

SHARED CARE
An Ideal Model for the
Management for Chronic
Hepatitis C

BY

SAROJ NAZARETH NP

M Clin Spec(NP) M App Sc,BHlth Sc,RN,NP

ROYAL PERTH HOSPITAL

PERTH, WESTERN AUSTRALIA

Hepatitis C – a major cause of morbidity



Epidemiology

- Chronic hepatitis C affects more than 170 million people world-wide
- Leading cause of liver disease
- One of the most common reason for liver transplantation world-wide
- In Europe and USA - 70% genotype 1
- In WA - 50% genotype 1

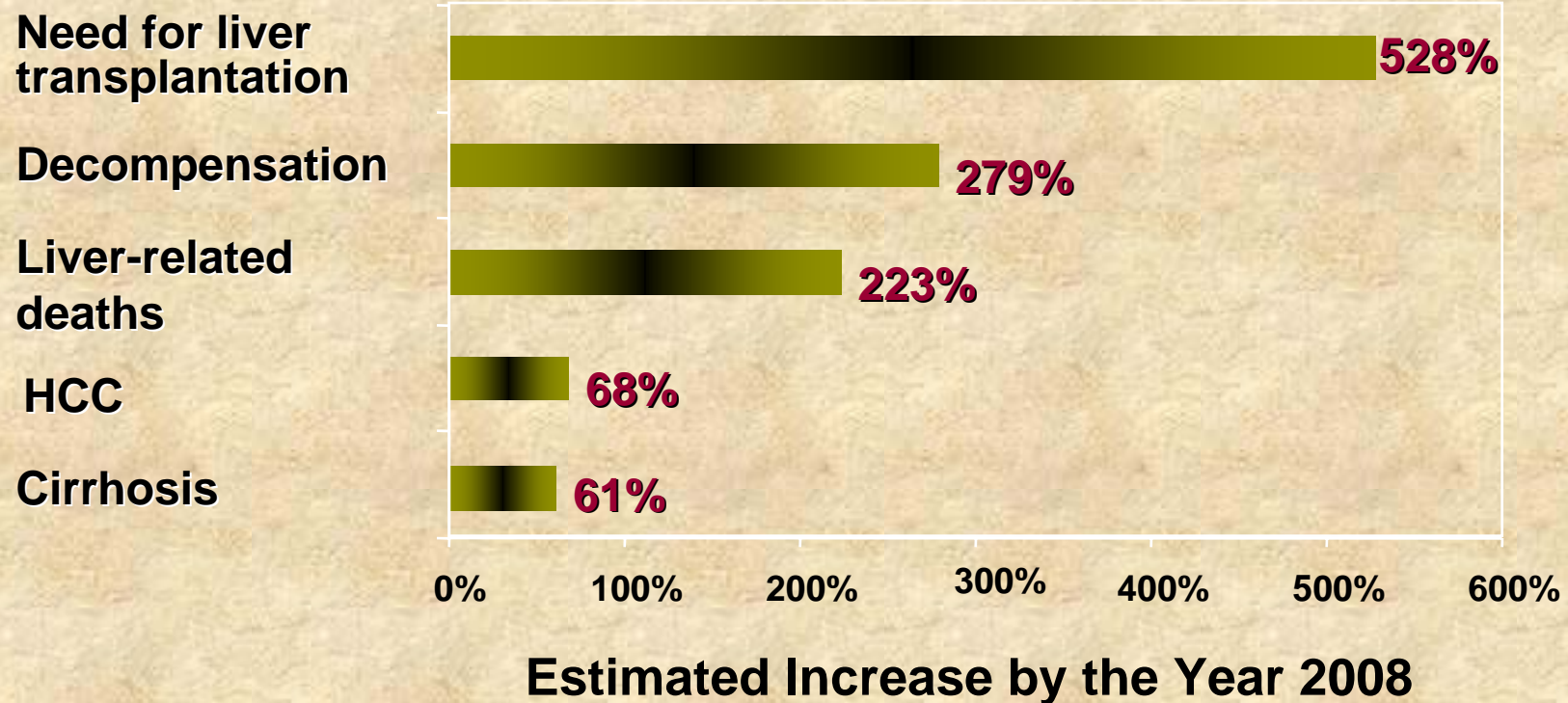
Hepatitis C - Australia

- 250,000 Australians affected by chronic hepatitis C
- 14,000 new cases per year
- 35,000 patients eligible for treatment annually
- <2,000 treated annually

Hepatitis C - WA

- About 20,000 people affected by Chronic Hepatitis C
- 1,200 notifications every year for the last 5 years
- Still under-reported

Future HCV Disease Burden



WA - IMPLICATIONS

- \$5.73 million over last 10 yrs for HCV admissions
- \$89,000 – liver transplantation
- 2020 – Liver failure - \$146,472.00/per episode
HCV - \$88.325.00/per episode
- Community – reduced ability to work, increased absenteeism, premature death
- Individual - stigmatism & marginalisation

Goals of Anti-HCV Therapy

- Primary goal
 - Eradicate HCV infection
- Secondary goals
 - Reduce hepatic inflammation
 - Slow disease progression
 - Reduce risk for hepatocellular carcinoma

WA Experience



Why Shared Care?

