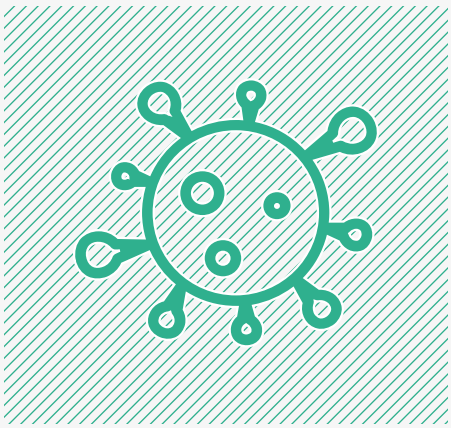
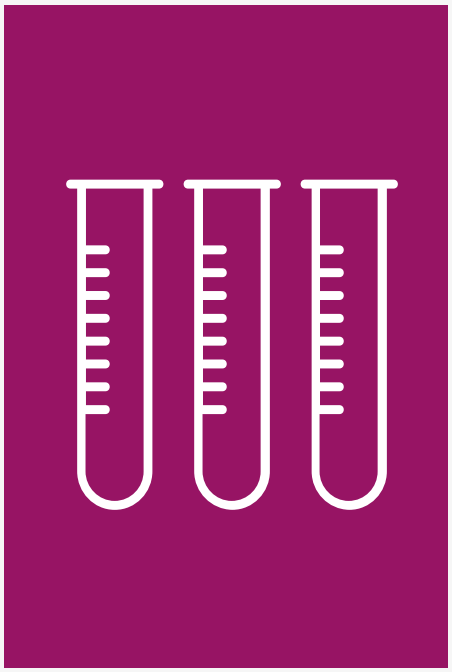
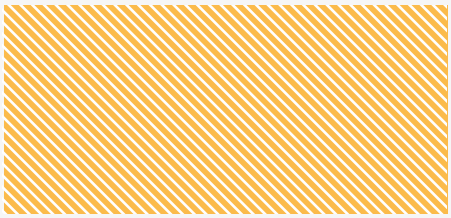
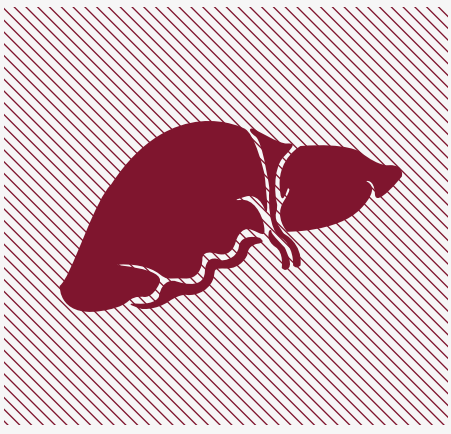




Key Documents for Hepatitis C





paul ramsay FOUNDATION

Eliminate C PARTNERSHIP

Eliminate Hepatitis C Partnership

paul ramsay FOUNDATION

Eliminate Hepatitis C (EC) Australia is led by the Burnet institute and funded by the Paul Ramsay Foundation (2019-2021) to support and facilitate a national coordinated response to ensure Australia meets its hepatitis C elimination target by 2030.

This toolkit was originally developed by the Eliminate Hepatitis C (EC) Partnership with assistance from clinical providers, peak bodies and community organisations. It has been adapted for use in EC Australia.

All materials provided in the Toolkit and accompanying Appendix are used with permission from those who produced the materials.

Contact EC Australia: ecaustralia@burnet.edu.au

For inquiries relating to the Practice Support Toolkit please contact EC Partnership Nurse Coordinator Chloe Layton: chloe.layton@burnet.edu.au or 03 8506 2345

Appendix

“It felt like a weight lifted off my shoulders. I hadn’t felt that elated in such a long time. You couldn’t wipe the smile off my face. It was so easy to do the treatment - it was just a pill a day.”

– Anne, cured of hepatitis C

Clinical guidance for treating hepatitis C virus infection: a summary

Four key questions before commencing pan-genotypic treatment for hepatitis C virus (HCV) infection

- Is cirrhosis present?
- Is the patient treatment-naive?
- Is HBV–HCV or HIV–HCV coinfection present?
- Are there potential drug–drug interactions?

Checklist for pre-treatment assessment for people with hepatitis C virus (HCV) infection

	HCV virology: • Anti-HCV (serology) • HCV PCR • HCV genotype (where possible)	 • Indicates HCV exposure • Confirms current HCV infection • May influence choice and duration of treatment regimen
	HCV treatment history — previous regimen and response	Determines treatment regimen and duration
	Potential for non-adherence?	Consider medical and social issues that may be barriers to medication adherence
	Alcohol intake history	Cofactor for cirrhosis
	Check for drug–drug interactions	**www.hep-druginteractions.org** Includes prescribed, over-the-counter, herbal, illicit drugs
	Pregnancy discussion*	
	Weight and body mass index	Non-alcoholic fatty liver disease is a cofactor for cirrhosis
	Signs of chronic liver disease	
	FBE	• Baseline haemoglobin level • Low platelets — suspect portal hypertension
	LFTs and INR	Low albumin, raised bilirubin, raised INR suggest advanced cirrhosis
	U&Es and eGFR	• Patients with comorbidities or with advanced liver disease are at risk of chronic kidney disease • Rarely, chronic HCV infection is associated with kidney disease
	HBV (HBsAg, anti-HBc, anti-HBs), HIV, HAV serology	• Specialist referral is recommended for people with HBV or HIV coinfection • If seronegative, vaccinate against HAV, HBV
	Cirrhosis assessment • e.g. FibroScan® • e.g. APRI	Thresholds consistent with no cirrhosis: • Liver stiffness < 12.5 kPa • APRI < 1.0 Specialist referral is recommended for people with cirrhosis

anti-HBc = hepatitis B core antibody; anti-HBs = hepatitis B surface antibody; APRI = aspartate aminotransferase to platelet ratio index; eGFR = estimated glomerular filtration rate; FBE = full blood examination; HAV = hepatitis A virus; HBsAg = hepatitis B surface antigen; HBV = hepatitis B virus; HCC = hepatocellular carcinoma; INR = international normalised ratio; LFT = liver function test; MELD = Model for End-Stage Liver Disease; U&E = urea and electrolyte.

* As there are no safety data for the use of any direct-acting antiviral regimen during pregnancy, treatment of pregnant women is not recommended.

