- determining how ACCHSs can be integrated into the treatment framework to improve access to services for Aboriginal and Torres Strait Islander people
- involving the Clinical Services Redesign Program[72] and the Greater Metropolitan Clinical Taskforce[73] in developing a statewide approach

8.5 Resolve issues around shared care by GPs and hospital based specialists in the provision of anti-viral treatment of people with HCV (see sections 7.6, 7.9)

Shared care of HCV anti-viral treatment by GPs and hospital based specialist services should be formally adopted as part of the service delivery framework because of its advantages including the fact that:

- it takes some of the anti-viral treatment load off the specialist services
- it facilitates access to services, especially in rural areas

The evaluation of the GP prescriber pilot in NSW and the ACT identified some issues that could enhance the effectiveness of shared care (see section 7.6). These include:

- provision for GPs to initiate treatment
- recognition of the pivotal role of nurses in the treatment process in terms of case management, facilitating communication between the specialist and the GP, maintaining the necessary paperwork and exploiting opportunities available through Medicare such as Enhanced Primary Care (EPC) and access to counselling (the nurse involved does not need to be from the specialist HCV service, he/she could be the GP practice nurse if given the appropriate training)
- the importance of psycho-social support
- the need for better access to hepatitis C treatment drugs (i.e. option to dispense via community pharmacy as well as the hospital pharmacy)

These issues should all be addressed in the proposed pilot of community prescriber initiation of hepatitis C anti-viral therapy (section 7.6).

In addition there should be:

- flexibility of the model so that it accommodates GPs working in ACCHSs
- active encouragement of s100 prescribers in ACCHSs to facilitate an increase in the number

8.6 Develop strategies to involve AOD services in HCV anti-viral treatment (see section 7.7)

There is much potential and goodwill around the involvement of AOD services in provision of HCV anti-viral treatment. Priority areas for action include:

- discussions with the Mental Health and Drug and Alcohol Office of NSW Health
- assessment of the feasibility of public and private methadone prescribers providing HCV anti-viral treatment
- development of a detailed plan including resource, training and education requirements (of both staff and clients) to enable greater AOD involvement in HCV treatment and care
- close monitoring of the project being undertaken by NCHECR to pilot and evaluate the uptake of hepatitis C testing and treatment in drug dependency settings
- obtaining client perspectives including people from an Aboriginal and Torres Strait Islander and people with a culturally and linguistically diverse background in understanding how best to work with people with HCV in AOD settings

8.7 Articulate optimal model of care for HCV anti-viral treatment (see sections 7.5, 7.6, 7.7, 7.8, 7.9, 7.10)

A key element of the HCV services is the provision of anti-viral treatment. An increase in numbers receiving anti-viral treatment is fundamental to reducing HCV related liver disease. The optimal model of treatment needs to:

- define the role of the each of the providers — hospital specialists, private specialists, GPs, nurses, counsellors, SHSs, ACCHS, AOD services, support services (HCCNSW, NUAA) in metropolitan and rural AHSs

72 The Clinical Services Redesign Program (CSRP) is an ambitious and important reform program established by NSW Health. Clinical service systems are being redesigned to improve patient journeys across multiple care centres in local health services. Each Area Health Service has been given funding and support to help redesign clinical services. A program office has been established within the NSW Department of Health to provide support and to lead the program at a statewide level. http://www.health.nsw.gov.au/csrp/about.html

73 The Greater Metropolitan Clinical Taskforce (GMCT) was established in 2004 to continue the work (which was begun by the Greater Metropolitan Transition Taskforce (GMTT) in implementing the recommendations of the Greater Metropolitan Services Implementation Group (GMSIG)) of engaging clinicians and consumers in planning and implementing improved health services. Some 24 Specialty Service Networks were developed during 2002–2007 with ongoing support from the GMCT Executive. These groups became cohesive multi-disciplinary teams from multiple facilities, with Chairs and Co-chairs elected to guide their work. Networks gather information, develop consensus documents to standardise and guide clinical practice — referral protocols, clinical practice guidelines, resources for patients, educational resources for staff, undertake research and coordinate clinical services and provide advice to the Department of Health. Most Networks devote resources to ensuring better access to pertinent clinical data. Minimum data sets and standardised data collection systems are being implemented. The collated clinical data from across the networks helps to identify trends and provide a more accurate picture of patient disease patterns and demand, which in turn drive improvements in clinical practice and the provision of services. Source: http://www.health.nsw.gov.au/gmct/background/history_gmsig.html

- define the key elements of the model — shared care with GPs, case management by nurses, importance of peer support groups, networks of metropolitan and rural services, referrals to community based organisations for support and information
- define the resource modules needed to treat a specific number of cases taking into account patient complexity (current research by Digiusto et al.[74] could assist in this process)
- confirm treatment protocols
- define patient complexity to facilitate definition of the relative roles of GPs and specialists
- explore opportunities that exist in Medicare to enhance the model — EPC, access to counselling
- review other opportunities that are currently in place for other chronic diseases e.g. diabetes education
- assess the potential role of the nurse practitioner in the provision of HCV anti-viral treatment

In defining this model of HCV anti-viral treatment services, the AIDB should seek the involvement of, and possible funding from, the Clinical Services Redesign Program (see footnote to recommendation 8.4).

8.8 Create awareness of the impact of HCV on AHSs (section 7.4) and tighten organisational structures (section 7.3)

Area Chief Executives need to be made aware of the potential impact of people with chronic hepatitis C on their health services (see section 7.4 Comment). One way of achieving this may be to include HCV service performance measures in Chief Executives' performance contracts e.g. number of people who received anti-viral treatment, inpatient costs of treating HCV related illness etc.

