

A piece of the jigsaw of primary care: health professional perceptions of an integrated care model of hepatitis C management in the community

Carla Treloar PhD; Rebecca Gray PhD; Loren Brener PhD

ABSTRACT

INTRODUCTION: There is growing interest in increasing uptake of hepatitis C (HCV) treatment. HCV is strongly associated with injecting drug use and is a stigmatised illness. People with HCV may be reluctant to engage with health care services. A community-based, nurse-led integrated care clinic was established in Christchurch, New Zealand with the intention of bridging the health care gap for those unwilling or unable to access mainstream health care. This paper explores the experiences and perceptions of health professionals regarding the implementation of this clinic, with particular attention paid to the interprofessional relationships relevant to the clinic.

METHODS: Qualitative, in-depth interviews were conducted with 24 stakeholders, including four staff of the clinic and other service providers with varying relationships to the clinic.

FINDINGS: Participants generally endorsed the clinic model and described its operation as easy to access, non-judgmental and non-threatening, and, therefore, able to attract and engage 'hard-to-reach' clients. The clinic model was also thought to support more effective use of health resources. Some participants expressed concerns regarding the potential 'poaching' of patients from other services (particularly general practice) and indicated a preference for HCV treatment services to be restricted to hospital settings.

CONCLUSION: The findings of this study suggest the need to address concerns of general practitioners regarding patient poaching. Key information to disseminate is the clinic's success in engaging with complex clients and contribution to more efficacious use of health service resources. These activities may require the advocacy of a key local opinion leader acting as 'knowledge broker'.

KEYWORDS: Community health services; hepatitis C; interprofessional relations; primary health care; qualitative research

Centre for Social Research in Health, The University of New South Wales, Sydney, New South Wales, Australia

Introduction

Hepatitis C (HCV) is a major public health challenge, with a prevalence of more than 50% among people who inject drugs in 49 of 52 countries reviewed.¹ Efforts to increase levels of treatment uptake are important to both reduce the impact of the disease for people living with HCV and also to decrease the health care burden relating to advanced liver disease.² However, treatment is long (6–12 months depending on genotype) and arduous, with a range of physical and psychiatric

side effects. The majority of people living with HCV have acquired this via injecting drug use.¹ Some of this group may have complex physical health, mental health or broader social needs.³ Hence, conventional health care system delivery for HCV located in specialist tertiary hospital clinics does not meet the needs of many people living with HCV,⁴ and these needs may not be adequately addressed in primary care.⁵

In many countries, alternate systems of delivery to provide HCV care and treatment are being tri-

J PRIM HEALTH CARE
2014;6(2):129–134.

CORRESPONDENCE TO: Carla Treloar

Centre for Social Research in Health, The University of New South Wales, Sydney, NSW 2052, Australia
c.treloar@unsw.edu.au

alled including drug treatment settings,^{6,7} general practice,⁸ prisons,⁹ and in community settings,^{4,10} some of which use multidisciplinary teams and include peer workers.^{11,12} These shifts in health care provision are built on the recognition of low uptake of HCV treatment among people with a history of injecting drug use,¹³⁻¹⁵ and moreover, an understanding that this client group may be reticent to enter health systems because of concerns of stigma and discrimination.¹⁶ Further, these initiatives recognise that although services may exist to address health and social needs, service provision is typically fragmented (for example, social work and mental health services are provided separately to drug treatment).⁷

Integrated service provision has been promoted as more able to flexibly and responsively meet the needs of people with chronic conditions, compared to fragmented services

International literature has noted that general practice consultations have retained a focus on periodic visits, with a curative medical approach that may not meet the needs of people with multiple health and social problems.^{5,17} Integrated service provision has been promoted as more able to flexibly and responsively meet the needs of people with chronic conditions, compared to fragmented services.¹⁸ Managed care networks, otherwise known as shared or integrated care networks, aim to address the low numbers of patients accessing mainstream health care.^{4,19} These models emphasise the importance of providing services beyond clinical care, and to work in ways that broach the boundaries of primary and secondary care in offering a comprehensive range of services.²⁰⁻²³

Emergent literature that describes innovative health care approaches, including for HCV, typically includes descriptions of care arrangements and evidence of effectiveness via reporting of treatment uptake, treatment completion, and sustained virological response (or cure). While useful for replication in other sites, this literature does not provide a critical account of the chal-

lenges in implementing innovative health care models, particularly the structures, processes and interprofessional relationships that facilitate development and implementation of these models.²⁴

New Zealand, like most developed countries, faces a number of challenges regarding the provision of HCV care and treatment. The New Zealand *Action on Hepatitis C Prevention* plan included the statement that HCV-positive individuals' 'lifestyle and psychosocial factors, and their marginalisation from the wider community, may limit their desire to access treatment and support services or prevent them from talking about their injecting drug use with those involved in their care'.²⁵ To address the range of issues outlined, an innovative HCV care model was implemented in Christchurch, New Zealand.

