SUPPORTING PATIENTS WITH CHRONIC HEPATITIS B: IMPROVING THE PATIENT EXPERIENCE THROUGH A SHARED MODEL OF CARE

Stone K[1,2], Robotin M[2], Porwal M[2], Tam N[2], George J[1]

[1]Storr Liver Centre, Westmead Hospital, NSW [2]Cancer Council NSW

Background: In Australia the prevalence of chronic hepatitis B (CHB) is increasing, with approximately 1% of the population affected. This is a key driver for rising levels of hepatocellular cancer (HCC), now one of the top 10 causes of cancer death in Australia. CHB is the main cause for rising HCC rates in Western Sydney, where the greatest burden of disease is among people born in hepatitis B endemic countries. Although viral hepatitis-related liver cancer is preventable by antiviral therapies, multiple barriers remain in the diagnostic and treatment continuum. Well trained and supported general practitioners (GPs) are critical in overcoming these barriers.

Method: A shared care model of CHB management was developed to support local GPs to deliver optimal care for their CHB patients which relies on a strong relationship between GPs, a Clinical Nurse Specialist, Liver Specialists and patients. A nurse-led Fibroscan clinic provides additional assessment toward appropriate care planning according to current management guidelines. A program specific CHB registry facilitates disease management and HCC surveillance. The model provides culturally appropriate, in-language CHB information to a diverse patient population with limited health literacy.

Results: The shared care model of CHB management was piloted in Western Sydney, 200 patients have been enrolled in the disease registry. The nurse led Fibroscan clinic provided assessment for 80 patients, supporting the initiation of antiviral medication. As a result 30 patients have been successfully initiated onto appropriate antiviral medication. All patients are invited to engage in a patient specific, in-language education program to increase community knowledge and further aid their CHB management.

Conclusion: The model enhances timely referral, monitoring and surveillance of patients according to guidelines, assisting in the prevention of HCC in the population at risk. Patients are empowered through engagement in regular chronic disease management education.

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