Integrated Approach to Hepatitis C Services for Refugees in Rural and Outer Urban Victoria. What Parallels Apply When Developing Services for Indigenous Communities

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Introduction

Evidence suggests that marginalised populations respond to client centred models of service provision.
Barriers exist that limit access to services by these groups as identified in the Department of Health National Hepatitis C Strategy 2010-2013 and again in the revision for 2014-2017.
Barriers to engagement include language, economic and travel constraints. prescribing complexities or competing health priorities.

Identified priority groups included culturally and linguistically diverse (CALD) and Aboriginal or Torres Straight Islanders (ATSI). The Victorian Infectious Diseases Service (VIDS), Integrated Hepatitis C Service (IHCS) was established to improve treatment access through a range of community based services. The IHCS is coordinated by a Clinical Nurse Consultant (CNC) supported by Infectious Diseases Specialists, community partners and a service advisory committee

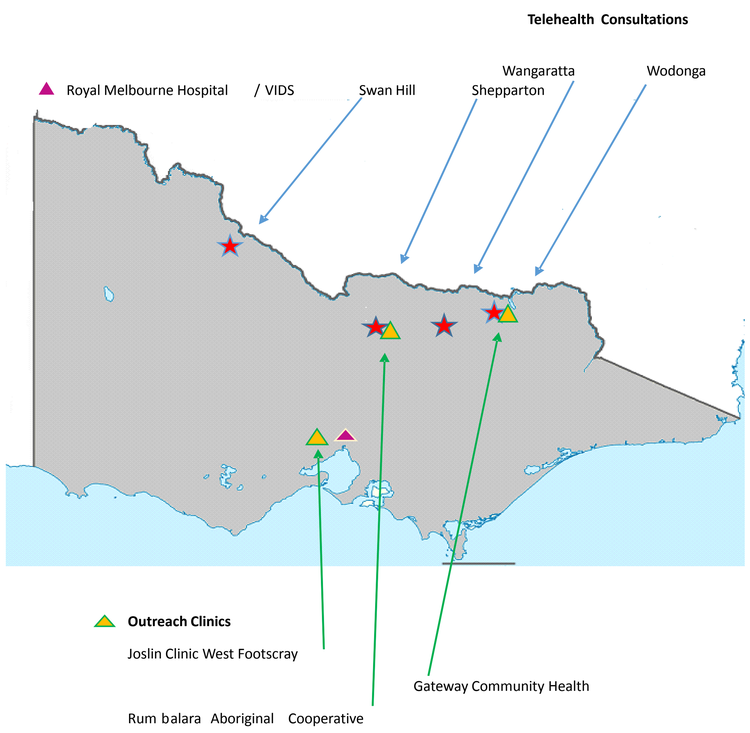
Aim

Our program included establishment of community based clinical services reaching an asylum seeker and refugee population and providing treatment access and care coordination in these settings.
The aim of this service was to provide community based treatment options and increase capacity by establishing sustainable hepatitis c management models which are culturally appropriate and accessible to the client group.
It was anticipated that the development of this service could be expanded include an aboriginal community cooperative in regional Victoria

Methods

Community Viral Hepatitis clinics were established and attended by an Infectious Diseases Physician. These clinics where located at community health services with high refugee case load in outer urban Melbourne and regional services at Wodonga and Shepparton.

This was also supported by a Telehealth service from VIDS



Integrated Hepatitis C Service locations and community health partners providing telehealth access to Infectious diseases specialist

Program Features

Telehealth (a video link over the internet) was utilized for consultations with clients in regional Victoria where an onsite clinic was not available.

Patients were required to attend the tertiary hospital only for a fibroscan and education session, otherwise all care could be provided locally by the General practitioner with specialist support via telehealth.

Portable fibroscan was used in the community clinics to minimize the requirement of additional appointments and travel

Interpreters used were either on site or telephone as per availability. The CNC was able to use interpreters when phoning patients to see how they were managing on treatment.

Local dispensing from regional hospital pharmacies or community pharmacies that were willing to participate in the program and supply medications

GP's provided monitoring between specialist consultations and facilitated with the provision of pathology referrals.

Community service partners enabled access to allied services including psychology, trauma counseling and case management

Care coordination

The CNC provided care coordination and links between client, specialist and GP. Treatment education was initiated by the CNC in the clients local outreach service, or for telehealth patients at a tertiary centre. Subsequent reviews were then provided via telehealth.

Emergency back up

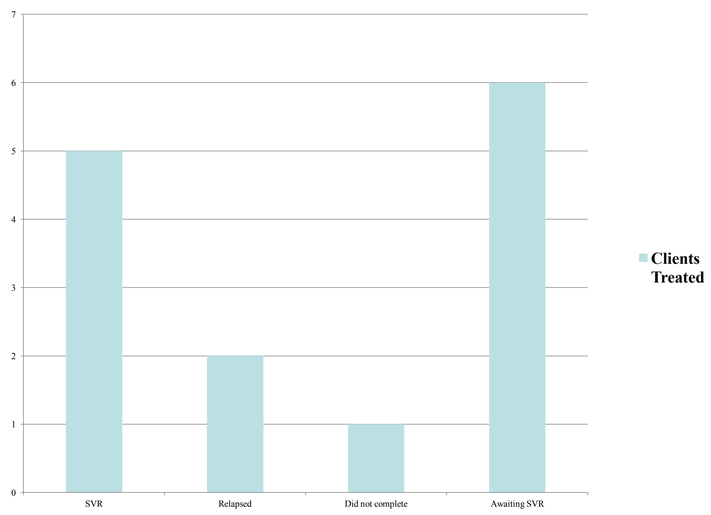
The CNC monitored treatment compliance, provided side effect management with 2-4 weekly support phone calls or scheduled visits. Additional contact was provided as required. Clients received copies of their treatment management plans including contact details of CNC and advice for out of hours or emergency support. Infectious Diseases Specialists were available at any time to provide specialist advice if needed.

Results

Patients country of origin

Burma – 5
Afghanistan – 5
Sudan – 2
Iran – 2

Patient outcomes



Referrals have increased from targeted priority groups seeking information, assessment and treatment. Refugee Clients commenced treatment via three community based infectious diseases clinics or via Telehealth

Fourteen clients from Afghanistan, Burma, Sudan and Iran commenced treatment with 93% (13/14) requiring interpreters. Six clients remain either on therapy or are awaiting SVR. Of the 8 that have reached post treatment review at 6 months, 5 have achieved SVR, 2 have relapsed and 1 client did not complete treatment and was lost to follow up.

The client that did not complete treatment, moved interstate. A transfer arrangement was coordinated by the CNC and a new local treatment centre but the client did not return to care or provide new contact details

Rumbalara Aboriginal Cooperative

Joslin Clinic

Conclusion

Hepatitis C treatment can be successfully managed in community settings employing varied and adaptable models of care

Care provision and shared care arrangements can be supported by access to telehealth to reduce client travel and cost restrictions

Uptake and compliance with treatment is achievable with care coordination and access to Clinical Nurse Consultants

Community partner support is critical for increasing capacity and ongoing sustainability of integrated services.

Culturally appropriate care can be enabled by use of interpreting services at all times when required or requested by the client

Acknowledgements

DoHA. (2010b).Third National Aboriginal and Torres Strait Islander BBVs & STIs Strategy 2010-2013. Australian Government Department of Health and Ageing. Canberra, Australia accessed at: www.health.gov.au.