- HCV treatment – significant workload
- Increase in HCV: 1100-1300 notifications
- Improved treatments available
- Change in S100 criteria
- Currently only 1% access treatment

Hepatitis C Shared Care

Patient

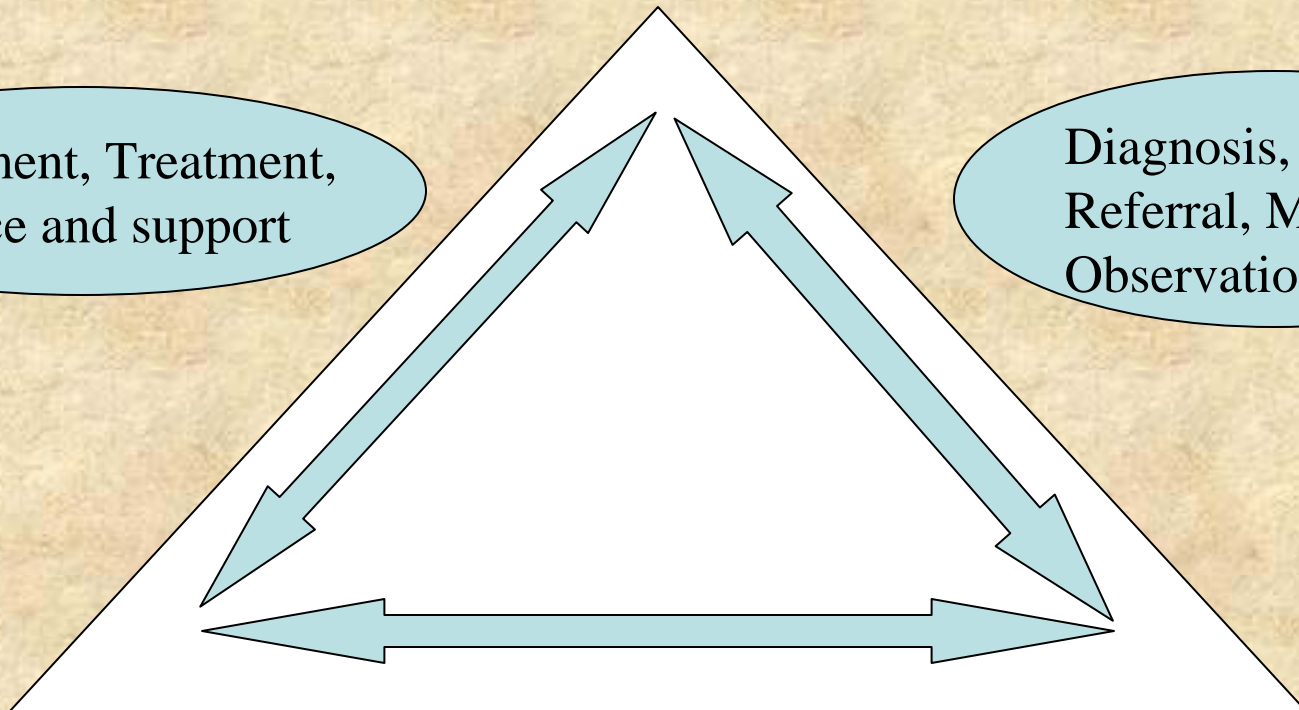
Assessment, Treatment,
Advice and support

