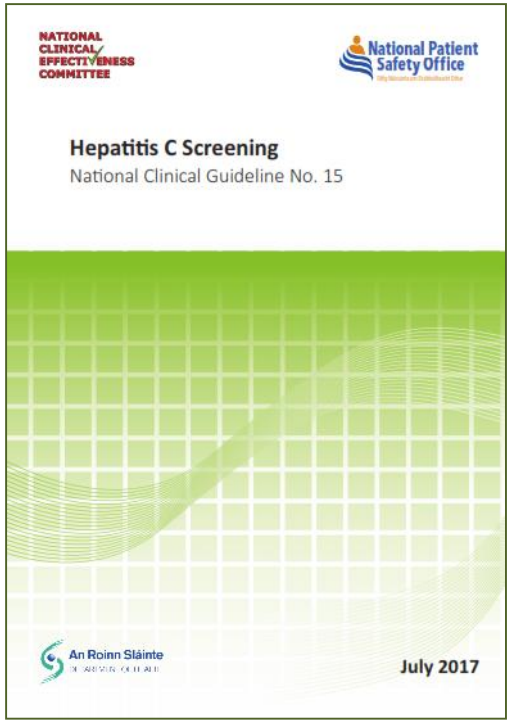
Hepatitis C Screening
National Clinical Guideline No. 15



NPSO Conference October 2017

Dr Lelia Thornton
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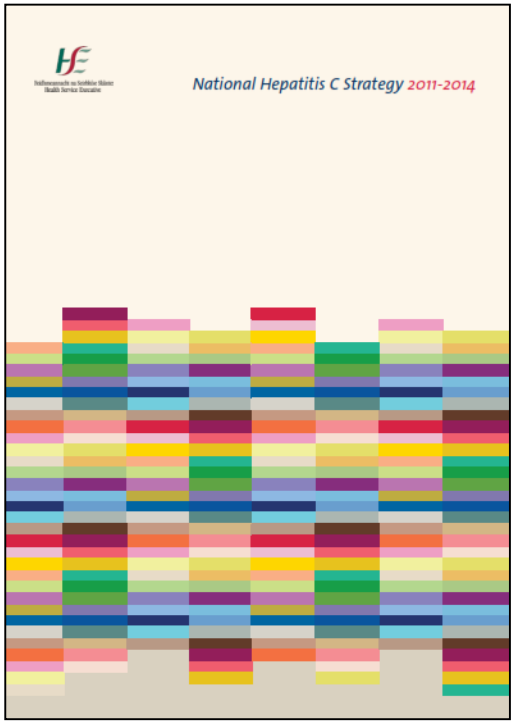
National Hepatitis C Strategy 2011-2014



Recommendation 23a	Access to diagnostic facilities
Recommendation 24b	Screening of prisoners
Recommendation 26	Screening of migrants
Recommendation 27a	Targeted antenatal screening
Recommendation 27b	Review evidence on antenatal screening
Recommendation 28	Screening at harm reduction
Recommendation 29b	Standard protocols for testing and diagnosis

Rationale for a national guideline

- With the development of new treatments the paradigm has shifted towards elimination
- Ireland has committed to a WHO target to eliminate HCV by 2030
- Aim to offer treatment to all
- However, up to 60% of those with HCV infection in Ireland are undiagnosed
- Cases may go undetected for decades, with significant future healthcare costs and risk of ongoing transmission
- Screening already in many settings but no comprehensive national guidance
- *WHO*: "….national testing policies are needed, as are increased investments in HCV screening services in order to reach the goal of elimination"*

*WHO Global Health Sector Strategy on Viral hepatitis 2016-2021

Summary of key questions

- Who should be offered screening for hepatitis C?
  - Specific population groups or risk factors
- Is there a role for birth cohort screening?
- How should screening be performed?
  - Test, specimen, frequency?
- Interventions to increase uptake and linkage to care

Who should be offered HCV screening?