Support for people living with hepatitis C

People living with hepatitis C can receive information, support and referral from community services, including:

- Hepatitis Australia: http://www.hepatitisaustralia.com
- Hepatitis Information Line: 1800 437 222
- Australian Injecting & Illicit Drug Users League: http://www.aivl.org.au

On-treatment and post-treatment monitoring for virological response

Routine monitoring for an 8–12-week treatment regimen:

Week 0	• Pre-treatment blood tests, including LFTs, HCV PCR
Week 12 post-treatment (SVR)	• LFTs, HCV PCR (qualitative)

- More intensive monitoring may be required in certain populations (see *Australian recommendations for the management of hepatitis C virus infection: a consensus statement* (June 2020), http://www.gesa.org.au).

HCV = hepatitis C virus; INR = international normalised ratio; LFT = liver function test; PCR = polymerase chain reaction; SVR = sustained virological response at least 12 weeks after treatment (cure).

Ongoing monitoring of people after successful hepatitis C treatment outcome (SVR)

SVR, no cirrhosis and normal LFT results (males, ALT ≤ 30 U/L; females, ALT ≤ 19 U/L):

- People who are cured do not require clinical follow-up for hepatitis C

SVR and abnormal LFT results (males, ALT > 30 U/L; females, ALT > 19 U/L):

- Patients with persistently abnormal LFT results require evaluation for other liver diseases and should be referred for gastroenterology review. Investigations to consider include: fasting glucose level, fasting lipid levels, iron studies, ANA, ASMA, anti-LKM antibodies, total IgG and IgM, AMA, coeliac serology, copper level, caeruloplasmin level and α-1-antitrypsin level

SVR and cirrhosis:

- Patients with cirrhosis require long-term monitoring and should be enrolled in screening programs for:
  - hepatocellular carcinoma
  - oesophageal varices
  - osteoporosis

SVR and risk of reinfection:

- Patients with ongoing risk of HCV infection should have at least annual HCV RNA testing
- Anti-HCV antibodies will remain positive in all people with prior exposure and this does not require repeated testing

ALT = alanine aminotransferase; AMA = anti-mitochondrial antibody; ANA = anti-nuclear antibodies; ASMA = anti-smooth muscle antibodies; LFT = liver function test; LKM = liver–kidney microsome; SVR = sustained virological response at least 12 weeks after treatment (cure).

People who do not respond to hepatitis C treatment

- Specialist referral recommended

GESA Gastroenterological Society of Australia

AUSTRALASIAN HEPATOLOGY ASSOCIATION

ASID

ashm Supporting the HIV, Viral Hepatitis and Sexual Health Workforce

hepatitis australia

Recommended pan-genotypic treatment protocols for treatment-naive people with hepatitis C virus (HCV) infection and compensated liver disease, including people with HCV–HIV coinfection

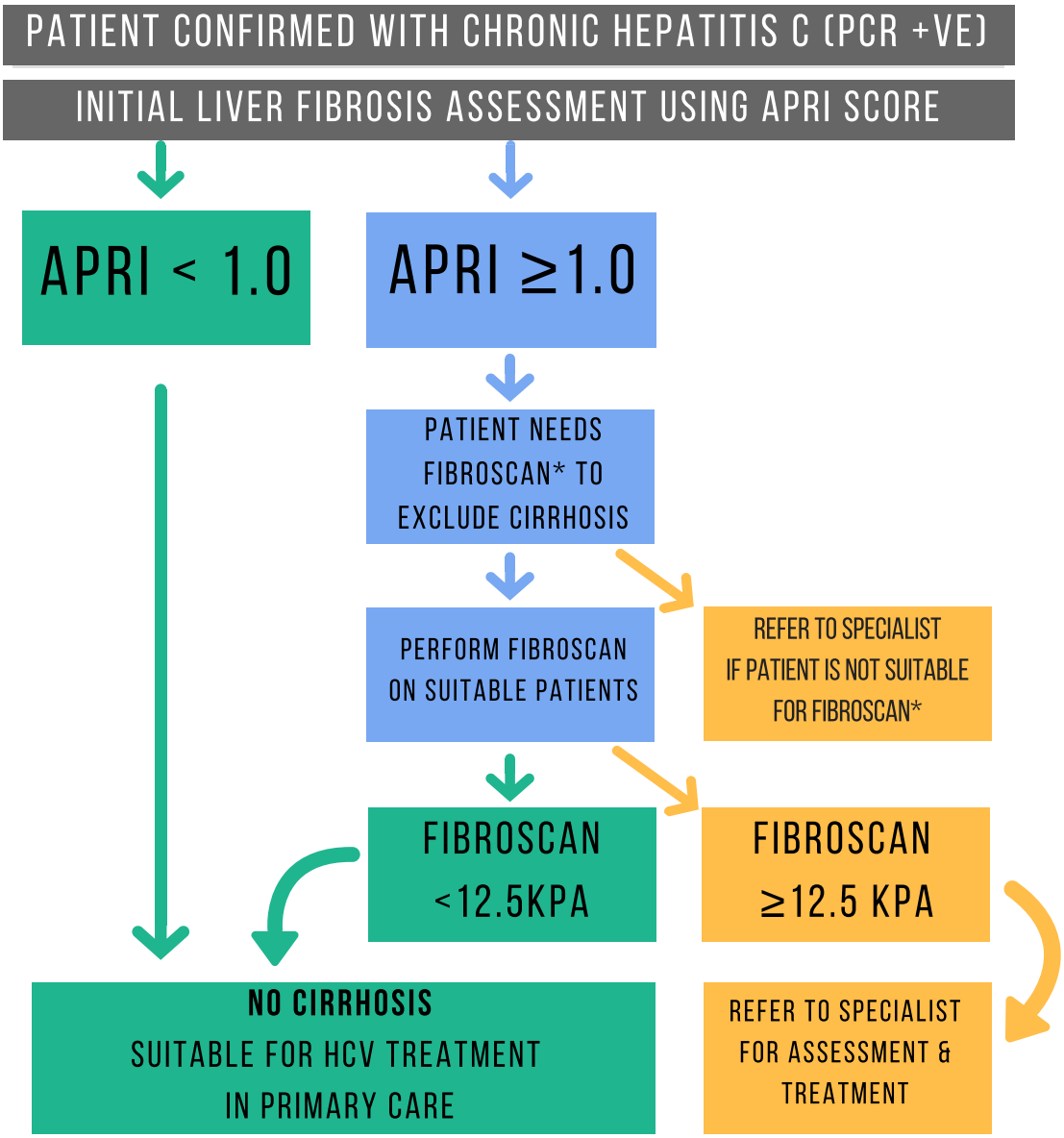
			Treatment duration	
Regimen*	HCV genotype	Pill number	No cirrhosis	Cirrhosis
Sofosbuvir 400 mg, orally, daily + Velpatasvir 100 mg, orally, daily	1, 2, 3, 4, 5, 6	1 pill daily	12 weeks	12 weeks†
Glecaprevir 300 mg, orally, daily + Pibrentasvir 120 mg, orally, daily	1, 2, 3, 4, 5, 6	Once daily (3 pills)	8 weeks	12 weeks

HIV = human immunodeficiency virus. * Dose reduction or dose interruption of direct-acting antiviral therapy is not recommended.