Diagnosis, Counselling,
Referral, Monitoring,
Observation

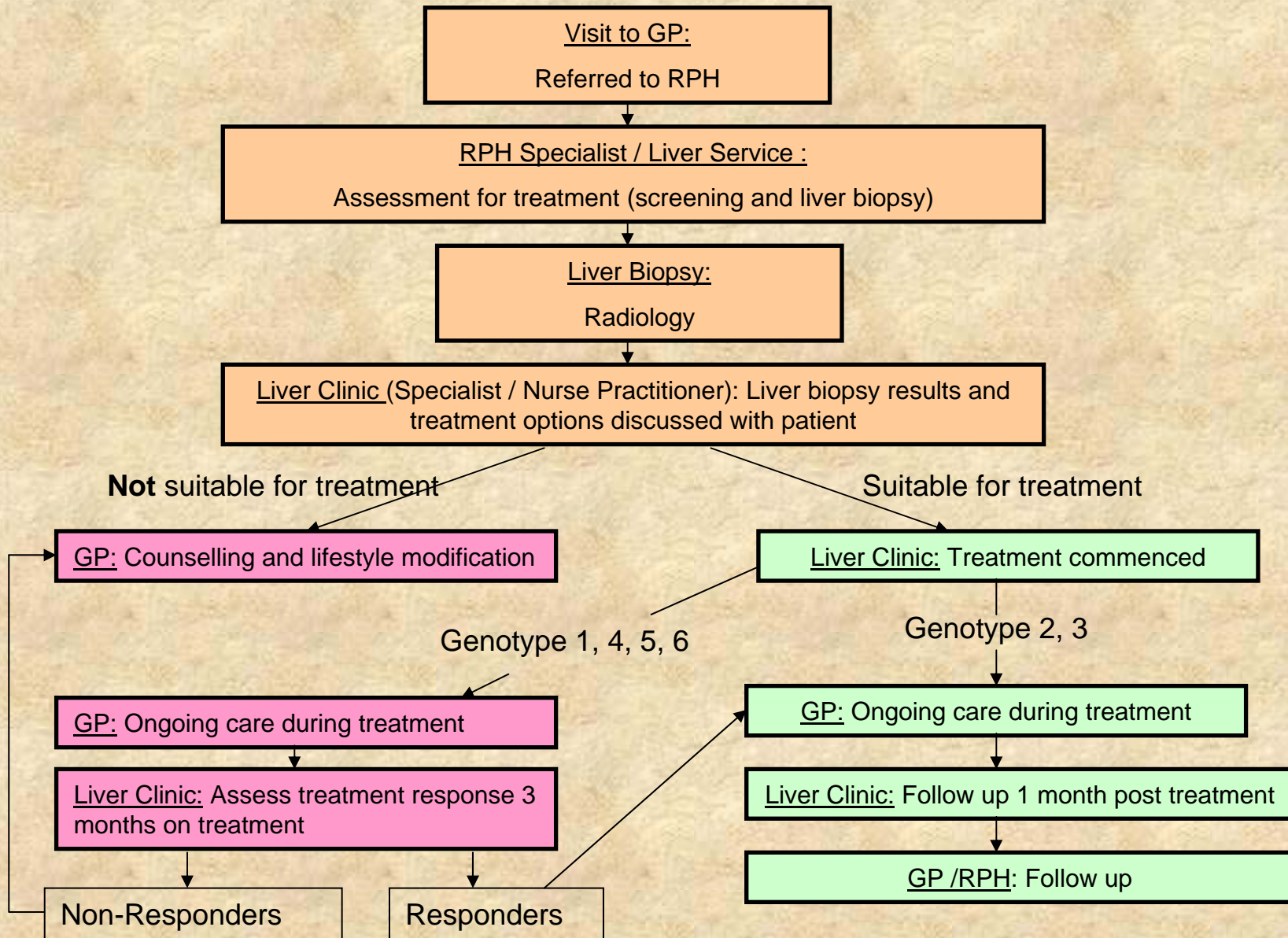
Specialist/Nurse

GP

Referral, Monitoring,
Education, Collaboration



GP Shared Care (RPH Model)



Guidelines for referrals for General Practitioners

- Patients suitable and ready for interferon/ribavirin therapy
- Patients with signs of chronic liver disease
- Patients with decompensated liver disease
- Patients with hepatoma
- Patients requesting referral

Initial Work-up

- Confirmation of Hepatitis C status
- Assessment of eligibility for antiviral treatment
- Assessment of severity of liver disease
- Counselling

Confirmation of Hepatitis C status

- History
 - Risks & source
 - Symptoms
- Examination
 - Signs of chronic liver disease
 - Signs of decompensation
- Investigations

Hepatitis C - History

- Source of infection
- Duration – severity of liver disease
- Symptoms
 - None
 - Non-specific
 - Symptoms suggestive of severe disease
 - Extrahepatic manifestations
(cryoglobulinaemia, PCT etc)

Hepatitis C – Investigations (1)

- Anti-HCV
- HCV RNA
- HCV genotype (implication for treatment duration)
- LFT – ALT elevation not longer required for treatment eligibility

Hepatitis C – Investigations (2)

- **Synthetic function**
 - Albumin (LFT)
 - INR
- **Other basic tests**
 - FBP
 - U&E Creatinine

