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World Liver Conference 2018

May 25-26, 2018 | New York, USA

Successful cascade of care and cure HCV in more than 2000 drugs users: How increase HCV treatment rate in drug users by nurse outreach care, since screening to treatment

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Introduction: Although highest European screening rate in France, 33% of patients didn't take care of hepatitis C because there were no diagnosed. Drug injection was main contamination route of hepatitis C virus (HCV) in France and western Europe since 1990. French guidelines were to treat all inmates and drug users, even fibrosis level. Access of HCV screening, care and treatment in drugs users, prisoners and homeless was low in France. They were considered as difficult to treat populations. All these patients need support especially psycho-educative interventions. Hepatitis Mobile Team (HMT) was created in July 2013 to increase screening care and treatment of hepatitis B and C patients. HMT was composed of 1 hepatologist, 3 nurses, 1 secretary, 2 social workers, 1 health care worker, for a cross-disciplinary approach.

Objective: Increase outreach screening care treatment access and cure of our target population. Patients and methods Target population was drugs users, prisoners, homeless, precarious people, migrants and psychiatric patients. We proposed part or all of our services to our medical and social partners. There were 15 services for 42 medical and social units in half million people area. There were 4 steps: for early detection and primary prevention. 1) Screening by point of care testing PDBS (dried blood test) for HIV HBV HCV. 2) Green thread: outside POCT/DBS and FIBROSCAN** in specific converted van. 3) Outreach open center 4) Drug users information and prevention 5) Free blood tests in primary care for patients without social insurance 6) Staff training. For linkage to care and fibrosis assessment: 7) Social screening and diagnosis (EPICES score) 8) Mobile liver stiffness Fibroscan* (indirect measurement of liver fibrosis) in site 9) Advanced on-site specialist consultation. For access to treatment: 10) Easy access to pre-treatment commission with hepatologists, nurses, pharmacist, social worker, GP, psychiatric and/or addictologist. 11) Low cost mobile phones for patients. For follow up during and after treatment. 12) Individual psycho-educative intervention sessions 13) Collective educative workshops 14) Peer to peer educational program 15) Specific one day hospitalizations. All services were free for patients and for partners.

Results: From 2013 July to 2017 December, we did 4021 DBS for 3291 people (2053 HCV DBS) and 1165 Fibroscan*. HCV new positive rate was 19.8%. Our HCV active file was 504 patients included these 19.8% new patients screened by DBS; 96% realized HCV genotype, HCV viral load and FIBROSCAN. DAA treatment was proposed to 94%; 78% started treatment, 12% were lost follow up and 4% refused treatment. After treatment, there was 5 relapse and 3 reinfections by drug injection. Our cured rate was 76%. Sociological evaluation of our program showed that 4 program qualities for patients were free access, closeness (outside hospital), speed (of the results) and availability (of nurse and social workers).

Conclusions: Specific nurse follow-up of drugs users and other HCV high-risk patients including screening, early detection, diagnosis and treatment increase rate of treated and cured patients, with low rate of relapse and reinfections.

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