Hepatitis C capacity strengthening program with Aboriginal Medical Services in regional Australia

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ASHM is a signatory to the ACFID Code of Conduct and is committed to the principles of the Ottawa Charter for health promotion and the Jakarta Declaration on health promotion.
Disclosures

• None
Acknowledgement of country

This program has been conducted in various locations across Western NSW but has been administered from ASHM’s Sydney office.

ASHM acknowledges the Gadigal people of the Eora nation on whose land the ASHM office stands.
ABORIGINAL AUSTRALIA

David R Horton, creator, © Aboriginal Studies Press, AIATSIS and Auslig/Sinclair, Knight, Merz, 1996.
Aboriginal Health disparity

• 10 year life expectancy difference between Aboriginal and non-Aboriginal people, previously 17 years (1)

• “Indigenous Australians have lower incomes, higher rates of chronic disease, are more likely to live in overcrowded housing and are less likely to continue their education.” (2)

• “Aboriginal and Torres Strait Islander people experience a burden of disease two-and-a-half times that of other Australians. A large part of the burden of disease is due to chronic diseases such as cardiovascular disease, diabetes, cancer, chronic respiratory disease and chronic kidney disease” (3)

1. WHO 2008
2. Fred Hollows Foundation
3. Department of Health 2013
Epidemiology

“It is estimated that between 13 000 and 22 000 Aboriginal and Torres Strait Islander peoples are living with hepatitis C in Australia, representing 4% of all Indigenous Australians, compared with 1% of non-indigenous Australians.”

Department of Health and Ageing 2010

“Indigenous Australians are almost three times more likely to contract hepatitis C than the rest of the population”

Sarah Dingle 2014
Figure 35
Notification rate of hepatitis C infection newly diagnosed in 2012, by Aboriginal and Torres Strait Islander status\(^1\), sex and age group

1 Jurisdictions (NT, SA, TAS & WA) in which Aboriginal and Torres Strait Islander status was reported for more than 50% of diagnoses

Source: State/Territory health authorities
Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander people: annual surveillance report 2013 Kirby Institute UNSW
Factors increasing HCV risk in Aboriginal communities

- Higher rates of IDU & incarceration (1)
- HCV status is associated with Indigenous status within prisons (2)
- Unsafe injecting behaviour
  - More than 50% of Aboriginal people outside prisons share injecting equipment (compared with 18% non Aboriginal people) (3)
- Aboriginal people may be more at risk of HCV due to cultural factors such as values of kinship and sharing, and practices involving tattooing and blood to blood contact (4)

2. National Drug Research Institute, Curtin University of Technology 2001
4. van der Poorten D, Kenny DT, George J. 2008
Hepatitis C Treatment in Australia

- HCV treatment is generally delivered by gastroenterologists or ID physicians in a tertiary setting
- S100 drugs restricted to accredited prescribers
- A small number of doctors are trained and accredited to prescribe antiviral maintenance HCV treatment in a primary care setting
Background

- Close the Gap campaign, launched in 2007 unified voice of 40 organisations calling for a government commitment to close the gap.

- Endorsed by the Australian government in 2008, agreed to a National Partnership Agreement (NPA) on closing the Gap in Indigenous Health

- “Closing the gap a strategy that aims to reduce Indigenous disadvantage with respect to life expectancy, child mortality, access to early childhood education, educational achievement, employment outcomes.”

Australian Indigenous HealthInfoNet 2013
Program goals and objectives

**Goal:** Reduce the impact of Hepatitis C on the Aboriginal community accessing services within Bila Muuji Aboriginal Health Services Inc.