Strong recommendations

- ✓ Those who have ever **injected drugs**
- ✓ **Non-injecting** drug users
- ✓ **Prisoners** or former prisoners
- ✓ **Homeless** people with risk behaviours
- ✓ **Migrants** intermediate/ high prevalence of HCV
- ✓ **Infants** of HCV-RNA positive women
- ✓ Men who have sex with men (**MSM**)
- ✓ People **on renal dialysis** or kidney transplant
- ✓ Recipients of substances of human origin
  - ✓ blood or blood components
  - ✓ anti-D immunoglobulin

Screening should be offered

Who should be offered HCV screening?

Conditional recommendations

- ✓ Those with a **tattoo** - decades ago, non-professional settings, prisons, high prevalence countries, poor infection control
- ✓ **Household** contacts – certain circumstances
- ✓ Recipients of **solid organ transplants**
- ✓ Medical or dental **treatment abroad** – high prevalence countries and poor infection control
- ✓ **Sexual** partners of known HCV cases:
  - ✓ If the case or contact is also HIV positive
  - ✓ If the HCV-infected case is an injecting drug user
- ✓ Commercial sex workers

Screening should be considered

Birth cohort screening

- Birth cohort screening – requires health technology assessment

Request for HTA submitted to HIQA. Included in prioritisation process – scored highly.

Implementation

- Who will be involved in implementation?
  - A range of services and sectors
    - HSE services, general practice, non-governmental organisations
- Areas of work
  - Education and training
  - Raising awareness
  - Access to testing
    - Existing services
    - Outreach services
    - New settings/ new services
  - Linkage to care
  - Integration of services
  - Overcoming language and cultural barriers to testing
  - Monitoring and evaluation

Implementation plan

Barriers to implementation	Facilitators to implementation	Possible actions to facilitate screening	Who will be responsible for implementation	Other stakeholders	Specific action required by GDG
Recommendation 5 and 6 - People who currently use or have a history of unprescribed medications or illicit drug use All those who have ever injected unprescribed or illicit drugs should be offered screening for HCV. This includes those who only injected once, and those who injected any type of drug which was not prescribed, including performance enhancing drugs like steroids, and novel psychoactive substances.					
Some may not perceive they are at risk (e.g. those that inject steroids). Poor venous access. Fear of testing of subsequent treatment. Unwillingness to admit behaviour to HCW. Access to testing for those not in services. Payment for testing if not in addiction services or don't have GMS card. Resources within addiction services. Lack of computerised system to indicate when last test performed. Laboratory resources.	Current practice for those attending HSE Addiction Services and methadone level 1 and 2 GPs. HepCare project. A number of NGOs provicing education and peer support. Needle exchange sites could be a setting to encourage testing. Safe injecting facilities being developed. MedLIS.	Awareness raising amongst public and other HCPs for those not attending addiction services and for those who have used drugs in the past. Outreach testing services. Targeted testing outside addiction services e.g. in GP. Education programmes in addiction services. Needle exchange as an opportunity to encourage testing (statutory, NGO and pharmacy). Safe injecting facilities being developed which provide a setting for education or testing. Audit of practice. Reminder systems on addiction services IT system.	HSE Social Inclusion/ Primary Care, Addiction services, GPs, HSE NHCTP and those providing outreach community treatment	Patient groups, NGOs, needle exchange sites, new consultants responsible for vulnerable patients in St James's Hospital and Mater Hospital. Relevant faculties and societies (ICGP, IDSI, ISCM, Public Health, Pathology) Diagnostic laboratories	Consult with stakeholders and disseminate final recommendations. Awareness raising for public/risk group.
Screening should be offered to all those who have used unprescribed or illicit drugs by a route other than injecting (non-injecting drug use (NIDU)), if there is a possibility of transmission of infection by the route of administration. This includes those who currently use intranasal drugs (i.e. snort or sniff), or have done so in the past, or share other equipment or drugs where there is a risk of contamination with the blood of others.					
Some may not perceive they are at risk. Lack of awareness amongst HCWs. Fear of testing. Unwillingness to admit behaviour to HCW. Access to testing for those not in services. Payment for testing. Laboratory resources.	Current practice in addiction services.	Awareness raising amongst public and other HCPs for those not attending addiction services and for those who have used drugs in the past. Outreach testing services. Targeted testing outside addiction services e.g. in GP. Education programmes in addiction services. Referral pathways to care for detected cases. Care co-ordinator and/ or peer support (e.g. HepFriend) to support retention in care. Community treatment services.	HSE Social Inclusion/ Primary Care, Addiction services, GPs, HSE NHCTP and those providing outreach community treatment	Patient groups, NGOs, new consultants responsible for vulnerable patients in St James's Hospital and Mater Hospital. Relevant faculties and societies (ICGP, IDSI, ISCM, Public Health, Pathology) Diagnostic laboratories	Consult with stakeholders and disseminate final recommendations; Awareness raising for public/ risk group Develop promotional and educational materials