† Addition of ribavirin may be considered for patients with genotype 3 HCV and compensated cirrhosis. Ribavirin dosing is weight-based; recommended dose is 1000 mg for people weighing < 75 kg and 1200 mg for people weighing ≥ 75 kg.

PATHWAYS TO LIVER FIBROSIS ASSESSMENT FOR PATIENTS IN PRIMARY CARE

Created by EC Partnership



*FibroScan is not approved for use in people <18 years, women who are pregnant, people with ascites and people with a pacemaker or implantable defibrillator

FibroScan and APRI results should be interpreted in conjunction with a full clinical picture by a trained clinician

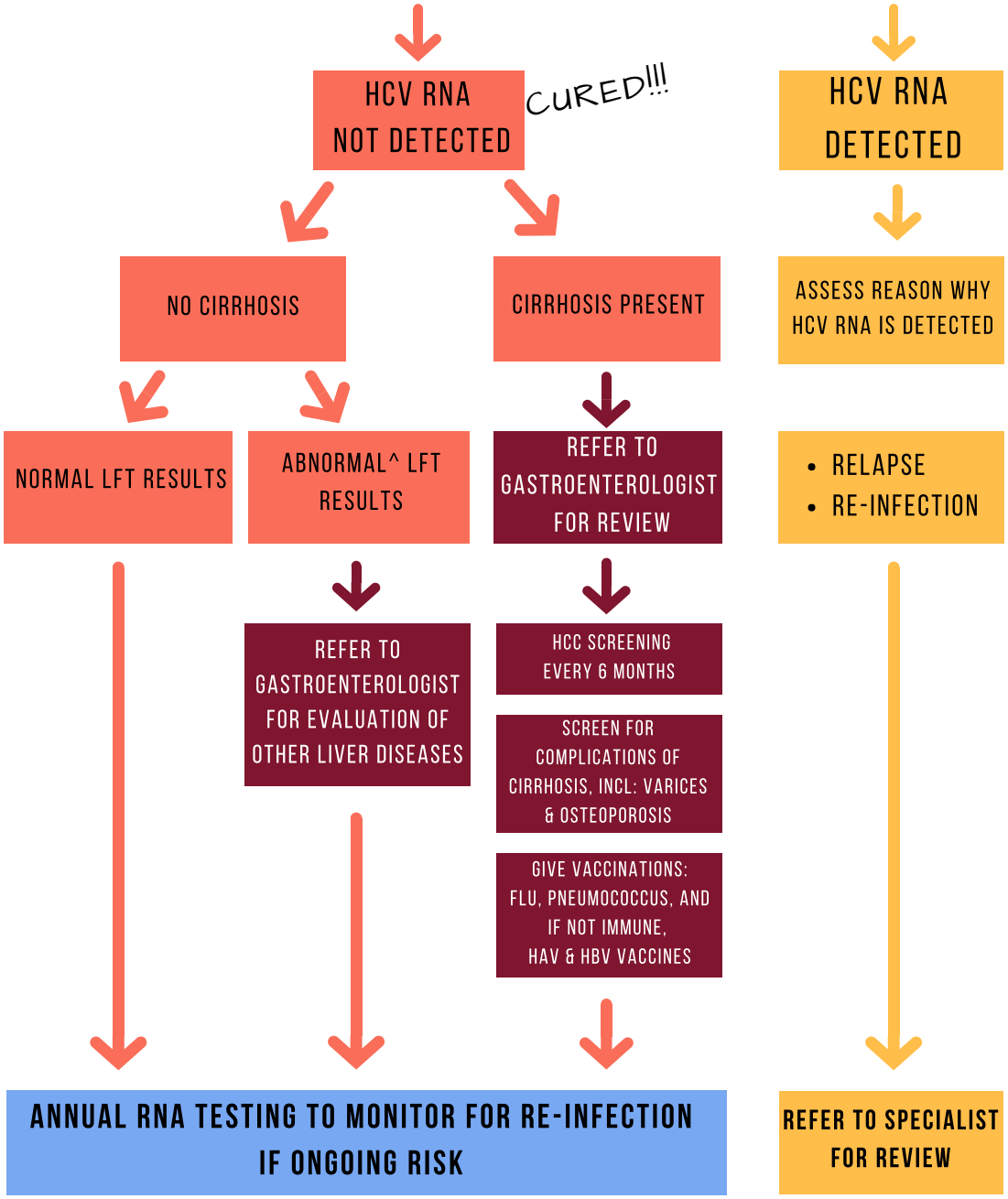
APRI Calculator available here: https://www.hepatitisc.uw.edu/page/clinical-calculators/apri

Note: suitable specialists include gastroenterologists, hepatologists and infectious disease physicians. Appropriate specialist depends on your local referral processes

HEPATITIS C TREATMENT FOLLOW-UP REQUIRED

PATIENT COMPLETED HEPATITIS C TREATMENT

REQUEST HCV RNA/PCR TEST* & LFTS AT LEAST 12 WEEKS AFTER TREATMENT COMPLETION



Note: suitable specialists include gastroenterologists, hepatologists and infectious disease physicians. Patients will need to see a gastroenterologist for any liver related follow up (persistent abnormal LFTs, HCC screening, oesophageal varices monitoring) and can see another specialist for relapse/re-infection assessment.

Note: Liver fibrosis assessment should be completed before commencing treatment to determine whether patient has cirrhosis.
*HCV RNA (PCR) tests for hepatitis C RNA and determines whether the patient is currently infected with HCV
^Abnormal LFT results - males: ALT >= 30 U/L; females: ALT >=19 U/L

Insert Hospital Name **Gastroenterology and Liver Services**

Remote Consultation Request for Initiation of Hepatitis C Treatment

Hospital Phone: ( ) Hospital Fax: ( )

FOR ATTENTION OF: Dr **Date:**

Please note this form is not a referral for a patient appointment.