The Hepatitis C Community Clinic was funded by the Canterbury District Health Board, and established in 2008 as a three-year pilot aimed at bridging the health care gap for those unwilling or unable to access mainstream health care. This free clinic uses a model of integrated care, in collaboration with primary care, drug treatment and HCV treatment services. Alongside a nurse, the clinic is staffed by a social worker, general practitioner (GP) and a receptionist. The clinic had auspicing from the local Needle Exchange Programme and the two services were closely located to facilitate referral. The majority of clinic clients are past or current injecting drug users and self-refer to the clinic. An Advisory Group was convened with the aim of providing a forum for consultation and collaboration, to meet operational and strategic goals and to identify best practice within the service. The group was composed of stakeholders associated with the wider health community response to HCV in Christchurch, including academics, consumer representatives, methadone service providers, hospital-based HCV staff, representatives of primary health organisations, community organisations, and the auspicing Needle Exchange Programme. The clinic nurse promoted the service to local GPs and drug treatment services. The aim of the clinic was to work in concert with clients' GPs, where clients were registered and agreed to this, and to promote registration of a client with a GP if the client was not already

registered. Funding of the clinic was extended for 12 months and then an additional two years at the conclusion of the initial trial period. At the end of 2012 (three-and-a-half years of operation), 718 clients had been registered with the clinic, 131 clients had been referred by the clinic for HCV treatment, 43 people had started treatment, 32 people had completed treatment and 24 had achieved a sustained viral response.

This paper explores the experiences and perceptions of a range of stakeholders regarding the implementation of this community-based clinic, with the aim of illuminating the opportunities and challenges of working at the interface of conventional health care service divisions. In examining stakeholders' views of the interprofessional relationships that impacted on the functioning of the clinic, this paper contributes to the growing literature regarding novel and innovative health care models in HCV care and treatment.

Methods

In total, 24 interviews were conducted, including 20 staff members, stakeholders and health care professionals involved with, or making referrals to, the Hepatitis C Community Clinic, and four participants who were not involved with the clinic and who had not referred clients to the clinic. These four individuals were targeted to ensure that the sample included participants who may have chosen not to engage with the clinic. These 24 participants represent the majority of relevant stakeholders. Individual, semi-structured in-depth interviews of 30–90 minutes' duration were conducted by two experienced researchers (RG, LB) between April and November 2010. Interviews were digitally audio-recorded and transcribed verbatim. Transcripts were checked for accuracy, de-identified and pseudonyms applied to protect participants' anonymity. Written consent was obtained from all study participants prior to the interview. Ethics approval for the research was given by the Human Research Ethics Committee of the University of New South Wales, Australia, and the Health and Disability Ethics Committee, New Zealand.

Participants were asked to describe their professional backgrounds, their knowledge of HCV and

WHAT GAP THIS FILLS

What we already know: There is a need for different models of care to meet the multiple and complex needs that some people with hepatitis C can experience. Integrated care has been explored in a number of areas to provide coordinated and multidisciplinary care and may be particularly useful for those experiencing vulnerability and marginalisation.

What this study adds: Implementing innovative health care models requires work to effectively position the service within existing services, and to manage the relationships between the service and its stakeholders. Incorporating a specific diffusion or brokering component to implementation of innovative health care models is important, to examine and negotiate any sources of misunderstanding.

the sector (including their opinions of the experience of people with HCV seeking health care), and their experience and opinion of the clinic (including strengths and weaknesses). In analysis of the data, a SWOT framework was used in order to establish key features of the clinic's current operation and provide suggestions for the future. A SWOT analysis aims to explore participant perceptions and experiences of the Strengths, Weaknesses, Opportunities for improvement, and Threats to future operation. The SWOT analysis was complemented by an inductive analysis that aimed to produce additional key themes, enabling a deeper interpretation of the data. Periodic meetings between research staff were conducted to critically examine these key themes. The analysis presented here focuses on the themes of interprofessional relationships that related to the strengths, opportunities, weaknesses of and threats to the clinic. The participants described various weaknesses or threats to the clinic model related to interprofessional relationships in this setting. To ensure that these weaknesses are seen in the context of the participants' overall evaluation of the clinic, participants' views of the clinic's strengths are also presented.

