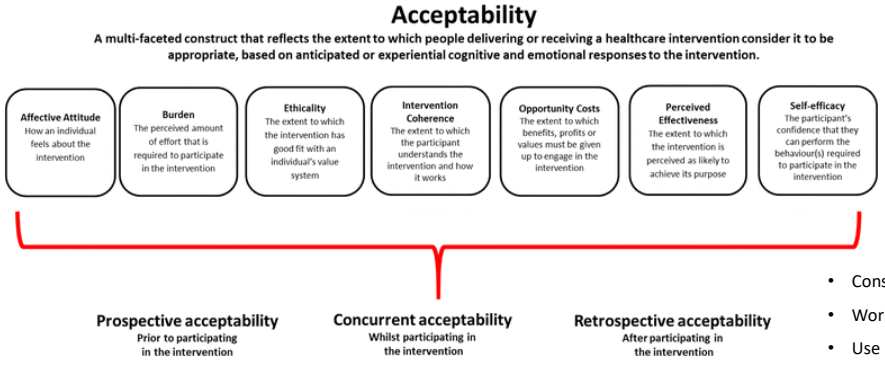
CHAMPS study HIV/HCV co-infected

- HCV genotype 1, 12% cirrhosis, 25% recent cocaine/heroin use



Sulkowski M, et al. ILC 2017, (SAT-228)

Acceptability

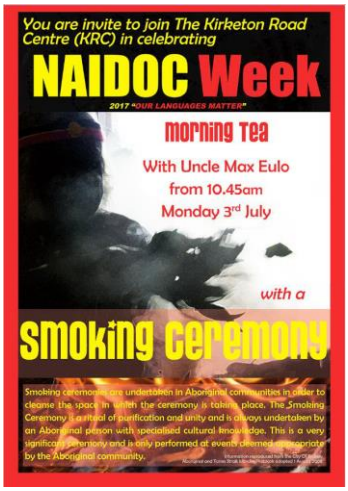


Sekhon, Cartwright & Francis, BMC Health Services Research, 2017 **17**:88

- Consumer consultation/representation
- Working with people with lived experience
- Use networks, word of mouth vital
- Consider not just clients who come, but try to find out about clients who don't come
- Orientation of space and service around client needs and expectations of the service
- Culturally informed practice
- Employment of representative staff

Aboriginal program “Itha mari”

- 2004- Itha mari
  - Barkindji “this way in the right direction”
- Holistic model- wellbeing, not disease focussed
- Employment of Aboriginal staff to drive program
- Issues and content determined by Aboriginal clients
- Aboriginal reference group- key partner organisations
- Client centred- set agenda
  - Decide which issues are important
  - Which barriers exist
  - What local solutions might work
- Activities/health promotion:
  - Groups- including on liver health
  - Lunches- NAIDOC week
  - Workshops
  - Art
  - Storytelling
  - Movies



Equitability

“…Equity in health reflects a concern to reduce unequal opportunities to be healthy [which are] associated with membership in less privileged social groups, such as poor people; disenfranchised racial, ethnic or religious groups; women and rural residents…” . Braverman P, Gruskin S. Poverty, equity, human rights, and health. Bulletin WHO 2003; 81: 539-545

Barriers

- Confusing equity with equality
- Underestimating the impact of the social determinants of health
- Underestimating the pervasive impact of stigma and discrimination
- Believing that lack of success equates to lack of effort
- Lack of resources to provide the extra support vulnerable populations need within an activity focussed health budget

Facilitators

- Working with clients and community groups to understand needs/barriers
- Focus first on client priorities
- Training staff on key issues
- Measure service delivery and set targets for vulnerable groups
- Equity lens on service delivery
- Work with partners to advocate and explain resourcing requirements
- Apply for funding

Summary

- Clinical orientation towards vulnerable populations is vital for individual and societal health equity, but also elimination goals
- Elimination requires lots of models for care of different populations
- Primary health care delivering integrated Accessible, Affordable, Acceptable and Equitable models well suited to complex health and social needs of vulnerable groups
- Multiple barriers exist, but small inexpensive initiatives can make a big difference
- Measurement of equitable health care access is imperative

Thank you

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