Eliminate Hepatitis C Australia Partnership
Year 1 – Annual Report

Name of Organisation	Burnet Institute
Program Title	Eliminate Hepatitis C Australia Partnership
Program Summary	The long-term goal of EC Australia is to eliminate hepatitis C as a public health threat by 2030. The Australian public will benefit more broadly from the health system savings that will occur through a targeted and cohesive approach to hepatitis C testing and treatment and from the consequent reduction of hepatitis C incidence and prevalence. Bringing together researchers and implementation scientists, government, health services and community organisations, EC Australia will support services to increase hepatitis C testing and treatment among key affected populations, including people who inject drugs, Aboriginal and Torres Strait Islanders and prisoners. The EC Australia Partnership uses a health-system strengthening approach, which is structured around four key components: 1. Health promotion and awareness raising; 2. Workforce development and health service delivery; 3. Implementation research; and, 4. Evaluation and surveillance
Program objectives	1. Ensure that at approximately 15,000 Australians with chronic hepatitis C are treated and cured of their infection annually. 2. Ensure that people identified with cirrhosis related to hepatitis C infection are treated and cured, and regularly monitored for liver cancer. 3. Establish a national collaborate framework to facilitate a coordinated response to the elimination of hepatitis C as a public health threat from Australia by 2030.
Reporting period	Year 1 Annual Report: September 2018 – September 2019
Report submitted to	Paul Ramsay Foundation, Grants Administrator
Date submitted	Tuesday October 1st

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Executive Summary, Overview of key milestones achieved in Year 1 and, Progress to date

The EC Australia program has made significant progress in the last six months across all four key components, and has added a fifth work stream (Aboriginal Health Strategy) in response to learnings gathered during the State Consultations process. Notably, we delivered the first report on **Australia's progress towards hepatitis C elimination**, partnering with The Kirby Institute and other key collaborators and presented findings of this report at the Australasian Viral Hepatitis Elimination Conference (AVHEC) in August. Highlights and milestones from each of the components are detailed below in the Table: **Year 1 – Key Activity Reporting**, with more detailed information about lessons learnt and challenges included in the body of this report.

The **Health Promotion** component established a Core Reference Group, who are responsible for coordinating the National Health Promotion Campaign – phase 1 which will target people who currently inject drugs (PWID). This group has established key principles for the campaign, including a commitment that the work be led by PWID, from campaign development through to delivery and an understanding that increases in hepatitis C service uptake will need to be supported by considerable workforce development to promote stigma-free health services. The National Reference Group are completing their evidence generation and collation phase, where there is strong support for peer-driven education and messaging. The next steps include development of the campaign strategy in consultation with a media agency, which will leverage work currently being undertaking in NSW to develop their state-based campaign targeting PWID.

The **Workforce Development and Health Service Delivery** component has been a key focus of the last six months. Following the completion of the State Consultation Process, all jurisdictions were then requested to prioritise activities that they felt would significantly increase access to hepatitis C testing and treatment either through addressing a specific funding/service gap, or an opportunity to scale up a successful program within their state/territory. Jurisdictions then submitted proposals for funding consideration. All of the proposals were shared in an open forum at a National Workforce Development workshop in August (Adelaide), which provided an opportunity for information sharing, peer-review and cross-pollination of ideas across all states and territories. Twenty proposals were received in total, and we are currently progressing these through approval and contracting. These projects are due to begin roll out before the end of 2019.

The **Implementation Research** component has started an initial piece of research to understand community and policymakers' attitudes to utilising the existing disease notification and surveillance systems in each jurisdiction to enhance the uptake of hepatitis C treatment and care. A key stakeholder meeting was held in August (Sydney), where Department of Health representatives were invited to discuss existing approaches being piloting across different jurisdictions. There was agreement across the group to support a national review and evaluation of surveillance systems for enhancing follow up and linkage to care of people recently and historically notified as being exposed to hepatitis C. The outcomes of this formative work will be the basis of a NHMRC Partnership grant submission in November 2019. However, it was agreed

that an initial piece of qualitative research was needed to explore the acceptability of such approaches with both the affected community and government. EC Australia has since received ethics approval from Alfred Health for this initial piece of research and stakeholder interviews have commenced.