Referring Practitioner *Note: General practitioners and nurse practitioners are eligible to prescribe hepatitis C treatment under the PBS*			
Name			
Suburb		Postcode	
Phone	( )	Fax	( )
Mobile phone			
Email address			

Patient	
Name	
Date of birth	
Postcode	

Hepatitis C History

Date of HCV diagnosis:

Known cirrhosis* ☐ Yes ☐ No

* Patients with cirrhosis or HBV/HIV coinfection should be referred to a specialist

Intercurrent Conditions

Diabetes	☐ Yes	☐ No
Obesity	☐ Yes	☐ No
Hepatitis B	☐ Yes	☐ No
HIV	☐ Yes	☐ No
Alcohol > 40 g/day	☐ Yes	☐ No

Discussion re contraception ☐ Yes ☐ No

Prior Antiviral Treatment

Has patient previously received any antiviral treatment? ☐ Yes ☐ No

Prior treatment:

I have checked for potential drug–drug interactions with current medications† ☐ Yes ☐ No

Current Medications
(Prescription, herbal, OTC, recreational)

† http://www.hep-druginteractions.org
If possible, print and fax a PDF from this site showing you have checked drug–drug interactions.

Laboratory Results‡ (or attach copy of results)					
Test	**Date**	**Result**	**Test**	**Date**	**Result**
HCV RNA			eGFR		
ALT			Platelet count		
AST			INR		
Bilirubin			HIV		
Albumin			HBsAg		

‡ HCV genotyping is no longer mandatory before HCV treatment with pan-genotypic medications.
Patient MUST be HCV RNA positive.

Insert Hospital Name **Gastroenterology and Liver Services**

Remote Consultation Request for Initiation of Hepatitis C Treatment

Hospital Phone: ( ) Hospital Fax: ( )

Liver Fibrosis Assessment§		
Test	**Date**	**Result**
FibroScan®		
Other (eg. APRI)		

APRI: http://www.hepatitisc.uw.edu/page/clinical-calculators/apri

§ People with liver stiffness on FibroScan® of ≥ 12.5 kPa or an APRI score ≥ 1.0 may have cirrhosis and should be referred to a specialist.

Treatment Choice			
I plan to prescribe *(please select one):*			
Pan-genotypic treatment regimen	**Duration**		**Genotypes**
Sofosbuvir + Velpatasvir	12 weeks ☐		1, 2, 3, 4, 5, 6
Glecaprevir + Pibrentasvir	8 weeks ☐ *No cirrhosis*	12 weeks ☐ *Cirrhosis*	1, 2, 3, 4, 5, 6

Multiple regimens are available for the treatment of chronic HCV. Factors to consider include pill burden, cirrhosis status, drug–drug interactions and comorbidities.

See *Australian Recommendations for the Management of Hepatitis C Virus Infection: A Consensus Statement* (June 2020) (http://www.gesa.org.au) for all regimens and for monitoring recommendations.

Patients must be tested for HCV RNA at least 12 weeks after completing treatment to determine outcome. Please notify the specialist below of the Week 12 post-treatment result.

Patients who relapse after DAA therapy should be referred to a specialist for retreatment.

Declaration by General Practitioner/Nurse Practitioner *I declare all of the information provided above is true and correct.*	
Signature:	
Name:	
Date:	

Approval by Specialist Experienced in the Treatment of HCV *I agree with the decision to treat this person based on the information provided above.*	
Signature:	
Name:	
Date:	
Please return both completed pages by email: **or fax: ( )**	

Table 1. Pre-treatment assessment of people with chronic hepatitis C virus (HCV) infection

History	• Estimated duration of HCV infection • Previous HCV treatment experience — date, regimen and response • Cofactors for liver disease progression: alcohol intake, marijuana use, virological cofactors (HIV, HBV), diabetes, obesity • For those planned to receive ribavirin, note history of ischaemic heart disease or cardiovascular risk factors • Vaccinations against HBV and HAV • Physical and psychiatric comorbidities • Ongoing risk factors for viral transmission and reinfection • Social issues — potential barriers to medication adherence
Medication	• Concomitant medications (prescription, over-the-counter, illicit)
Physical examination	• Features of cirrhosis: hard liver edge, spider naevi, leukonychia • Features of decompensation or portal hypertension: jaundice, ascites, oedema, bruising, muscle wasting, encephalopathy • Body weight and body mass index
Virology	• HCV PCR • HCV genotype (where possible)* • HBV (HBsAg, anti-HBc, anti-HBs†), HIV, HAV serology

Investigations	• Full blood examination, liver function tests, urea and electrolytes, eGFR, INR
	• Pregnancy test for women of childbearing potential
	• Liver fibrosis assessment, eg:
	  ▸ Elastography (FibroScan®, ARFI, SWE)
	  ▸ Serum biomarker (APRI, Hepascore, ELF test, FibroGENE‡)
	• Liver ultrasound should be performed in people with cirrhosis to exclude hepatocellular carcinoma (within 3 months before starting DAAs)

anti-HBc = hepatitis B core antibody; anti-HBs = hepatitis B surface antibody; APRI = aspartate aminotransferase to platelet ratio index; ARFI = acoustic radiation force impulse; DAA = direct-acting antiviral; eGFR = estimated glomerular filtration rate; ELF = Enhanced Liver Fibrosis; HAV = hepatitis A virus; HBsAg = hepatitis B surface antigen; HBV = hepatitis B virus; HIV = human immunodeficiency virus; INR = international normalised ratio; PBS = Pharmaceutical Benefits Scheme; PCR = polymerase chain reaction; SWE = shear wave elastography.

* HCV genotype is no longer required by the PBS criteria for pan-genotypic regimens: sofosbuvir + velpatasvir (first-line, treatment-naive); glecaprevir + pibrentasvir (first-line, treatment-naive); and sofosbuvir + velpatasvir + voxilaprevir (NS5A inhibitor-experienced). Genotype is important before prescribing elbasvir + grazoprevir or sofosbuvir + ledipasvir.

† All three tests for HBV may be requested if the clinical notes indicate acute or chronic hepatitis.

‡ Online calculator available at: www.fibrogene.com/viral_hepatitis.html.

Note: People living with hepatitis C can receive information, support and referral from community services, including:

- Hepatitis Australia: www.hepatitisaustralia.com
- Hepatitis Information Line: 1800 437 222
- Australian Injecting & Illicit Drug Users League: www.aivl.org.au

MBS billing options for Hepatitis C care

Examples of Medicare Benefits Schedule (MBS) items that may be considered for the provision of hepatitis C care.