Findings

The sample comprised 19 women and 5 men and included nurses (n=7), managers (n=7), counselors and case workers (n=4), general practitioners (n=2), academics (n=2), a consultant physician (n=1) and a receptionist (n=1). Participants had

been in their current professional role between 12 months and 25 years. The majority of participants (n=19) had been in their current role for five years or longer.

Participants generally endorsed the model of a community HCV clinic and identified a number of strengths relating to the philosophy and operation of the clinic. The style was described as 'low threshold' and easy for clients to access, 'non-judgmental' and 'non-threatening' and, therefore, able to attract and engage otherwise hard-to-reach clients. The clinic had established links with a range of health care and community services and had taken referrals from GPs and methadone clinics. Participants perceived that clients were provided with up-to-date diagnosis and treatment advice, as well as health care information that went beyond typical HCV treatment and GP consultations. In this way, the clinic was perceived as able to retain and support clients to enable treatment-readiness through case management and social support, and to provide information that would prevent further transmission of HCV. These aspects of the clinic operation, along with continuity of care, were also described as particularly important for 'marginalised' clients.

I think [the client] was reassured because he knew he was going to be going to the same person. He wasn't going to have to go into a big organization or a hospital and speak to a different nurse every time, and say, 'I'm here for the hep C clinic,' [whispers] you know. That stuff. It's like to have the same person, the same case manager; you don't want to have to 'spill your guts out' to someone in officialdom and then go back next week and that someone's not there, and you have to do it all again. (#1, clinic stakeholder)

Besides concerns about engaging with multiple workers at a larger clinic, participants felt that consulting a GP for HCV care was potentially problematic for this client group. This included the costs for a consultation and the brief style of care offered in general practice that may not meet the complex needs of some clients. It was felt that clients felt an HCV diagnosis made in the general practice setting may result in negative judgments:

I think a lot of people who access the service don't get health care, to be quite honest. They can't afford to go to a GP because they haven't got the money and can't come by the money to see the GP. And they tend not to go because it's not a priority for them perhaps or they fear judgment, or various other reasons they may have. A lot of it's just poverty and disadvantage. (#2, clinic stakeholder)

Participants also identified that the clinic was able to provide care beyond that available within a conventional general practice consultation. Some participants felt that health care for this client group requires taking other social determinants of health into account to assist clients to achieve better health outcomes.

To increase the uptake and access of treatment, you need to take in the contextual environment, or how your client group is living. And you're also bringing in your medical knowledge, to walk alongside the client and say: 'Well this is what your blood results were and this is what they indicate.' So you're explaining the whole way. If you go to see a GP or a specialist, and they say: 'Yes, you've got Hep C. Yes, you need treatment', that doesn't even 'touch the sides' with our client base! (#3, clinic staff member)

A further strength of the clinic was described as the potential to support more effective use of limited health resources. For example, it was noted that the community clinic could address patient issues that otherwise fell to hospital clinics to resolve for clients who did not have GPs or who did not want to discuss HCV with their GP; also that the clinic undertakes preparatory work (blood tests and education) that would otherwise take the time of relatively more expensive hospital staff and services. Further, one stakeholder noted the efficacy of triaging clients who need hospital services, while those who do not need such services can be attended to by the clinic.

If you really think of a kind of a 'lean' model of care, people who are coming to the hospital should only be those who, at the end of the day, really need to be in the hospital: the very sick ones, the ones who need more investigation, intensive treatment, etc. (#4, clinic stakeholder)

A number of weaknesses and threats to the clinic were also identified by participants relating to interprofessional relationships. The tensions between the clinic and other services were perceived to be underpinned by a lack of understanding of the clinic's role and purpose. Participants explained that clients accessing the clinic were probably not registered with GPs and did not receive HCV care elsewhere. Nevertheless, participants identified that GPs may see the clinic as a threat, due to potentially 'poaching' existing and potential clients, and that some GPs may have concerns of lost income or double handling of clients, resulting in a waste of resources.

