

## **Input to evaluation of Victorian Hepatitis C Strategy**

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### **Background and purpose of this paper**

GPV is the peak body for Victoria's 29 divisions, associations and local networks of general practice. Divisions build capacity in general practice, working at the local level towards a skilled, viable and effective general practice sector to improve the health and well-being of Victorian communities. Supported by funding from the Victorian Department of Health, GPV works with the Alfred Hospital Infectious Diseases Unit and the Australasian Society for HIV Medicine to deliver the **Sexual Health, HIV and Hepatitis Education (sh<sup>3</sup>ed)** program: a comprehensive training and support program for general practitioners and other healthcare workers in relation to blood-borne and sexually transmissible infections.

This paper is a response to the Department of Health's invitation to make comments to inform its evaluation (to be conducted by Urbis Pty Ltd) of the Victorian Hepatitis C Strategy 2002-2004 and Addendum 2005-2009. We are making comments only on those aspects that are relevant to our role as a funded education and training program in the BBV-STI area, and our perspective as the peak body for divisions of general practice in Victoria.

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### **Responses to specific questions posed by the survey conducted by Urbis Pty Ltd.**

#### **2. How much influence you think the strategy/ies have had in Victoria – and why**

The strategy would have been far more influential had it been accompanied by a comprehensive action plan transparent to all stakeholders. For future action plans, we recommend that the identification of roles, responsibilities and timelines allocated to funded programs and stakeholders are contained within the document with the aim to promote better coordination among organisations and services.

#### **3. The main value, achievements or success of the strategy/ies**

The strategy has provided a platform for:

- The establishment of the "Victorian Guidelines for Accreditation and Maintenance of Accreditation as a s100 prescriber in Hepatitis C" and the related "Victorian Clinical Placement Guidelines"
- The establishment of the **Sexual Health, HIV and Hepatitis Education (sh<sup>3</sup>ed)** program, to deliver education to the general practice sector at all levels in order to increase testing, diagnosis, referral, and uptake of community based service provision including prescribing of Hepatitis C Virus (HCV) therapy
- Ongoing (community based) needle/syringe exchange programs
- Ongoing funding for peer groups/advocacy such as Hepatitis C Victoria and Harm Reduction Victoria. The sh<sup>3</sup>ed program coordinators have commenced integrating peer

groups into educational events, in recognition of their value as educators as well as important link between vulnerable patient groups and health care providers.

- The provision of funding for the Positive Speaker Bureau (maintained through Hepatitis C Victoria / People Living with HIV/AIDS Victoria) has made the availability of trained HCV positive speakers possible. We found the use of patient narrative incredibly powerful when providing education to (high case load) GPs.

#### 4. The main limitations or failures

Priority 1 in Addendum: The lack of needle syringe exchange programs in correctional facilities.

Priority 3 in Addendum: A key component of the draft national strategy for hepatitis C is that GPs should provide community based HCV management through a shared care model. There are a number of issues that are currently limiting this work in Victoria:

- Specialist centres do not have the capacity to provide services required for shared care to work. Specifically, the ongoing shortage of hepatology nurses results in extended waiting times for patients which leads to frustration of patients and referring GPs (bottleneck). This appears to have been a contributor to disengagement of GPs.
- In addition, the shortage of hepatology nurses also represents a significant barrier to efficient communication between referring GPs and the specialist centre, which has discouraged HCV s100 GPs from prescribing (only 3 of 14 prescribers appear to be actively and regularly prescribing HCV treatment through more or less well maintained shared care arrangements). A significant increase in the capacity of specialist centres is urgently needed to allow a shared care program to be established and maintained successfully. State government funded hepatology nurses are urgently needed.
- It is concerning that no specific funds have been allocated by the state government towards increasing numbers of hepatology nurses. This results in a lack of trained hepatology nurses. The existing hepatology nurses appear to be funded through four avenues:
  - The pharmaceutical industry (directly or indirectly)
  - Funds generated through participation in (often pharmaceutical sponsored) clinical trials
  - The cost being absorbed by the hospital
  - Regional offices of the department of health (isolated cases, for example Ballarat)

This results in insufficient capacity to accommodate shared care arrangements and therefore prevents a significant increase in patient numbers treated. We (sh<sup>3</sup>ed staff) are already encountering this barrier and identify it as **the biggest single obstacle to increasing numbers of patients treated for chronic hepatitis C infection.**

Furthermore, the potential impact of funding for nurses provided directly or indirectly through pharmaceutical companies is concerning and may challenge the independence of services provided. Financial support from the pharmaceutical industry cannot be taken for granted and its durability in a more aggressively regulated environment is

questionable. Other states have recognised the importance of providing significant state led investment in hepatology nurses. (for example: the draft discussion/consultation paper for the national hepatitis C strategy 2009-2013 shows that Queensland state government has committed to funding 10 hepatology nurses. Available under this link:

<http://www.ashm.org.au/images/pdfs/hepatitiscstrategyconsultationpaper310809.pdf>)

- The current hospital centric model of care fails patients who cannot access hospitals easily. This is particularly relevant to rural areas, where limited access to specialists paired with long travel times represents an unsurmountable barrier to many patients. Expanded access could be achieved through establishing state or Medicare funded satellite clinics which work closely with local GPs in shared care arrangements.
- There is insufficient funding for the education sector which compromises the ability to provide comprehensive shared care program coordination with the aim of enabling general practice to create and maintain effective links with liver clinics. This coordination is crucial to encourage accreditation and to maintain community based prescribers through a facilitation role in implementing and maintaining shared care protocols.
- Lack of adequate shared care model development including piloting, testing and evaluation of possible models of shared care. If a new model is indeed in development or planned, the provider of s100 accreditation and ongoing s100 training should be involved. Moreover, it is critical that all stakeholders (sh<sup>3</sup>ed program, RACGP addiction medicine committee, specialists, mental health services, and advocacy) are consulted in the development of such a model.

Priority 5 in Addendum: The implementation of a Hepatitis C specific education program through divisions of general practice needs to be maintained and expanded. A key issue is the reliance on pharmaceutical funding in order to afford the delivery of local educational events. This can lead (and has led) to conflicts of interest that make the provision of education difficult. For example, companies have attempted to influence speaker selection (funding withdrawn due to unwillingness to use a specific speaker), attempts to influence educational material have occurred, and sponsorship of education for rural events (which can be the most costly) is generally unavailable.

##### **5. Any significant new developments since the strategies were prepared**

A need for community s100 prescribing has been noted by several recent publications (*Gidding et al. Journal of Gastroenterology and Hepatology 2009, vol 24 pp 1649; Hellard Medical Journal of Australia 2009 vol 191(10)*) as well as by the national strategy (draft available at [www.ashm.org.au](http://www.ashm.org.au)). On 5 Dec 2009, approximately 30 GPs, mostly high case load pharmacotherapy providers, undertook the first step towards accreditation through the s100 course offered through the sh<sup>3</sup>ed program. This development is likely to triple the number of authorised s100 providers and has the potential to increase the number of active prescribers tenfold. It also emphasises the need for increased government support for more comprehensive services with respect to education and hepatology units. Specifically, there is urgent need for the following:

- Community based management through shared care
- Specialist outreach to primary care

- Multi-disciplinary team approach in primary care setting
- Maximising the use of MBS items (e.g. GP management plans, team care arrangements, mental health care plans), and access to commonwealth funded allied health (whether through MBS or other funding streams).
- State investment in service capacity e.g. hepatologists, hepatology nurses, and mental health professionals with outreach capacity
- Up-skilling of, and ongoing education for, clinicians in primary care setting.

A shared program in the absence of the above is unlikely to maximise its potential, as has been made evident by the failure of previous attempts to promote shared care.

#### **6. The content of and priorities for future strategy/ies**

1. There is an urgent need to support and formalise an emerging best practice model for general practice clinics with high Hepatitis C caseload (pharmacotherapy providers) (see response above under 5.) Key aspects of this involve:
  - Hospital centric care has proven to be a significant barrier for patients (including lack of capacity in public hospitals; patients do not want to or cannot travel frequently to public hospitals with liver units). This underlines the need for community based care.
  - Specific funding for the coordination of a comprehensive shared care program, including the implementation and maintenance of the Victorian Guidelines for Accreditation and Reaccreditation as Community based Prescribers of Hepatitis C medicine.
  - The implementation of the model must coincide with a formal evaluation to allow for measurement of its impact and provide evidence for amendments.
2. The need to expand the provision of Hepatitis C education to GPs within typical general practice and in particular, rural general practice, aimed at increased testing, diagnosis, workup for referral and referral.

#### **7. What form you think future strategy/ies should take – e.g., new versions of the existing three strategies, or an overarching document with separate action plans for each disease or group of diseases, or an overarching document with separate action plans for particular populations, etc.**

Separate strategies may be more appropriate. The epidemiology of HBV, HCV, and HIV is different, management is different, and the distribution and needs of the population at risk of infection is also different (with small areas of overlap). Therefore, each area requires a separate strategy and action plan.

Overlap should be identified and find inclusion in strategies and action plans for all disease areas concerned. The key commonality is the need for education of general practice with respect to risk assessment, testing, diagnosis, and referral.

Alignment with the national strategies currently in draft form is likely to be helpful. However, the commonwealth strategies are not at this point accompanied by an action plan, and it is unclear to our organisation when and how the action plan will be developed and implemented. We consider it imperative that any strategy is accompanied by an action plan

the development of which is transparent and immediate, for a strategy without an action plan (including measurable outcomes) is unlikely to have any effect at all.