Providers should refer to MBS explanatory notes to ensure eligibility criteria and service requirements are met: go to **http://www.mbsonline.gov.au** or **contact Medicare on 132 150**. For MBS chronic disease management fact sheets, templates and Q&A, see **bit.ly/Chronicdisease**. To track patient claims, see Health Professional Online Service (HPOS) at **https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/hpos**.

Hepatitis C care and management‡	*Examples of MBS Billing Options*	*Rebate*
Diagnosis and pre-treatment assessments		
HCV testing: Request HCV Ab, and HCV RNA if Ab+ *Pre-treatment assessment tests can be requested at the same time as diagnostic tests – using reflexive testing*	Level B consult (Item 23; < 20 minutes)	$37.60
	OR Level C consult (Item 36; 20- 39 minutes)	$72.80
	OR Health Assessment e.g. Aboriginal and Torres Strait Islander People (Item 715); people aged 45-49 years at risk of chronic disease, or with intellectual disability, refugee, former ADF member (items 701-707)+	**For example:** Item 715 $212.25 Item 703 $137.90
HCV results delivery, pre-treatment assessment and prescribe treatment or refer to specialist (if applicable) *This may require more than one consultation*	Level B consult (Item 23; < 20 minutes)	$37.60
	OR Level C consult (Item 36; 20- 39 minutes)	$72.80
Consider developing GP Management Plan (GPMP) Assess if multidisciplinary team care arrangement (TCA) will be beneficial	Preparation of GPMP (Item 721)^ *Recommended frequency 2 yearly; minimum claiming period 12 months unless 'exceptional circumstances'**	$144.25
	+/- Coordination of TCA (Item 723)^ *Recommended frequency 2 yearly; minimum claiming period 12 months unless 'exceptional circumstances'**	$114.30
On-treatment monitoring		
On-treatment monitoring as required	Level B consult (Item 23)	$37.60
Assess if multidisciplinary team care arrangement (TCA) will be beneficial* (if not performed above)	Coordination of TCA (Item 723)^ *Recommended frequency 2 yearly; minimum claiming period 12 months unless 'exceptional circumstances'**	$114.30
Post treatment follow-up and assessment of cure		
Treatment follow-up as appropriate including assessment of cure	Level B consult (Item 23; < 20 minutes)	$37.60
	OR Level C consult (Item 36; 20- 39 minutes)	$72.80
Review of GPMP and/or TCA and future management goals (if applicable)	Review of GPMP +/- TCA (Item 732)^ *Recommended frequency 6 months; minimal claiming period 3 months unless 'exceptional circumstances'**	$72.05

‡ This document does not provide comprehensive clinical advice – refer to 'Australian recommendations for the management of hepatitis C virus infection: a consensus statement'. See http://bit.ly/gesa_hcvmanagement.
+ May be included as part of a health assessment service provided to eligible patients – for more information, see https://www.humanservices.gov.au/organisations/health-professionals/subjects/mbs-and-health-assessments.
^ Co-claiming item numbers 23 and 36 (and others; see http://bit.ly/mbs_item732) with 721, 723, or 732 is not permitted for the same patient, on the same day.

Also consider, if applicable, Medication Review (DMMR item 900), case conferences (items 735 – 758), Mental Health Treatment Plan (items 2700 – 2717).

Current as of October 2018

Information Sheet

phn NORTH WESTERN MELBOURNE
An Australian Government Initiative

MBS Items for hepatitis B and hepatitis C care

Table 1: Medicare initiatives for chronic disease prevention and management

Information detailed in the attached table includes Medicare Chronic Disease Management (CDM) initiatives, MBS item numbers, brief details about application in primary care and frequency of application. Last updated March 2017 (incorporating MBS fees as at September 2014).

Check requirements: www.health.gov.au/mbsonline

Questions to ask:

Are you the patient's regular GP?

When was the last time a 721 and/or 723 item was billed for this patient and how many medicare rebates for allied health services have been claimed for this calendar year?

Contact Medicare on 132150 or Health Professional Online Service (HPOS) at www.humanservices.gov.au if unknown.

Table 2: Examples of nurse-led patient care[1]

Practices participating in the Practice Nurse Incentive Program (PNIP) may use the table as examples of nurse-led or nurse-involved care for people with hepatitis B and/or hepatitis C. The PNIP is used to cover the time of the nurse and apply the nurse billing items, while the general practitioner (GP) can bill consultation/assessment/chronic disease items.

For further enquiries contact:

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Web: www.nwmphn.org.au

Don't forget to find us on:

@NWMelbPHN and on www.facebook.com/nwmphn or on Linked in

We acknowledge the peoples of the Kulin nation as the Traditional Owners of the land on which our work in the community takes place. We pay our respects to their Elders past and present.

[1] ASHM. Hepatitis C: Your crucial role as a primary health care nurse. ASHM, Sydney, Australia 2015. Available at http://www.ashm.org.au/products/product/1-

Table 1: Medicare initiatives for chronic disease prevention and management

CDM INITIATIVE	MBS ITEM	REBATE	TARGET PATIENT GROUP	FREQUENCY
Health Assessments	701 *(duration <30mins)*	$59.35	People aged 75 or over	Annual
		$137.90	People aged 45-49 years with a chronic disease risk factor	Once only
	703 *(duration 30-45mins)*		Refugee / Humanitarian entrant (see eligibility criteria)	Once only
		$190.3	Person with an intellectual disability	Annual
	705 *(duration 45-60mins)*	$268.80	Former serving member of the Australian Defence Force	Once only
	707 >60mins			
	715	$212.25	Aboriginal and Torres Strait Islander People. Can then be referred for 5 Medicare allied health services per calendar year	9 monthly
	10987	$24.00	Practice nurse or Aboriginal Health Practitioner services following a 715 Health Assessment	10 per year
Case Conferences	735, 739, 743 747, 750, 758	Varied – dependent on time	Case conferences are based on time, 735/739/743 apply when the GP arranges the conference, 747/750/758 apply when the GP participates	5 per year
Chronic Disease Care Planning *(patients with a GPMP + TCA are also eligible for Medicare-rebated allied health services)*	721	$144.25	GP Management Plan (GPMP)	12 months *(recommended every 2 years)*
	723	$114.30	Team Care Arrangement (TCA)	
	732	$72.05	GPMP or TCA review	3-6 monthly
	729	$70.40	GP contribution to another organisation's care plan	See MBS
	731	$70.40	GP contribution to an aged care facility's care plan	See MBS
Mental Health Care Planning *(Patients also eligible for Medicare-rebated psychological services)*	2700	$71.70	GP Mental Health Treatment Plan, training not undertaken, at least 20 mins	12 months *(if required)*
	2701	$105.55	GP Mental Health Treatment Plan, training not undertaken, at least 40 mins	
	2715	$91.05	GP Mental Health Treatment Plan, skills training undertaken, at least 20 mins	
	2717	$134.10	GP Mental Health Treatment Plan, skills training undertaken, at least 40 mins	
	2712	$71.70	Review of GP Mental Health Treatment Plan	See MBS
	2713	$71.70	Mental Health Consultation (at least 20 mins)	N/A

Table 2: Examples of nurse-led patient care[2]

Practices participating in the Practice Nurse Incentive Program (PNIP) may use the following as examples of nurse-led or nurse-involved care for people with hepatitis C. For the examples used in the table below, the PNIP is used to cover the time of the nurse, while the GP is billing MBS item 23 Level B.

