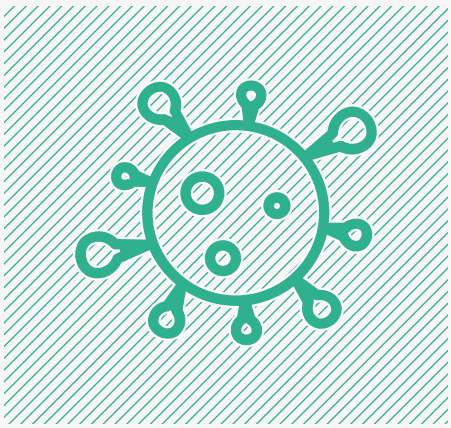
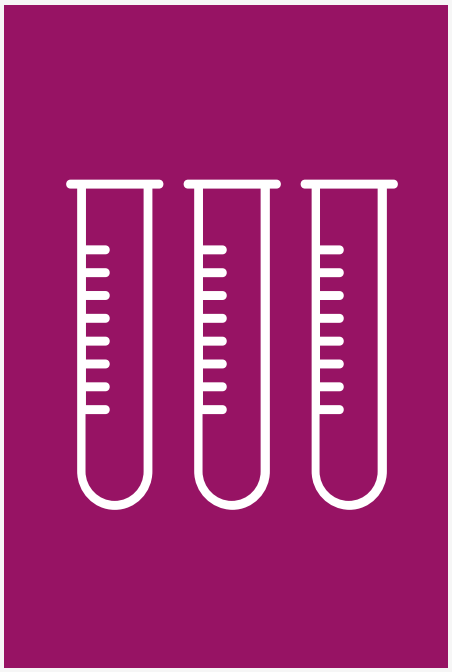
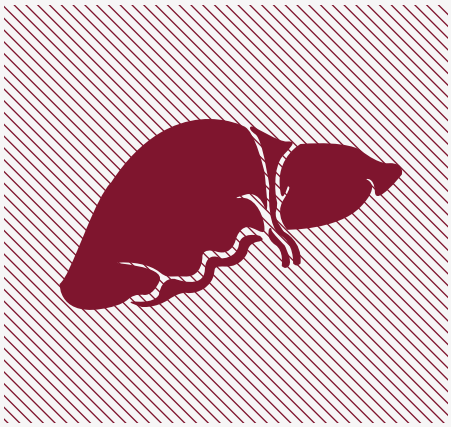




Key Documents for Hepatitis C



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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

Six key questions before commencing treatment for hepatitis C virus (HCV) infection

- Is cirrhosis present?
- What is the HCV genotype?
- Is the patient treatment-naive?
- Is HBV–HCV or HIV–HCV coinfection present?
- Are there potential drug–drug interactions?
- What is the renal function (eGFR)?

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

	HCV virology: • Anti-HCV (serology) • HCV PCR • HCV genotype, quantitative HCV RNA level*	 • Indicates HCV exposure • Confirms 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	• Sofosbuvir is not recommended if eGFR < 30 mL/min/1.73 m^2 • Ribavirin is renally cleared and needs dose reduction if eGFR < 50 mL/min/1.73 m^2
	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
	Electrocardiogram if ribavirin therapy planned and patient is aged > 50 years OR has cardiac risk factors	Screen for ischaemic heart disease

FBE = full blood examination. LFT = liver function test. INR = international normalised ratio. U&E = urea and electrolyte. eGFR = estimated glomerular filtration rate. HBV = hepatitis B virus. HAV = hepatitis A virus. HBsAg = hepatitis B surface antigen. anti-HBc = hepatitis B core antibody. anti-HBs = hepatitis B surface antibody. APRI = aspartate aminotransferase to platelet ratio index. MELD = Model for End-Stage Liver Disease. HCC = hepatocellular carcinoma. * HCV genotype is required by the PBS criteria; it is important before prescribing elbasvir plus grazoprevir or sofosbuvir plus ledipasvir. HCV RNA level is important for determining eligibility for 8-week treatment duration with sofosbuvir plus ledipasvir. † As there are no safety data for the use of any direct-acting antiviral regimen during pregnancy, treatment of pregnant women is not recommended. Ribavirin (Category X) and peginterferon-alfa are contraindicated during pregnancy.

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 8–12 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* (September 2018), http://www.gesa.org.au).
- People treated with elbasvir plus grazoprevir should have LFTs at Week 8 to screen for hepatotoxicity.

