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A dedicated hostel-based liver service for vulnerable/homeless adults. Response to: Needs Assessment of HCV- Infected Individuals Experiencing Homelessness and Implications.

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To the Editor

This is in reference to the excellent manuscript by Beiser et al titled “Needs Assessment of HCV-Infected Individuals Experiencing Homelessness and Implications”¹.

The study is perhaps one of the very few to address, from a qualitative aspect, the challenging issue of HCV in homeless populations. The authors quite rightly state that the uptake and treatment of HCV in marginalised populations remain exceptionally low despite the introduction of integrated models in primary care. Not surprisingly, this issue has been highlighted as one of the major hurdles in the global strategy towards elimination of HCV.²

It is interesting that more than two thirds (72.9%) of the homeless population included in this study felt that they were both interested in HCV treatment and confident they would complete the treatment course. More importantly, around half of those interested in treatment (53.6%) felt that a prompt from their community provider was a significant motivating factor. Our earlier work in Brighton (UK) supports this finding and suggest that that only about 5% of vulnerable adults with HCV engage with hospitals; thus, confirming the need for closer relationship with medical providers in the community to encourage HCV treatment in this cohort.³

Recognising these important observations, in 2015, we set up a dedicated homeless hostel based liver clinic for the vulnerable and homeless people in Brighton, UK. The Vulnerable Adults Liver Disease (VALID) study (three yr project) offers homeless people in the region a “one stop HCV clinic” that includes point of care testing, liver fibrosis assessment (fibroscan), alcohol and substance misuse counselling/social support (provided by primary care physician) and antiviral treatment. The clinics are run by a specialist registrar under the supervision of a Hepatologist. We have observed a 42% prevalence of a positive HCV serology with 27% having clinically significant hepatic fibrosis. In contrast to a common perception that this group do not engage with health services, uptake of the service has been excellent (90/91, 99%).⁴ Nine have commenced community-based HCV treatment with DAAs, and to date 6 (67%), have achieved sustained virological response. Four more are being worked up for HCV therapy. Compliance with treatment thus far has been 89%.

We attribute the success of the service to its integrated and multidisciplinary nature as well as the role played by the hostel manager thus ensuring a personalised approach for e.g. hostels often acting as a collection point for direct acting antivirals (DAAs).

This hostel based model is easy to replicate and should be widely considered to address the problem of low uptake of HCV in socially marginalised populations.

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