Nurse identifies need for testing based on risk.	Nurse alerts GP to need for testing, coordinates a review with the GP for a comprehensive assessment. GP orders pathology, nurse arranges sample collection and encourages patient to consider hepatitis A and B vaccination if non-immune and susceptible to infection.
Blood tests reviewed by GP, additional testing needs are identified	Nurse recalls patient for additional pathology testing. Prior to seeing GP, the nurse explains to the patient the need for additional testing and provides education about hepatitis C
Drug and alcohol consultation	GP suggests testing for blood borne viruses for a patient disclosing current or prior injecting drug use. Nurse discusses with the patient the need for testing, impact of a positive diagnosis, available treatments, and supports the patient to access safe injecting equipment if needed.
Consultation with a young person, or person at risk for blood borne viruses	Nurse discusses with the patient the transmission risks for hepatitis C, and other blood borne viruses, incorporating harm minimization strategies.
Chronic disease management consultation for a person with hepatitis C	Nurse supports the patient to explore strategies to achieve chronic disease management and identified patient-centred goals. For example, reducing alcohol and tobacco consumption, or improving nutrition & maintaining a healthy weight.

The examples below illustrate further situations where multiple MBS items can apply.

Follow up visit after a hepatitis B or C diagnosis	GP provides additional information following diagnosis and a GPMP/TCA is established for a patient. PHCN supports patient to understand issues around their condition and provides further information. (Billing items 10997 & 721/723/729/731/732 can apply)
General health check-up for someone with hepatitis B or C	GP discuss ongoing monitoring and health checks with patient, requests relevant pathology/radiology. PHCN facilitates collection/completion of tests, reinforces key health and monitoring messages, ensuring patient understands helpful lifestyle and dietary changes. (Billing items 10997 & 721/723/729/731/732 can apply)
Health Assessment for Aboriginal and Torres Strait Islander people	GP discusses need for testing in this population. PHCN supports lifestyle and dietary factors to support liver health if the patient is determined to have chronic hepatitis B or C. (Billing items 10987 & 715 can apply)

[2]ASHM. Hepatitis C: Your crucial role as a primary health care nurse. ASHM, Sydney, Australia 2015. Available at http://www.ashm.org.au/products/product/1-920773-40-1.

GP example scenario 1: patient is currently prescribed opioid substitution therapy (OST) AND has NEVER had a care plan, or the care plan is >12 months old:

a. If the OST prescriber **is** the usual doctor:

Prepare a new plan for hepatitis C management.

The plan should also consider the patient's co-morbidities.

b. If the OST prescriber **is not** the usual doctor and patient has a regular GP:

Liaise with patient's regular GP to prepare a new plan which will add hepatitis C management and OST prescribing to the plan, and add the OST prescriber as a care provider on the TCA.

GP example scenario 2: patient is currently prescribed OST AND has an existing care plan, that does not include hepatitis C management:

a. If the OST prescriber **is** the usual doctor:

prepare a new GPMP / TCA for incorporating hepatitis C management as per "exceptional circumstances".

the plan should also consider the patient's co-morbidities.

Definition of "exceptional circumstances": significant change in the patient's clinical condition, or care arrangements, or ability to function. E.g. hospitalisation; development of co-morbidities; death of a carer; onset of depression.

Note reason for preparing a new plan under "exceptional circumstances" in patient's file and the Medicare claim must use the words "exceptional circumstances" in the reason for claim.

b. If the OST prescriber **is not** the usual doctor and patient has a regular GP:

Liaise with patient's regular GP to prepare a new plan under "exceptional circumstances", incorporating hepatitis C management and OST within the plan, and add the OST prescriber as a care provider on the TCA.

Note the reason for preparing a new plan under "exceptional circumstances" in the patient's file and the Medicare claim must use the words "exceptional circumstances" in the reason for claim

Alternatively, the OST prescriber can liaise with that GP to review the GPMP/TCA under MBS item 732, and then add hepatitis C management and OST within the plan, adding the OST prescriber as a care provider on the TCA.

Language **matters**

Language is powerful—especially when discussing alcohol and other drugs and the people who use them. Stigmatising language reinforces negative stereotypes. "Person-centred" language focuses on the person, not their substance use.

When working with people who use alcohol and other drugs...

try this	instead of this
substance use, non-prescribed use	abuse; misuse; problem use; non-compliant use
person who uses/injects drugs	drug user/abuser
person with a dependence on...	addict; junkie; druggie; alcoholic
person experiencing drug dependence	suffering from addiction; has a drug habit
person who has stopped using drugs	clean; sober; drug-free
person with lived experience of drug dependence	ex-addict; former addict; used to be a...
person disagrees	lacks insight; in denial; resistant; unmotivated
treatment has not been effective/chooses not to	not engaged; non-compliant
person's needs are not being met	drug seeking; manipulative; splitting
currently using drugs	using again; fallen off the wagon; had a setback
no longer using drugs	stayed clean; maintained recovery
positive/negative urine drug screen	dirty/clean urine
used/unused syringe	dirty/clean needle; dirties
pharmacotherapy is treatment	replacing one drug for another

Adapted from *Language Matters* from the National Council for Behavioural Health, United States (2015) and Matua Raki, New Zealand (2016).

NADA network of alcohol and other drugs agencies

NUAA NSW USERS AND AIDS ASSOCIATION

Person-centred language in non government AOD services

About this resource

Person-centred language focuses on the person, not their substance use. It is a simple and effective way of showing you respect a person's agency, dignity and worth.

This resource has been developed for people working in non government alcohol and other drugs (AOD) services. It has been developed in consultation with people who use drugs.

The purpose of this resource is to provide workers with guidelines on how to use language to empower clients and reinforce a person-centred approach.

Why have we developed this resource?

Our attitudes towards AOD use and how we respond rests on the concepts and language we use.