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

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

People who do not respond to hepatitis C treatment

- Specialist referral recommended

Updated September 2018

GESA Gastroenterological Society of Australia ala Australian Liver Association

AUSTRALASIAN HEPATOLOGY ASSOCIATION

ASID

ashm Supporting the HIV, Viral Hepatitis and Sexual Health Workforce

hepatitis australia

Recommended 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	No cirrhosis	Cirrhosis
Sofosbuvir 400 mg, orally, daily + Velpatasvir 100 mg, orally, daily	1, 2, 3, 4, 5, 6	12 weeks	12 weeks*
Glecaprevir 300 mg, orally, daily + Pibrentasvir 120 mg, orally, daily	1, 2, 3, 4, 5, 6	8 weeks	12 weeks
Elbasvir, 50 mg, orally, daily + Grazoprevir, 100 mg, orally, daily	1, 4	12 weeks	12 weeks
Sofosbuvir 400 mg, orally, daily + Ledipasvir 90 mg, orally, daily	1	8 or 12 weeks†	12 weeks

HIV = human immunodeficiency virus.

* 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.

† 8 weeks may be considered if HCV RNA level is $< 6 \times 10^6$ IU/mL in people with no cirrhosis who are treatment-naive.

Notes:

- Sofosbuvir is not recommended for patients with an estimated glomerular filtration rate < 30 mL/min/1.73 m^2.
- Dose reduction or dose interruption of direct-acting antiviral therapy is not recommended.
- Dose reduction of ribavirin for the management of symptomatic anaemia according to the product information is appropriate and will not reduce the likelihood of SVR.
- The recommended treatment regimens differ in the setting of decompensated liver disease (Child–Pugh score ≥ B7) (see *Australian recommendations for the management of hepatitis C virus infection: a consensus statement* (September 2018), http://www.gesa.org.au).

Updated September 2018

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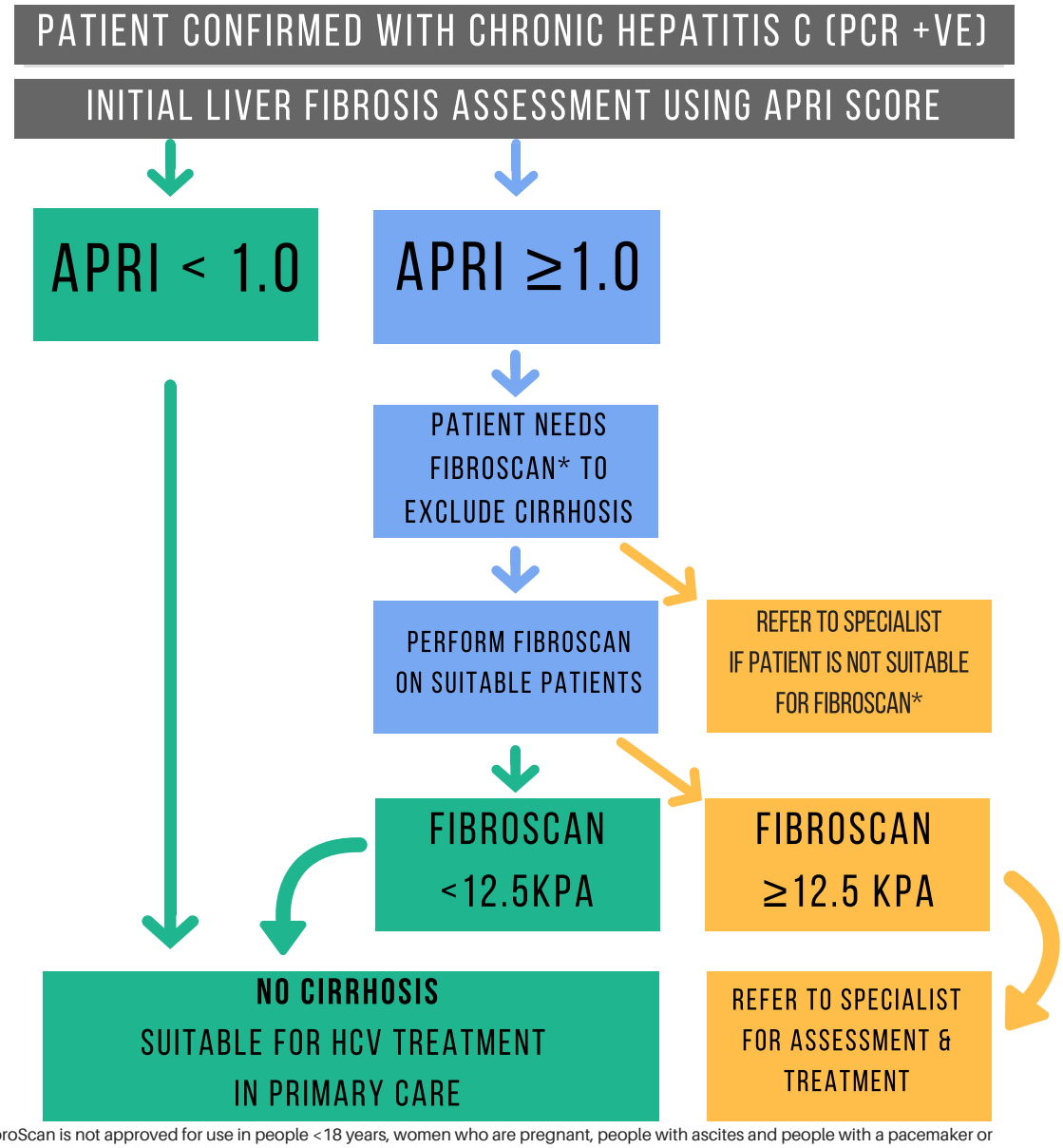
PATHWAYS TO LIVER FIBROSIS ASSESSMENT FOR PATIENTS IN PRIMARY CARE

