Hepatitis Community Outreach Program (HEPREACH)

This is a new model of care occurring in a community setting with clinical and community partnerships, to better reach, engage and care for key groups in the community at risk of viral hepatitis and liver disease. These groups include Aboriginal and Torres Strait Islander peoples, cultural and linguistically diverse (CALD) and people of a refugee background.

Aim:
To engage with groups in the community that have disproportionately high rates of viral hepatitis infection, may be socially disadvantaged and not well integrated into traditional health services. To improve access to care as well as build health literacy and engagement with difficult to reach populations. Varied models of care are being investigated including "In-house", remote access and "Lite" practice support. Models of funding being utilised include block funding & MBS item billing.

Suitable patients:

Existing practice patients meeting the following criteria -

- Male and female patients > 18 years of age
- Attending a local GP clinic and either 1. Being considered for referral, 2. Been referred or, 3. been reviewed for liver disease in a tertiary clinic
- Have evidence of liver disease such as cirrhosis or current HCV or HBV infection based on positive HCV RNA or HBV DNA test by PCR.

Referral process:
Mater referral link is materonline.org.au

Please request on referral for *HEPREACH* community clinic

Contact:

Burglind Liddle
Nurse Practitioner Chronic Diseases – Hepatology
Mater Hospital Brisbane
burglind.liddle@mater.org.au
0466 829979

Associated Networks

Refugee Health:

The Australian Refugee Health Practice Guide is part of a suite of resources to support GPs, nurses and other primary care providers. Support is provided on arrival and for ongoing care for people from refugee backgrounds and people seeking asylum.

refugeehealthguide.org.au/about-this-practice-guide/

This guide may hold particular relevance in support of patients eligible for care in HEPREACH clinics.

Ethnic Communities Council of Qld: (ECCQ)

This organisation is focused on support and advocating for the needs, interests and contributions of culturally and linguistically diverse communities in Qld.

eccq.com.au/

ECCQ supports making available a Fibroscan unit for utilisation in Mater HEPREACH clinics.

Hepatitis Qld:

This community based organisation provides amongst other things telephone support for patients with hepatitis and health professional friendly resources.

hepqld.asn.au/

Pictured: *Drs Armstrong & Chang alongside Practice Manager Eva and Mater Nurse Practitioner Burglind. Located in a practice supporting the in house model.*

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Frequently asked questions

What are some of the program strengths?

Patients have the option to attend a community based Hepatitis clinic rather than having to travel to a hospital outpatient clinic.

Implementing a community-based integrated model of care for patients with liver disease. This allows for early intervention for liver disease in order to prevent admissions with advanced liver disease or liver cancer.

How does the program improve General practice?

General Practice GPs can be upskilled in the clinical area of Hepatitis and may opt to complete Continuing Professional Development (CPD) training offered by the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM).

This is an exemplar of shared care arrangements between specialists, GPs and Nurse practitioners.

Community general practices can be identified in order to deliver greatest impact for patient care. These practices have high hepatitis caseloads, CALD and refugee background patients or are Aboriginal and Torres Strait Islander Health (ATSICHS) Clinics.

Models of Care-In house model

Visiting team

Hepatologist clinic with Fibroscan clinics (performed by NP) 4 weekly.
Nurse Practitioner (NP) weekly.
Research study co-ordinator weekly (While research project is occurring).

Patients care

Existing practice patients meeting HEPREACH criteria. Patients living in the area of outreach clinic who meet the HEPREACH criteria.
All patients referred via Mater referral system.
Patients can remain engaged at practice for ongoing chronic disease care.

Provision of support to medical and nursing team of practice

Learning and training opportunities to co-manage patients.
Weekly mentorship opportunities.
Shared clinical guidelines and tools.
Availability by phone established advice line.
Guided referral pathway for escalation of care to tertiary setting including but not limited to monitoring requirements i.e. screening endoscopies, and diagnostics Liver MRI.
Letters/ patient care summaries made available after patient review.

Maintenance and support

Availability by phone established advice line.
Referral pathways for escalation of care.
Remote consultation forms (Hepatitis C).
Health Management plan.
Supportive role for GP management plans- Chronic Disease Management Plan.
Infrastructure requirements from practice.
Memorandum of Understanding (MOU) signed by both parties.
2-3 consulting rooms.
Access to practice software and internet.
Timeframe for ongoing outreach clinic to be negotiated.

Evidence Data

Number of Hep B/C patients seen in community clinics: (June – July 2019)

ATSICHS Woolloongabba: New: 5 Review: 5
Beaudesert Road Surgery: New: 3 Review: 43
Inala Primary Care: New: 5 Review: 59
Total all clinics: 120

These numbers are testimony to consistence patient presentation at community clinics.

FTA rates for community clinics (June-July 2019):

Beaudesert Road Surgery & Inala Primary Care:
122 Appointments
13 FTA (10.65%)
Non- English 6 FTA (4.92%)

These fail to attend (FTA) rates are equivalent to Mater FTA outpatient's rates indicating performance is maintained in community clinics.

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