S100 Criteria for pegylated interferon and ribavirin

- normal ALTs in conjunction with documented hepatitis C infection
- Female patients of child bearing age are not pregnant or breastfeeding

Summary of S100 criteria (2)

- Alcohol < 7 standard drinks per week
- No significant medical problems esp. cardiac, CNS, renal (ribavirin)
- No significant psychiatric problems – can be treated if well controlled
- Other causes of liver disease excluded

Note: HIV & IVDU not excluded

Section 100 criteria for treatment of HCV – duration of therapy

- Genotype 2/3 : treat for 24 weeks
- Genotype 1, 4, 5-9 : treat for 48 weeks
 - ***Quantitative HCV RNA has to be done at wk 12***
 - HCVRNA negative at week 12
 - HCV RNA at week 12 showed a 2 Log drop
 - If HCV RNA positive at wk 12 – has to be negative at week 24 to continue

Successful Shared Care

- Agreed and clear roles and responsibilities of all medical practitioners
- GP education
- Defined referral policy
- Point of liaison and coordination
- Defined follow-up program detailing frequency of visits and record of same

Successful Shared Care (ctd)

- Clinic Consultants who are accessible to GPs
- Information exchange based on unambiguous method of communication between GP and clinic
- The ability to identify patients who fail to attend appointment

Main advantages of shared care model

- **Patient**

- better relationship with GP
- familiarity with GP
- taking charge of health care
- GPs more available

- **GP**

- increased knowledge
- GP involvement and control
- ability to provide continuity of care
- increased satisfaction with aspects of patient care

» (Watson, 1999. Greenfield, 1996)

Main advantages of shared care model

- Hospital clinic
 - reduced workload
 - less waiting time for new referrals
 - ability to treat more patients
 - reduced waiting times
 - use of specialised services appropriately
 - sharing of responsibilities

Shared Care Responsibilities for GPs in Hepatitis C (1)

- Important to maintain link with community treatment centre/institutions initiating treatment
- Provide laboratory results and notify adverse events especially if severe
- Dose reductions initiated by treating centre or Specialist and CNC

Shared Care Responsibilities for GPs in Hepatitis C (2)

- Ensure that patients are reviewed at specified times
- Maintain good communication with the community treatment centre/institutions
- Shared Care Protocol for schedules of visits

Roles of GP in HCV Management

- Identify high risk subjects for testing
- Counselling and psychosocial support
- Pre-test & post-test counselling
- Initial investigations
- Identify subjects suitable for treatment
- Commitment and participation in Shared Care
- Participation in continuous update

Shared Care Responsibilities for GPs in Hepatitis C (1)

- Important to maintain link with institutions initiating treatment
- Provide laboratory results and notify adverse events especially if severe
- Discuss with institutions before discontinuing treatment as other modalities may now be available eg EPO, GCSF (expensive but successfully used in a few)

Shared Care Responsibilities for GPs in Hepatitis C (2)

- Be readily accessible to patients undergoing treatment – support and supervision
- Ensure that patients are reviewed at specified times
- Maintain good communication with the institutions
- Shared Care Protocol for schedules of visits

Referral for Treatment

- Patient who has been worked up and suitable for therapy
- Duration of therapy to assess possibly eligibility based on fibrosis
- Patient with significant liver disease, signs of decompensation or HCC

Management of Hepatitis C

- Shared Care between Specialists & GPs
- Nurse Practitioners at teaching hospitals
- Co-ordination of care
- Ensure patient compliance
- Ensure Patient **SAFETY**
- Keep up to date with evolving Section 100 criteria and new treatment schedules

THE FUTURE

- Utilisation of enhanced primary care plans
- Implementation of the hepatitis C data base
- Establishment of Practice Nurses in the General Practice Setting
- Incorporation of the patient held record as part of the management plan
- Evaluation of the model to formalise the processes

Future for management of Hepatitis C (1)

- Better co-ordination between institutions and GPs
- Regular updates on changes in guidelines and new treatment
- Regular discussions between specialists, Nurse Practitioners and GPs to improve management strategies

Future for management of Hepatitis C (2)

- Easy accessibility for patients for treatment
- Evaluate the success of program by **treatment outcome** rather than number of patients treated
- Better and less toxic drugs
- More efficacious drugs required especially for patients with genotype 1

Increasing Access to Treatment

- Shared Care program especially rural areas
- Education programs
 - Rural
 - In conjunction with GP divisions
 - Conferences
 - Public awareness
- Other groups
 - Prison (RPH - Bandyup)
 - Ethnic groups – Vietnamese, Aboriginals
- Telehealth