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

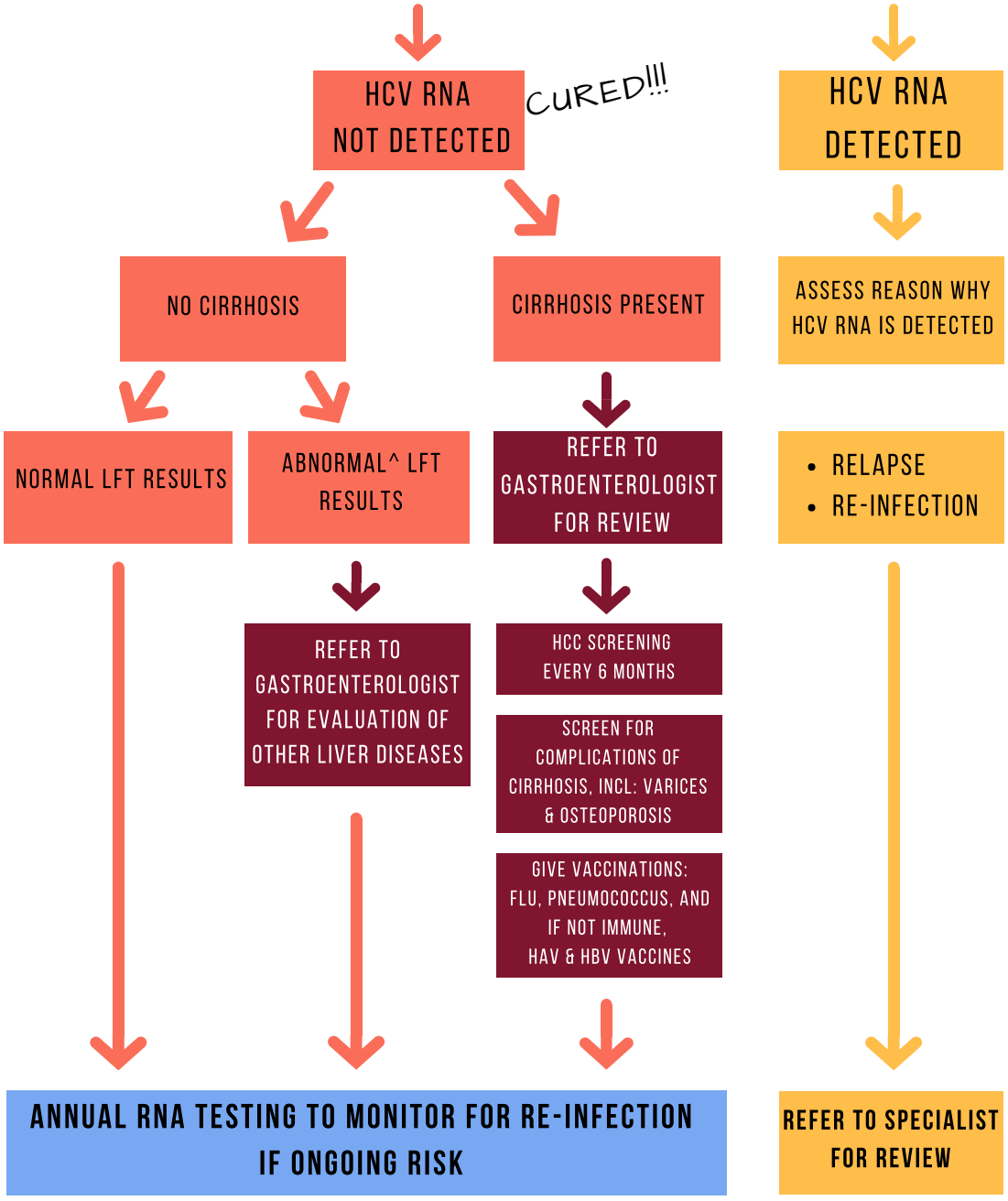
Note: suitable specialists include gastroenterologists, hepatologists and infectious disease physicians. Appropriate specialist depends on your local referral processes