I'm certainly aware [that] I've had a number of GPs very unhappy with it because they've had patients that they've seen... they've been in the process of referring [to the hospital] and then the patients have been seen at the HCV clinic, and ... had different things done from what the GP was already doing. And that's certainly made several GPs I've talked to very unhappy. (#5, participant not involved with the clinic)

Not all participants were in favour of the clinic model and some participants stated that they did not understand the role of the clinic. Moreover, participants also noted that they were aware of other health workers who did not understand the role of the clinic. Criticism of the clinic included the belief that providing HCV services in a community clinic setting was inappropriate and that such services should be restricted to hospital settings. To address these weaknesses, it was seen as imperative that the 'fit' of the clinic within current health infrastructure be further explained to stakeholders.

The clinic has to be seen as a piece of the jigsaw of primary care, focusing on HCV. So it shouldn't be seen as being in competition with primary care, which is one of the problems sometimes... that GPs might see it as a competition. ...It's there to complement. It's there to give an alternative pathway and an island of expertise within primary care, within that whole thing. So I think that's where it needs to become established, because you need to do it that way so then you'll get more primary care people referring patients in as well. (#4, clinic stakeholder)

Discussion

This nurse-led community clinic, which aims to promote HCV care and treatment in Christchurch, New Zealand, was generally endorsed by a range of health care staff and stakeholders. Participants noted a number of benefits to the HCV care sector. Firstly, the clinic was seen as providing continuous, high quality and holistic care. Secondly, the clinic was seen to attract clients who may not otherwise receive care for HCV and also that it prepared those who were interested in treatment to engage with the tertiary sector. Thirdly, the clinic model was noted as contributing to a more effective use of limited health resources by freeing up time in expensive hospital clinics. Participants perceived some weaknesses of the clinic operations in terms of the clinic being perceived as poaching clients from GPs, and in questioning the appropriateness of providing HCV care outside of the hospital setting.

This qualitative project involved interviews with 24 health professionals, including staff members of the clinic, health professionals actively engaged with the operations of the clinic and a small proportion of those not actively involved with the clinic. Other stakeholders not involved in this research may have held other views of the clinic operations. However, due to the voluntary, self-selecting sampling method these potential views are unknown. This study, therefore, does not provide an exhaustive account of views on the clinic's role and functioning. It does, however, contribute a comprehensive appraisal of the opportunities and threats to providing health care through such a model, by utilising a large dataset of rich, narrative material from a wide range of professionals directly and indirectly affected by these dynamics and phenomena. Other papers have explored the client experience of the clinic in detail.^{26,27}

These data must be seen in their larger context—that of the organisation of the New Zealand health system. Commentaries and analyses of New Zealand health care have identified that there is a general lack of clarity relating to the future of primary care.^{17,28} In this setting, services that work at the boundaries of primary and secondary care may be seen as threatening to those

who have previously had unrestricted access to the primary care market. Hence, focus is required on interprofessional relationships when establishing services, such as the HCV community clinic, to navigate sensitive territory.

The reporting of a lack of understanding of the clinic's role and concerns about poaching of clients suggests the importance of communication as a core part of establishing a new service. In the extensive literature on the diffusion of innovation, personal two-way communication is seen as a key means to reduce mutual distrust, promote interprofessional relationships and facilitate better understanding between innovator and clinician.²⁹ It may be that ongoing functioning of the community clinic requires additional efforts in 'knowledge brokering' via the advocacy of a key local opinion leader. These findings suggest two key aims of knowledge brokering. One potential endeavour would be to address the concerns of GPs regarding potential patient poaching. Another might be to promote the clinic's success in engaging clients with complex needs and contributing to more efficacious use of health service resources provided by hospital-based health workers.

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Acknowledgements

The authors would like to thank the Rodger Wright Centre and Hepatitis C Resource Centre Christchurch, and the participants in this study. Our thoughts are extended to those in Christchurch who lost so much in recent earthquakes.

Funding

The Centre for Social Research in Health is supported by a grant from the Australian Government Department of Health and Ageing. Funding was provided for this evaluation by the Canterbury District Health Board.

Competing Interests

None declared.