**Objective:**
- Increase testing, treatment and management of Aboriginal people living with HCV in the primary care setting
- Increased engagement and support for existing services in the Western NSW and Far West regions
Key program areas

Multifaceted approach to capacity strengthening:

- Training and Education
- HCV Clinical and organisational management tools
- Professional Development Network
Training

• Hepatitis Training for GPs and Health Care Professionals with Aboriginal Clients – delivered in four locations
• Hepatitis C Workshop for nurses supporting Primary Care – delivered twice

Overall 68 people attended training
Localised HCV decision making tool

STEP 1: Could it be hepatitis C?
- Patient request
- Abnormal liver function test (LFT)
- Doctor concern

Presence of risk factors:
- Injecting drug use
- Sharing of injecting equipment
- Birth in high prevalence countries
- Blood transfusions and blood products before 1990 in Australia
- Unsterile tattooing and body piercing
- Unsterile medical and dental procedures and blood transfusions in high prevalence countries
- Time in prison
- Needle stick injuries
- Mother to child transmission is around 5%
- Household transmission is very rare
- Sexual transmission is rare but can occur in certain populations, such as men who have sex with men (MSM) or those who are Human Immunodeficiency Virus (HIV) positive.
- Jaundice or acute hepatitis

Gain informed consent in a culturally appropriate manner
Discuss:
- Reason for test
- Risk factors
- Meaning of a positive antibody test
- Availability of treatment
- Mechanism for communicating test results

STEP 2: Review results
- Hep C Ab-ve LFT normal (means hepatitis C unlikely, PCR not needed)
- Hep C Ab-ve LFT abnormal or possible acute hepatitis C
- If possible acute hepatitis, also order Hep C polymerase chain reaction (PCR)* (to detect HCV RNA)

STEP 3: Check Hep C PCR
- Hep C Ab-ve PCR -ve means hepatitis C unlikely
- Hep C Ab-ve PCR +ve means acute hep C
- Hep C Ab +ve PCR +ve means chronic hepatitis C (chronic if > 6 months)
- Hep C Ab +ve plus repeated PCR -ve means cleared hepatitis C

Convey test result:
If positive, results should always be provided in person and explained:
- Natural history
- Modes of transmission and risk reduction
- Availability of treatment
- Need for ongoing, potentially lifelong monitoring
- Life style factors e.g. alcohol minimisation, diet
- Availability of peer support services, information and support services
- Refer to Hepatitis Australia National Introline 1300 437 222

STEP 4: Follow up and referral
- Repeat Hep C Ab LFT if recent (possible window period) or ongoing risk
- Option 1: Refer ALL PCR +ve
- Step 5: Further assessment in primary care (see next page)
- Repeat Hep C PCR, LFT if on-going risk

* Check Medicare schedule rebates for hepatitis C PCR testing

For further details on testing, see the National HCV Testing Policy 2012, available at http://testingportal.ashm.org.au/hcv

www.ashm.org.au

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STEP 5 Liver clinic and Referral

Local liver Clinics

**Bathurst Specialist Liver Clinic**
Heritage Building, Bathurst Base Hospital, Howick Street, Bathurst NSW 2795
Ph: (02) 6330 5866
F: (02) 6332 4502

**Dubbo Community Health Centre**
2 Palmer Street, Dubbo, NSW 2830
Ph: (02) 6885 8999
Fax: (02) 6885 8901

**Clingt 96, Orange Community Health Centre**
96 Kite St, Orange, NSW 2800
Ph: (02) 6392 8600
Fax: (02) 6392 8624

STEP 6 Roles and responsibilities for AMS and liver clinic

**Clinic**
- Clinical monitoring
- Coordination of visits with specialist
- Liaise with AMS regarding patient progress

**Evaluate risk factors for liver disease progression**:
- Heavy alcohol intake (> 4 standard drinks per day)
- Long duration of infection (>20 years since exposure)
- Older age at infection
- Coinfection with HIV or HBV
- Obesity/insulin resistance/diabetes
- Elevated ALT
- Male gender

Note that all patients should have an assessment of liver disease stage by Fibroscan if available.