Words like 'addict', 'clean' and 'dirty' reinforce negative stereotypes and encourage judgement, blaming and shaming.

Fear of stigma and being labelled as a 'drug user' can and does prevent people from accessing treatment and support. Use of such language also contributes to poorer treatment outcomes.

Being mindful about the words we use is not about being politically correct. Language is powerful and it is the power of language which makes it an important practice tool; a tool to empower clients and fight stigma.

What this resource is not

This resource is not an exhaustive list of 'dos' and 'don'ts'. Language is complex. What is considered 'person-centred' will depend on the individual and the context. Terms, like 'recovery' for example, might be stigmatising for some, while others may prefer such terminology. There is no one-size-fits-all approach. What is important is that we are respectful and person-centred in our approach.

To learn more, visit the International Network of People who Use Drugs website: www.inpud.net.

Better practice guidelines

When working with people who use drugs:

- Don't define a person by their substance use or diagnosis—emphasise the person first. For example, say 'person who injects drugs' instead of 'injecting drug user' or 'person living with hepatitis C' instead of 'they're infected with hep C.'
- Don't impose your language on others. Where appropriate ask the person what language they prefer and respect their wishes.
- Choose terms that are strengths-based and empowering. Avoid terms like 'non-compliant'; use terms like 'chooses not to' or 'decided against' which affirm a person's agency, choice, and preferences.
- Be mindful of the implications of your language. Avoid terms like 'clean' and 'dirty' when talking about urine drug screen results. Consider also the implications of referring to opioid pharmacotherapies as 'substitution' or 'replacement' treatment.
- Avoid expressions like 'has a drug habit' or 'suffering from addiction' which can disempower a person by trivialising or sensationalising their AOD use.
- Use language that is accessible. Don't speak above a person's level of understanding or assume that a person is not capable of understanding. Avoid slang and medical jargon which can be misinterpreted or cause confusion when used incorrectly.
- Don't make assumptions about a person's identity—be inclusive. For example, ask about a person's preferred gender pronouns or, if you are unsure, use gender neutral terms like 'their', 'they' or 'them'. Better still, avoid unnecessary references to gender altogether by using the person's name.
- Be aware of the context of the language being used. Some terms are ok when used by members of a specific community as a means of claiming identity; the same terms can be stigmatising when used by people outside that community.
- The community of people who use drugs, like all communities, can suffer from lateral discrimination. Be careful not to take on the biases of others. Your language should respect a diversity of experience and empower the person who is looking to you for help.
- Remember, we don't just use words to communicate. Use non-verbal cues, like eye contact, tone of voice and body language to demonstrate you respect the dignity and worth of all people.

References

International Network of People who Use Drugs (2011). Statement and Position paper on Language, Identity, Inclusivity and Discrimination.
International Network of People who Use Drugs (2015). Drug User Peace Initiative: Stigmatising People Who Use Drugs.
Matua Raki (2016). Language Matters.
Mental Health Coordinating Council (2015). Language of Mental Health Recovery.

DECISION MAKING IN HEPATITIS C

ashm

HCV

1 When To Test

Clinical Indicators

- Abnormal liver function tests (LFTs) (males, ALT ≥ 30 U/L; females, ALT ≥ 19 U/L)
- Jaundice

Presence of Risk Factors

- Injecting drug use (current/ever)
- Sharing of snorting equipment
- Born in high prevalence region^
- Blood transfusions and blood products before 1990 in Australia
- Unsterile tattooing/body piercing
- Unsterile medical/dental procedures/blood transfusions in high prevalence countries
- Time in prison
- Needlestick injury
- Mother to child transmission
- Sexual transmission in men who have sex with men (MSM)
- Sexual transmission in those who are HIV positive

^Africa, the Middle East (in particular Egypt), the Mediterranean, Eastern Europe, and South Asia

Other

- Initiating PrEP
- When someone requests a test

When gaining informed consent before testing, discuss:

- Reason for test
- Availability of curative treatment

2 Test/s, Results and Actions

Order HCV Antibody (Ab)*

HCV Ab negative

HCV Ab positive

HCV RNA (qualitative) **+ LFTs**

HCV RNA negative

HCV RNA positive

Does NOT have HCV

Has CLEARED HCV

Has CHRONIC HCV
(chronic = > 6 months)

NO action
However, if possible recent infection re-test (HCV Ab) or if ongoing risk factors repeat screening (HCV Ab) annually

RE-TEST if:
Ongoing risk factors
(repeat RNA test annually)

Further ASSESSMENT and TREATMENT
(see next page)

When conveying a NEGATIVE result, discuss:

- Modes of transmission and risk reduction

When conveying a POSITIVE result, discuss:

- Modes of transmission and risk reduction
- Availability of curative treatment
- Life style factors e.g. alcohol minimisation, diet
- Availability of peer support services, information and support services
- Refer to Hepatitis Australia National Infoline 1800 437 222

***If high level suspicion also consider requesting reflexive HCV RNA + LFTs**

DECISION MAKING IN HEPATITIS C

HCV

3 Pre-Treatment Assessment

Baseline screening after positive HCV PCR

- ☐ Full Blood Count
- ☐ Urea, electrolytes, creatinine
- ☐ LFTs (including AST) and INR

Assess liver fibrosis: cirrhotic status

- ☐ Signs of chronic liver disease (spider naevi, palmar erythema, jaundice, encephalopathy, hepatomegaly, splenomegaly, ascites, peripheral oedema)
- ☐ Non-invasive assessment of fibrosis:
  - Serum biomarkers such as APRI (<1.0 means cirrhosis unlikely). Calculator available www.hepatitisc.uw.edu/page/clinical-calculators/apri
  - Elastography assessment e.g. Fibroscan (>12.5 kPa consistent with cirrhosis)

Check for other causes of liver disease

- ☐ Check for viral coinfection:
  - HIV Ab
  - Hepatitis A – check hep A IgG; vaccinate if negative
  - Hepatitis B – check HBsAg, anti-HBc and anti-HBs; vaccinate if all negative
- ☐ Heavy alcohol intake
- ☐ Fatty liver disease - check weight, BMI

Check for other major co-morbidities

- ☐ Renal impairment (eGFR < 30)

Review previous HCV treatment

- Choice/length of treatment may be influenced by prior HCV treatment experience/response

Consider pregnancy and contraception

- HCV treatment not recommended for use in pregnant or lactating women

4 Treatment

Is your patient likely to have cirrhosis?
(APRI ≥ 1.0 or Fibroscan > 12.5 kPa

- ☐ Yes → Discuss with or refer to a specialist#
- ☐ No

Has your patient received previous treatment for HCV?

