Hepatitis c virus

Health & Medicine, Healthcare

With the WHO goal of HCV elimination seeming more achievable with the new DAA therapy, nurses are uniquely positioned to be the final and vital spoke to get the machine running efficiently. History has shown that nurse led programs in HIV treatment were successful and many developed and developing countries have adopted nurse led models in the fight against HIV.

Nurses have theeducationto be a useful ammunition in the fight against HCV infection. Nurse led programs can be a cost effective alternative and also help to decentralize HCV care and improve access. Certainly, progress in HCV care has been appreciable. Nurses have been integrated into the system in novel ways and numerous studies have shown that the effect is an improved rate of recognition of the infection, treatment uptake and adherence and achievement of sustained virologic response (SVR).

Nurse are currently supporting physicians in treating HCV patients. Yet, this is not enough in bringing about any observable change in the epidemic of HCV. With the shortage of physicians and specialists, it is imperative to bring about policy changes that will allow nurses to treat HCV. What is lacking is the involvement of nurse practitioners (NPs).

This is the age of DAA and no time has been better than today in involving NPs in the fight against HCV by giving them prescribing authority for DAA. Study conducted in United States (US) showed similar treatment outcomes for HCV infected patients with care by NPs, PCPs and specialists (Sarah et al, 2017) concluding that HCV treatment provided by NPs was as safe as that provided by specialists.

An Australian study (Lloyd et al, 2013) conducted between 2009 to 2010 utilizing a nurse led program in prisons with specialist supervision via telemedicine also showed safe and effective HCV treatment outcomes. The newer regimens of DAA which have lesser adverse effects can be easily prescribed by nurse practitioners who have the relevant education and experience.

NPs in Australia have already been given the authority to prescribe DAA (Gastroenterology Society, 2017), and US and Canada can take important lessons from the success of this policy change. Nurse practitioners working in nurse led models in prisons, rural areas, and with hard to reach groups like PWID can bridge the gap due to non-availability of specialists. Expanding the scope of practice of NPs is especially relevant today in order to improve uptake of high risk groups into treatment.

PWID have a high prevalence of HCV (systematic review 60 – 80% of IDUs in 25 countries had anti HCV while > 80% IDUs had anti HCV in 12 countries https://www. sciencedirect. com/science/article/pii/S0140673611610970) and are the core group of transmitters. Treatment uptake is low in this group and yet the success of HCV programs is not going to be substantial if issues of HCV detection and treatment in PWID are not addressed effectively.

PWID have many barriers to accessinghealthcare, including but not limited to criminalization, poverty, mental health issues, addiction related issues, stigma and marginalization. But they are more likely to be engaged with community level health care providers like primary care physicians and

nurses (Milne et al, 2015) in low threshold settings where they do not have fear of stigma or criminalization.

Expanding the role of NPs to improve capacity to provide HCV care in these settings will lead to shorter wait times, improve information sharing with patients, advance engagement with the health care team and deliver better treatment outcomes. Prison environments have a huge concentration of HCV infected inmates. 24% of federal prisoners and 23% of provincial prisoners were positive for HCV antibody (Trubnikov 2011).

Prisoners are at high risk of passing on the infection due to sharing of drug paraphernalia and are able to spread the infection once out in the community. Rural and remote areas also have disproportionate allocation of health services putting those living in these areas in the demographic of marginalized. Patients are less likely to travel large distances to start and complete treatment. Nurse led models in these two settings are urgently needed to improve HCV care.

Nurse led model: a protocol based treatment program can be developed and tailored to cater to the needs of specific populations in community care clinics, OST centers, prisons, rural/ remote areas. The protocol can include relevant history taking, clinical assessment, investigations including the nurse performing transient elastography and triaging patients to determine the risk of each patient.

Based on this the nurse would either start treatment, do a one on one consultation with the physician or refer the patient to consult with the

physician using telemedicine. Follow up assessments should be conducted and referred for any adverse effects. In prison environments, patients who are released before the end of treatment should be referred to the community center and appropriate continuation of care must be in place.

With shorter DAA regimens and better tolerated drugs, more number of prisoners may be offered HCV treatment and more number of inmates may be motivated to complete treatment upon release. Future research should focus on impact of nurses in protocol driven treatment of HCV, nurses dong fibro scan as compared to physicians, efficacy of DOTs therapy in HCV for those populations with adherence issues.

Increased funding for specialty education for nurses in viral hepatitis to improve HCV care would definitely improve capacity in the fight against HCV. Lack of treatment for the marginalized is unfair and inexcusable. Nurse led programs in HIV care provided improved outcomes in all indicators and is evidence that they will be crucial in the war against HCV.

Nurse practitioners need to rise to the challenge and advocate for better patient care among those affected with HCV by demanding prescribing authority for DAAs. Nurse led model in HCV care is an effective strategy to attain the WHO goal of elimination of HCV by 2030.