**AMS**
- Coordinate clinic visits including transportation if possible
- Social and emotional wellbeing
- Provide lifestyle advice
- Referral to AOD services and dietitian if appropriate
- General health
- Store treatment at AMS if necessary

Please undertake the following tests and include with your referral:
- HCV Antibody – Please write on pathology form if positive result; please do the following as patient is being evaluated for commencement of treatment –
  - HCV PCR Quantitative (Viral Load)
  - HCV genotype

As well as the following:
- EUC
- Fasting BSL
- LFT
- Fasting Chol/TG
- FBC
- HIV Screen
- HAV IgG
- AFP
- TSH/FreeT4/FreeT3
- Coagulation studies
- Abdominal ultrasound (within 1 year)
- Fe studies, B12, Folate, 25(OH) Vit.D
- HBV serology (HbsAg/HbAb/HbcAb) if patient is referred for Hepatitis B or known to have hepatitis B, please also add HBeAg/HBeAb/HBV DNA

STEP 7 Assess suitability for treatment

**Contraindications to current treatment**
Address possible contraindications to therapy with pegylated interferon and ribavirin:
- Decompensated cirrhosis - refer to specialist
- Alcohol abuse
- unstable social/accommodation/work situation
- Major untreated psychiatric illness
- Autoimmune disease
- Major concurrent medical disease
- Pregnant or unwilling to comply with adequate contraception

Note: injecting drug use does not exclude people from treatment, but unstable injecting drug use is a contraindication.

AMS and clinic support before, during and after treatment.

Clinical management tools

Team care plan

• Outlines the multidisciplinary approach to the management of patients with Hepatitis C in an ACCHS.

• Details patient monitoring and lifestyle changes to minimise disease progression and/or in preparation for treatment

• To be utilised and updated by all health professionals involved in patient care.
Dr Penny Abbott's Model of care

Community education or health promotion initiatives, referral to ACCHS

- Self presentation for testing, education or management
- Identified as needing screening in AHW or nurse risk assessment / Aboriginal health check / Care planning process
- GP identifies HCV risk

AHW or nurse assessment / education / case management / support

GP assessment / general health management / clinical workup re suitability for treatment

- chronic HCV – not currently suitable for / choosing to have treatment
- Regular reappraisal
- chronic HCV potentially suitable for / interested in treatment

Referral for HCV treatment
- specialised treatment services
- Shared care
- GP initiation
- Private gastroenterologist

Closing the Gap chronic disease initiatives to support ACCHS and patient living with HCV

Education for ACCHS staff on HCV accessed through Aboriginal Health College, ASHM & Hepatitis NSW

Multidisciplinary health care delivered within ACCHS in partnership with local services
- Primary care – GPs, nurses, AHWs
- Social and Emotional Wellbeing
- Child and Family, including antenatal, care
- Sexual health
- Substance misuse
- Chronic care
- ACCHS Healthy liver clinic

Local community consultations including through ACCHS Board
Collaborative partnerships with culturally safe local HCV services and health practitioners
Clinical pathway agreements

- Between AMSs and local treatment services
- Outlines patient management between services
- May include: outreach clinic at the AMS, case management meetings attended by the local hepatitis CNC and the use of telehealth.
Professional development network

• Hepatitis C Champions
• Representatives from each service involved
• Meetings to discuss program activities and receive clinical updates
HCV Webpage

• Clinical management resources
• All resources -
• To encourage program sustainability
Program challenges

• Burden of chronic disease – competing priorities
• Distance
• Access to services
• Temporary staff, staff turnover, lack of clinical staff

Addressed by:

• Tailoring program activities to service capacity and timelines
• Emphasis on sustainability
Outcomes

• Evaluation ongoing
• Clinical pathway agreements resulting in increased engagement with specialist services, regular visits or outreach clinics
• Clinical pathways agreements allow for effective referral and continuity of care
• 3 nurse-led outreach clinics are being conducted on a regular basis
Outcomes cont.

• Increased service engagement with HCV overall, incorporation into health promotion activities
• Utilisation of the team care plan to ensure regular monitoring of patients
World Indigenous People's Conference on Viral Hepatitis
15 – 16 September

Back-to-back with
9th Australasian Viral Hepatitis Conference
17 – 19 September
Alice Springs Convention Centre, Alice Springs, Northern Territory, Australia

Save the dates and start planning your trip now!
Further information available
www.hepatitis.org.au
Thank you!

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