- ☐ Yes → Discuss with or refer to a specialist#
- ☐ No

Treatment	Dosage	Duration if no cirrhosis present	Duration if cirrhosis present
SOF/VEL~ (Epclusa®)	400/100mg Once-daily (1 pill)	12 weeks	12 weeks
GLE/PIB~ (Maviret®)	100/40mg per pill Once-daily (3 pills)	8 weeks	12 weeks

- ☐ Check for drug-drug interactions at www.hep-druginteractions.org
- ☐ Call the PBS Authority Script Line (1800 020 613) for approval

Consult with your local specialist or complete the online remote consultation form at reach-C.ashm.org.au

(turn-around time <24 hours).

#All patients with cirrhosis or prior HCV treatment experience should be reviewed by someone experienced in hepatitis C treatment. If cirrhosis is suspected (APRI ≥ 1.0 or elastography > 12.5 kPa), further evaluation is required before commencing treatment.

5 Monitoring

Monitoring while on treatment

- Generally not required but approach should be individualised
- Side effects of HCV treatment are generally minimal

12 weeks post treatment

- ☐ HCV RNA to confirm cure (sustained virological response SVR12 = cure)
- ☐ LFTs

6 Follow Up

If your patient has no cirrhosis and normal LFT results (males, ALT< 30 U/L; females, ALT < 19 U/L) ALT = alanine aminotransferase

No clinical follow-up for HCV required

If your patient has ongoing risk factors

Annual HCV RNA test. If re-infected offer re-treatment and harm reduction strategies

If your patient has abnormal LFT results

(males, ALT ≥ 30 U/L; females, ALT ≥ 19 U/L) Evaluate for other causes of liver disease and refer to specialist for review

If your patient has cirrhosis

Refer to specialist. Patients with cirrhosis require long-term monitoring:

- 6-monthly abdominal ultrasound (hepatocellular carcinoma screening)
- Consideration of screening for oesophageal varices
- Osteoporosis: 2-yearly DEXA scans and monitor serum vitamin D

CONSULT WITH A SPECIALIST IF:

Pre-treatment

- Prior treatment failure of HCV treatment
- Cirrhosis is present or likely – APRI ≥1 and elastography score not available; elastography >12.5kPa
- Coinfected with HIV or HBV
- Renal impairment (eGFR < 30)
- Complex drug interactions
- Complex co-morbidities
- Not comfortable prescribing HCV treatment

During treatment

- Major medication side effects

Post-treatment

- RNA positive 12 weeks post treatment
- Abnormal LFTs at SVR12

For more information www.hepcguidelines.org.au.

To discuss cases with your peers visit the ASHM Hepatitis C Community of Practice at www.ashm.org.au/hepc-forum/

~SOF/VEL = Sofosbuvir/Velpatasvir ; GLE/PIB = Glecaprevir/Pibrentasvir

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Disclaimer: Guidance provided on this resource is based on guidelines and best-practices at the time of publication. This quick-reference guide is not intended to be a comprehensive list of all available options. Refer to the General Statement for Drugs for the Treatment of Hepatitis C for all current PBS-listed regimens.

ACCESS

Australian Collaboration for Coordinated Enhanced Sentinel Surveillance

Can we eliminate HIV and hepatitis C in Australia?

With new ways to treat and prevent HIV and hepatitis C, Australia is among the first countries globally to contemplate elimination. This exciting prospect is bolstered by political and financial support from around the country.

Achieving elimination requires health surveillance that can assess targets and identify gaps. That is why the Australian Department of Health has funded ACCESS, a sentinel surveillance system that can evaluate and inform health policy, assess interventions, and monitor population health.

Started in 2008, today ACCESS collates de-identified data on blood borne viruses and sexually transmissible infections from over 120 health services and pathology laboratories in every state and territory. ACCESS is an essential component of Australia's efforts to eliminate and manage these infections.

How does ACCESS work?

ACCESS automatically extracts de-identified patient data from participating services using customised health extraction software called GRHANITE™. Developed at the University of Melbourne, the software employs industry-leading cryptography to ensure the secure extraction and transmission of all data. GRHANITE™ has been used to securely and anonymously extract data from hundreds of Australian health services.

Patients are only ever identified using an irreversible signature code, which means that no identifying details such as name or date of birth ever leave a participating service. Extracted data are stored in an encrypted format on a secure server at the Burnet Institute and ACCESS only ever reports aggregate information to further ensure patient anonymity.

Participating in ACCESS

Participating ACCESS sites are required to install GRHANITE™ on a system within their service. Because the software is tailored to the individual database of a participating site, some upfront work is required to properly configure the extractions. Once the system has been established, however, ACCESS employs automated data extraction processes that require little ongoing effort from participating sites. Sites are encouraged to nominate a site investigator to be involved with data interpretation and article authorship. Site investigators are also welcome to propose analyses of the ACCESS database either specific to their service or across the whole network with analytical support available as needed.

What does ACCESS collect?

From electronic patient records, ACCESS extraction software will automatically collate the following details. No patient identifiers are collected.

Not all variables will be available at every service or relevant to every service type.

Domain	Indicators (health services)	Indicators (pathology laboratories)
Visit and service details	Service or clinic name and location Service date Reason for attendance	Laboratory name and location Date of consultation Requesting doctor Clinic name and postcode
Patient details	Unique patient identifier Sex Age Aboriginal or Torres Strait Islander status Home postcode Country of birth Traveller or recent arrival in Australia Preferred language	Sex Postcode Year of birth Age at time of testing Patient ID at request clinic
Pathology and diagnoses	Test(s) requested Test results Recorded clinical diagnosis	Specimen identification number Laboratory of origin Tests requested (STIs and BBVs) Test results (STIs and BBVs) Specimen type Specimen site
Vaccination details	HPV vaccination status HAV vaccination status HBV vaccination status	
Treatment	Treatments Prescriptions issued	
Sexual behaviours and drug use	Gender(s) of sexual partners Number of sexual partners Condom use Sex overseas Sex with a sex worker Sex work Drug use	

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accessproject.org.au

ACCESS

More information

If you are interested in ACCESS and would like more information, please contact the study coordinator or visit the study website.

accessproject@unsw.edu.au

02 9385 9958

www.accessproject.org.au

Notes

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paul ramsay FOUNDATION

Eliminate C PARTNERSHIP

To download a copy of the Toolkit visit our website:
ecpartnership.org.au/toolkit

To order hard copies of the Toolkit contact us on:
ecpartnership@burnet.edu.au