EC Partnership

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

EC Partnership

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

Has prior treatment included oral antiviral therapy? ☐ 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 genotype			Creatinine		
HCV RNA level			eGFR		
ALT			Haemoglobin		
AST			Platelet count		
Bilirubin			INR		
Albumin			HBsAg		

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):*

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
Elbasvir + Grazoprevir	12 weeks ☐		1 or 4
Sofosbuvir + Ledipasvir	8 weeks ☐ *No cirrhosis, treatment-naive*	12 weeks ☐	1

Multiple regimens are available for the treatment of chronic HCV. Factors to consider include HCV genotype, cirrhosis status, prior interferon treatment, viral load, potential drug–drug interactions and comorbidities.

See *Australian Recommendations for the Management of Hepatitis C Virus Infection: A Consensus Statement (September 2018)* (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 direct-acting antiviral 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:	
Once completed, please return both pages by email: **or fax: ( )**	

Table 2. 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* • Consider HCV RNA level (quantitative)† • 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)
	• Electrocardiogram should be performed if ribavirin therapy is planned and patient is > 50 years of age or has cardiac risk factors

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

* HCV genotype is required by the PBS criteria; it is important before prescribing elbasvir plus grazoprevir or sofosbuvir plus ledipasvir.

† HCV RNA level is important for determining eligibility for 8-week treatment duration with sofosbuvir plus ledipasvir.

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

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

Note: 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

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

[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.

Here are some tips for introducing hep C testing to patients in your clinic...

Starting the conversation

"WE HAVE A FOCUS ON LIVER HEALTH AT THE MOMENT AND ARE OFFERING EVERYONE TESTING FOR HEP C"

THE MOST COMMON WAYS YOU CAN GET HEP C ARE:

- Injecting drugs
- Receiving blood products or organ transplant before 1990
- Time in prison
- Needle stick injury
- Unsterile tattoos /piercings
- Born overseas

"DO YOU THINK YOU MIGHT BE AT RISK AND WOULD YOU LIKE A TEST TO FIND OUT?"

"HAVE YOU BEEN TESTED BEFORE?"

Things to cover before a test:

- ☑ Previous testing
- ☑ Information on testing, treatment and prevention
- ☑ Allow the person to be in control of their disclosure of risk – they don't have to tell you how they got hep C.
- ☑ What does the person think the result will be? Do they have someone they could talk to about it if it was positive?
- ☑ Reason for why a positive test result requires notification to DHHS (public health purposes)
- ☑ Has the person given consent to be tested?

Getting someone ready for treatment

WOULD YOU LIKE TO GO ON TREATMENT TO CURE YOUR HEP C?

WHAT DO YOU THINK YOU CAN DO TO MAKE SURE YOU COMPLETE THE TREATMENT? WHAT CAN I DO TO HELP?

HOW ARE YOU GOING GENERALLY?

DO YOU THINK THAT YOU WILL BE FINE REMEMBERING TO TAKE A PILL EVERY DAY FOR 2 OR 3 MONTHS?

WHAT'S YOUR MAIN REASON FOR WANTING TO GO ON TREATMENT FOR HEP C?

DO YOU THINK ANYTHING ABOUT YOUR DRUG OR ALCOHOL USE MIGHT MAKE IT TRICKIER TO COMPLETE TREATMENT? IF THERE IS ANYTHING WE CAN DO OR ORGANISE FOR YOU LET ME KNOW

Provide some information on the treatment:

- ☑ The treatments cure 95% of people with hep C
- ☑ Some people may get mild side effects from the medications such as fatigue, nausea and headaches
- ☑ Tell the patient to let you know if side effects are impacting on daily life
- ☑ Explain the importance of adherence to the medication
- ☑ Let them know the pharmacy might have to order the medication
- ☑ Explain what you will need to do to get them ready for the treatment

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.

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paul ramsay FOUNDATION

Eliminate C PARTNERSHIP

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

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ecpartnership@burnet.edu.au