The variation between AHSs of the organisational position of HCV services within AHS structures and the ambiguous role of HARP managers in the management and planning of services needs to be addressed. The pros and cons of coordinating HCV services at an AHS level — e.g. joint planning, monitoring and budgeting, shared protocols for treatment and patient management, education program for GPs — needs to be explored (see section 7.3).

8.9 Acknowledge and equitably address specific requirements of populations at risk

Services need to be designed so that they are accessible for at risk populations. Specific needs of these groups are:

People who inject drugs (see section 7.9)

- non-discriminatory and empathetic staff in services
- good support services including social, peer, psychological and physical
- low threshold access (not too many eligibility criteria) to anti-viral treatment
- detailed information
- knowledgeable, supportive and caring GPs

People in custody (see section 7.9)

The high prevalence of HCV among the prison population and the potential for it to increase because of the high rates of injecting drug use and the non-availability of sterile injecting equipment, makes access to treatment services very important. In their submission to this review, Justice Health lists and costs their priorities for enhancement. Justice Health needs to be included in the service enhancement proposed in section 8.1. Discussions also need to occur with the Department of Juvenile Justice to determine how best to ensure that young people in custody know about the signs and symptoms of HCV, future treatment options and liver care.

Aboriginal and Torres Strait Islander people (see section 7.9)

Hepatitis C treatment and care services for Aboriginal populations need to be flexible, locationally specific and include Aboriginal health workers. Specific needs include:

- increased availability of HCV treatment from ACCHSs, by increasing number of s100 trained GPs
- further involvement of ACCHS and other Aboriginal services in hepatitis C care and treatment service delivery planning and implementation
- partnerships between liver clinic specialists and ACCHSs so that treating staff in ACCHSs are supported
- better access to mainstream services by developing good partnerships with the local ACCHS and ensuring all staff undertake cultural awareness training, to create a number of options for obtaining treatment
- more outreach services, especially in rural areas
- local access to anti-viral drugs
- case management for Aboriginal people during treatment
- involvement of peers assisting in raising awareness of treatment, explaining the issues around treatment (side effects, cure rates, support available)

74 Digiusto E, McPherson M, Ang, J (2007) 'The nature of services available to patients undertaking hepatitis C antiviral therapy in NSW', paper presented at the National Hepatitis C Health Promotion Conference, Melbourne, June.

- counselling and support for Aboriginal people during treatment
- consideration of transport issues when planning treatment for Aboriginal people
- culturally appropriate information about HCV for the wider Aboriginal community

People from a culturally and linguistically diverse background (see section 7.9)

- culturally and linguistically appropriate information about treatment services
- greater use of bi-lingual/bi-cultural co-workers in liver clinics
- better informed GPs from culturally and linguistically diverse backgrounds
- peer support and targeted outreach clinics within the geographic areas in which specific culturally and linguistically diverse communities reside

Children (see section 7.11)

Currently there are no identified HCV services for children. However there are a substantial number of notifications each year with over 500 notifications in the last five years — most of these in the 15–17 age group. The international literature suggests a similar response rate to anti-viral therapy as seen in adults. A statewide children's service along the lines proposed by the submission from the three children's hospitals seems to be the most cost effective and efficient approach to service provision. Funding for such a service appears warranted and is recommended to avoid the development of advanced liver disease in an estimated 2-4% of children who acquire the disease.[75] To enable this recommendation to be implemented the HSDP of the Australian Government will need to be convinced that s100 drugs should be made available to children less than 18 years of age.

Pregnant women (see section 7.10)

The extent of antenatal screening for HCV varies throughout Australia and there appears to be much more testing than would be expected if the National Testing Policy recommendations were being adhered to. The extent of antenatal screening should be monitored to ensure adherence to National Testing Policy guidelines.

8.10 Develop workforce strategies (see sections 7.12, 7.10, 7.9, 7.6)

Priority areas of action include:

- supporting the work of the Australasian Hepatology Association in developing national standards in hepatology nursing
- facilitating negotiations with the relevant medical College about increasing hepatology component in advanced gastroenterology training
- working with universities and colleges to enhance medical, nursing and allied health undergraduate programs so that they include relevant issues in relation to HCV (access and equity, stigma and discrimination)
- reviewing all aspects of HCV in GP education in conjunction with relevant education organisations and develop a comprehensive education plan that covers all aspects of GP treatment and care (not just prescribing). GP education strategies should include a focus on changing health professionals' attitudes towards people with hepatitis C and people who inject drugs (see section 7.10) and on the advantages of referring to community based organisations for information and support
- working with AHSs to integrate HCV treatment and care issues into relevant health worker training programs
- working with AH&MRC to improve the knowledge of Aboriginal sexual health workers, ACCHS GPs and RNs about HCV treatment and care
- developing resource and training requirements to facilitate greater AOD involvement in HCV treatment and care
- supporting specific hepatitis C workforce development for the Aboriginal health workforce

8.11 Develop a system for monitoring the use of HCV inpatient and ambulatory services (see section 7.13)

This review has demonstrated that there is no standardised data on the utilisation of HCV inpatient and ambulatory services. This information is essential to monitor the number of patients on anti-viral treatment and the impact of HCV related liver disease on the use of inpatient services.

Priority areas of action include:

- close scrutiny by clinicians of the method used in section 6.2 to describe and cost the use of inpatient services by people with HCV related illness, to determine its adequacy.
- development of a standardised reporting system with standard data definitions, especially the term 'Aboriginality', and data collection methods.
- assessment of the feasibility of developing an HCV ambulatory data system as part of the HIV/AIDS Minimum Data Set.
- investigation of the possibility of creating HCV DRGs, similar to the HIV DRGs.

75 Joint submission from the three NSW children's hospitals.