People who inject drugs

Barriers to implementation	Facilitators to implementation	Po scr
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Migrants

Barriers to implementation	Facilitators to implementation	Possible actions to facilitate screening	Who wil implem
Recommendation 10 - Migrants Migrants from a country with an intermediate to high prevalence of HCV (anti-HCV ≥ 2%) should be offered screening.			
There is no dedicated health service for screening of migrants except for those who are asylum seekers. Many migrants may have poor access to health services due to language, financial, cultural, or legal barriers. Migrants are a diverse group with varying health needs and social circumstances. Different strategies are needed for different groups. There may be a lack of perceived risk. Fear of stigmatising migrants. Access to and payment for testing Laboratory resources.	Asylum seeker and refugee health programme is in place. HSE Social Inclusion/ Primary Care have commissioned SafetyNet to provide outreach services for some newly arrived refugees. This sets a precedent model for outreach services. Migrant screening guidelines are already in place for a range of infectious diseases including HCV (level of 3%). Some GPs are offering services to migrant populations in different languages. New HSE Intercultural Health Strategy is being developed.	Awareness raising amongst public and HCPs. Culturally appropriate information material. Education sessions in community venues frequented by migrants. Outreach testing in community (e.g. religious venues, cultural centres). Establishment by HSE of a testing service or HSE support for outreach testing services by NGOs as for HIV. Translation and interpretation services. Targeted programmes within GP. Inclusion in the new intercultural health strategy	HSE Soci Care; GP services, NGOs co care

Facilitators and barriers/challenges

Facilitators

- Current practice in many services
- Availability of safe and effective treatments
- Support from key stakeholders
- Initiatives and services such as Community Response, SafetyNet, HepCare Europe, many more – testing, education and peer support
- Rainbow Clinic
- Excellent lab services
- MedLIS
- Many more…

Barriers/challenges

- Vulnerable and difficult to reach population groups
- Lack of access to screening or treatment services
- Loss to follow-up – mobile pops
- Lack of awareness – public and health professionals
- Language/cultural barriers
- Lab resources – volume
- Limited resources for contact tracing
- Poor/absent IT systems
- Many more…..

Support for implementation

- Launch by Minister Catherine Byrne
- Endorsement by Minister Simon Harris with letters to HSE and key agencies
- HSE 2017 service plan:
  - "Support the development and implementation of relevant national clinical guidelines (…hepatitis C screening…) ensuring that the essential clinical leadership is in place"
  - "…progress the recommendations of the national clinical guidelines on hepatitis C screening (when published) within available funding"
- HSE 2018 service plan?
- Support of Department of Health

HSE National Hepatitis C Treatment Programme

- Very successful to date
- >2,000 patients treated over the past 2 years
- Essential facilitator for implementation of the screening guideline
- Temporary suspension of programme > temporary barrier to communication about screening recommendations

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Resources

- Will require some funding for full implementation
- Budget impact analysis: **€1.1m** annually for 5 years
  - Additional testing, additional services for key risk groups, information and promotion
- Since 2015, **€30m** annually for HCV drug treatment
- Many of recommendations are budget neutral – guidelines will help to standardise and streamline practice

Elimination of hepatitis C as a public health concern in Ireland

Recommendation 27

27.2 A national HCV programme with a mandate spanning the entire HCV continuum of care, including prevention, screening and treatment, should be established.

Guideline Development Group

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