INTEGRATING HEPATITIS C TESTING AND TREATMENT INTO MULTIPLE COMMUNITY HEALTHCARE SETTINGS FOR THOSE WHO INJECT DRUGS: FACILITATORS AND BARRIERS

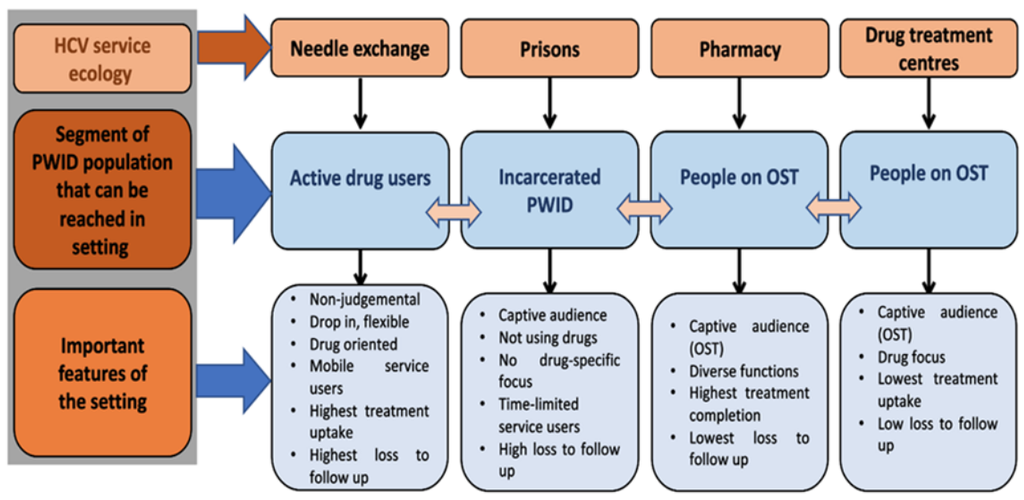
Vojt G[1], Murray A[2], Brown T[2], Fox S[2], Mudie P[2], Stephens, B[3], Tait, J[3], Hutchinson S[1], Hickman M[4], Dillon J[5], Flowers P[6], Elliott L[1]

[1]Glasgow Caledonian University; [2]Scottish Drugs Forum; [3]NHS Tayside; [4]University of Bristol; [5]University of Dundee; [6]University of Strathclyde

Background

The scale up of hepatitis c virus (HCV) testing and treatment provides opportunities to reach segmented, yet highly mobile, populations of people who inject drugs across various community outreach settings. Scale up of HCV treatment in this population may lead to HCV elimination. Research to date, however, has focused on facilitators and barriers in single settings. We report on the first qualitative study to explore systemic barriers and facilitators during the rapid scale up across a region in Scotland, NHS Tayside. By systemic we mean those that appear across the service landscape.

Diagram 1 Systemic upscale of HCV treatment across a regional service landscape: overlapping and segmented populations characterised by high rates of service user mobility



Methods

We interviewed 40 service providers and 31 service users from four HCV pathways: community-based needle and syringe exchanges, drug treatment services, pharmacies and prison. Using thematic analysis, we identified systemic barriers and facilitators to the key steps in the HCV pathway, and we grouped these into care areas of Access, HCV testing, HCV treatment and Support (WHO, 2016).

Results

We identified multiple systemic key facilitators across the four settings. There was only one systemic barrier, which was easily amenable via the provision of training, practice and staff supervision (diagram 2).

Diagram 2 Overview of key systemic barriers and facilitators

Access	Testing	Treatment	Support
• Nurse-led model • Co-location of services • Peer workers • Drop-in model • Teamwork and collaborations • HCV case tracing via (clinical) databases.	• Guidance and audit of HCV testing via the Managed Care Network • Diversity of staff skills in teams • HCV nurse specialists' skill set (interpersonal and phlebotomy) • Lack of staff skill and confidence in HCV testing	• Co-ordinating HCV care with other services (prescriptions). • Tailoring of treatment plans to service users' needs and preferences. • Service users' motivation to be healthy.	• The provision of support was a systemic facilitator per se. • Elements of support were evident in HCV access, testing and treatment. Specific forms and means of support, arguably, were typically setting-specific.

Conclusions

Scaling up HCV treatment across community settings is highly complex, however it is possible and evidence suggests that it is effective, i.e. bringing HCV care to mobile segments of PWID population. Policy makers and managers should be aware of the systemic facilitators required for successful scale up. These could be highlighted in service agreements and prioritised during implementation.

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Glasgow Caledonian University
Research Centre for Health (ReaCH)