Challenges & Opportunities of HIV & HCV Care in Northern BC

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(Slide: Challenges & Opportunities of HIV & HCV Care in Northern BC)
Helmut Albrecht: This brings us up to Dr. Abu Hamour, who is an assistant professor at UBC and a consultant physician in internal medicine and ID in Prince George. Dr. Hamour is the director of numerous Northern BC health initiatives, including the Northern BC Travel Health and Vaccination Clinic, the Northern BC Hepatitis Care Society, and the medical director within the Northern Health Authority. Dr. Hamour is going to talk about challenges of HIV and hepatitis C care in Northern BC.

Dr. Abu Hamour: Thank you very much, and thank you very much to organizers for inviting me to speak today. One of the nice things about being last is that everything that we want to say has already been said [*laughs*]. So thank you very much.

(Slide: Initial Challenges)
I'm just going to give you a perspective, a clinician's perspective, on some of the challenges that we face in Northern BC. As I said, we mentioned – most of them we mentioned before me – social isolation; mobile population; before the STOP HIV Project, we had rising prevalence and rising mortality – thankfully that is now being reversed; late diagnosis; poor access to healthcare; multiple co-morbidities; adherence issues. Those are some of the main challenges that we deal with.

(Slide: Northern Health Authority)
Like Saskatchewan, we have lost area in northern BC, probably the size of France post-Germany plus Belgium, put together. Geography and distance is a big barrier to access to healthcare.

(Slide: Marginalized Populations Have Poor HIV Health Outcomes)
Most of the things that have been mentioned, in terms of access to antiretroviral therapy – adherence issues, mobility, and things that we face on a daily basis.

(Slide: HIV Exposure Patterns in NH, 1995-2005)
Mostly, our HIV population is IV drug use-related, and that brings with it major challenges.

(Slide: Late Diagnosis)
Late diagnosis is a major problem, in terms of people presenting late.

(Slide: Case History)
This is just an example. Aboriginal lady, 42 years of age, presented very late. Had many labs along the way. Being hep-C, being – having – had shingles, presenting with dysphagia and weight loss and she actually developed neurological symptoms. And it dropped and she was diagnosed with CD4 count 40 or less.

(Slide: HIV Associated Dementia)
She had HIV dementia with pontine demyelination. That doesn't project very well but she has a big hole in her pons.

(Slide: 26 yrs old male: 3-wks SOB, Cough & Weight Loss, CD4 = 40)
Another example is a young man who presented with breathlessness and cough. PCP was diagnosed. CD4 count was 40. And we see this on a regular basis.

(Slide: PCP)
This was the CT and the similar stains.

(Slide: Multiple co-morbidities)
Our patients seem to have all the co-morbidities related to hepatitis, viruses, or TB, or STIs.

(Slide: A Patient with Multiple O.I.)
This was an example of a patient, one of our patients, who had almost every symptom, opportunistic infection, in the book. Now she's on antiretrovirals and she's actually doing well. She's had every single infection you can think of along the way, from PCP to CMV to MAC – recurrent MAC infections.

(Slide: HIV and TB co-infection)
We see a lot of TB in our population. This patient has pulmonary TB.

(Slide: Miliary TB)
We also see miliary TB.

(Slide: TB osteomyelitis)
Disseminated TB or osteomyelitis.

(Slide: HCV in NH: 2004-2014)
HCV co-infection, HCV in general, is common in the north. Over the past 10 years or so, we've seen over a thousand patients in our clinic with hep-C.

(Slide: HIV & HCV Care in Corrections PGRCC)
But hep-C co-infection with HIV is also common, especially in the correctional facility. About 60% of HIV-infected patients in jails are co-infected with hep-C. In general, in Northern BC, the average rate is about 50% of hep-C infection among our HIV population.

(Slide: HIV-HCV co-infection management issues)
Hep-C itself comes with its own challenges of care. I won't go into the details, but I'm sure some of you may be aware of the – especially in the days of interferon, and thankfully now we moved to a new era of oral therapy – those are not a major problem. We don't have to deal with

interferon as much, though we still have to use it for certain patients with genotypes 2 or 3 in our province.

(Slide: Adherence to HAART)
Adherence is a major challenge, and that is, you know, we try to spend time and energy trying to improve patients' adherence and getting them as close to 90-95% as much as possible, but that is often not achieved.

(Slide: HIV Patients Jan. 2013)
So this just gives you an idea about our patient population, a snapshot a couple years ago of the patient population we have. We had 229 patients. Of those, 80% were on HAART and about 63% were suppressed. And of those, over 50% were HCV co-infected.

(Slide: Current Cascade of HIV Care in Northern Health)
This is a scene of the current clinical, or the cascade of care, at the moment, where we see that the retention rates are a bit better. We have 86% people attending care, 82% on treatment, 76% adherent to treatment, and about 68% were suppressed and undetectable.

(Slide: HIV/HCV at PGRCC)
In the jail population, this is just another graph to show you the breakdown of the patients in the jail maybe earlier last year. Of those, 20 (54%) were on treatment and suppression was better. Adherence was better, obviously, as you can imagine. 75% suppression in the jail population. But the rate of hep-C, again, was about 50%.

(Slide: Medication Adherence Support Program (MASP))
We have a medication support program, led by our HIV pharmacist, Jen Hawkes, who's done a great, tremendous amount of work in establishing this program, with those who are disadvantaged.

(Slide: What is MASP?)
The main aim is really to get people to take their medication by monitoring them and blister-packing and making sure that there are [*inaudible*] for those who need it.

(Slide: HIV Specialist Pharmacist)
So, promoting adherence, looking after the supply of medication, making sure that there's not going to be interactions, and looking also after, filling, basically, any gaps in the HIV care continuum. So our HIV pharmacist is a very important member of our care team.

(Slide: Interdisciplinary Team)
This is our interdisciplinary team. We have HIV specialist nurse, a hep-C specialist nurse and we have a nurse practitioner. And obviously the HIV pharmacist. And the clerical support staff.

(Slide: Picture of clinic)

This is our clinic. It's a purpose, sort of, design – in a way. It wasn't really. It was an engineering office and we just happened to find that suitable and we took it over. But it was perfect for us, in terms of the team numbers and so on. And it's where most of the patients are in downtown Prince George, so most patients actually walk to the clinic.

(Slide: Outreach)
We do a lot of outreach for a lot of communities. And we have got a little plane that my wife would let me travel on very often. Always have an argument before I fly on [*laughs*].

(Slide: Outreach & Support for Primary Care)
Outreach is an important dimension of our care to get to the population. Tsay-Keh and Fortware populations is where we have a number with HIV.

(Slide: Telehealth)
We also have a telehealth link that we use to connect with our patients.

(Slide: Partnerships)
We have, sort of, partnerships that we work on building all the time to promote HIV testing and screening.

(Slide: HIV Testing in Acute Care)
Especially HIV testing in acute care. That's one of the biggest challenges we have now, because there is a lot of resistance and reluctance.

(Slide: HIV101.ca)
And we developed the HIV101 website with information both for healthcare workers and for patients, and has been a tremendous addition to our educational efforts.

(Slide: HIV/AIDS Hope to Health)
So we're hoping to move from the STOP program to Hope to Health.

(Slide: Together)
We're hoping that with our combined efforts, we can continue the fight and keep our patients healthy and prevent HIV and make some strides towards an AIDS-free generation, as we would all hope. Thank you.