The **Evaluation and Surveillance** component delivered its first national report on **Australia's progress towards hepatitis C elimination,** partnering with The Kirby Institute and other key collaborators. The report highlights the great strides Australia has made towards hepatitis C elimination over the past two to three years, with over 70,000 Australians having accessed direct acting antivirals (DAAs) by the end of 2018. Importantly, the report shows a decline in the number of people receiving hepatitis C RNA testing for treatment work up and a subsequent slowing of treatment uptake, indicating the need to enhance efforts to facilitate diagnostic testing and linkage to care. This report is a landmark in the hepatitis C elimination effort and provides an important gauge for which national hepatitis C elimination efforts and targets can be measured against.

The fifth work stream of work has been the development of an **EC Australia Aboriginal Health Strategy**, that focuses on supporting accessible hepatitis C care among Aboriginal and Torres Strait Islander Peoples. The strategy brings together all four EC Australia components within a holistic and comprehensive approach that directly engages with the Aboriginal Health Sector whilst positioning hepatitis C elimination within the broader Aboriginal health strategies. It will focus on supporting mainstream health services to strengthen or develop culturally safe hepatitis C care for Aboriginal and Torres Strait Islander People living with hepatitis C, assist Community Controlled Organisations to expand and develop models of hepatitis C care and facilitate opportunities to strengthen and develop partnerships and referral networks between Community Controlled Organizations and mainstream health services.

Progress to date against Program Objective 1:

Ensure that approximately 15,000 Australians with chronic hepatitis C are treated and cured of their infection annually.

Efforts to eliminate hepatitis C as a public health threat by 2030 are progressing in Australia with approximately 70,000 people estimated to have received treatment with DAA's by the end of 2018 and a further 10,000 to 15,000 in 2019.

However, Australia's elimination efforts have reached a pivotal moment with declining treatment uptake each year since DAA therapy became available in March 2016 signalling the need to review, renew and refocus our efforts. Approximately two-thirds of the estimated population living with hepatitis C in Australia is yet to be treated. We believe that this slowing down of numbers is a combination of reduced testing of people at risk, and also incomplete linkage to treatment of those diagnosed with infection. If the current trend continues, Australia will fall behind in the number of people who need to be treated annually to achieve the elimination targets.

Who have we reached to date?

The 70,000 people treated in the past 2-3 years, reflect a population that were already diagnosed and were linked into health services including tertiary hospitals, drug and alcohol community services and in the prison systems. They were already engaged in their hepatitis C care, and interested in commencing treatment as soon as DAA therapy became available. Also, a significant subset of these were experiencing effects of hepatitis C, such a cirrhosis, advanced liver disease complications and liver cancer and these patients were well placed and motivated to cure their infection. This reflected in the high levels of DAA uptake among people with cirrhosis, with estimates of more than 70% having been treated by end 2017.

For this reason, we have seen the benefits of cure translate into dramatic declines in hepatitis C related morbidity and mortality, with 20% declines in liver failure, a plateauing of liver cancer, and a 20% decline in liver-related deaths from 2015 to 2017; a stark contrast to increasing number of hospitalisations for liver failure and liver cancer during the pre-DAA era. People with cirrhosis who are cured through DAA therapy have a very low risk of progression to liver failure, but remain at risk (albeit reduced compared to those not cured) of liver cancer. Thus, declines in liver cancer numbers are likely to be more delayed.

The uptake of treatment has also been accompanied by declines in new hepatitis C infections among key risk populations, including people who inject drugs and gay and bisexual men. Declining hepatitis C incidence among these populations and lower prevalence of infection among recent injectors suggests that we are seeing early evidence of the treatment as prevention benefit; which has largely been driven by engaged drug and alcohol community services and the scale up of treatment in the prison systems.

Together, these data give us clear signals that the assumptions underpinning our elimination models and subsequent targets for reducing morbidity, mortality and new infections are achievable.

Who are we missing?

Given the nature of hepatitis C infections; mostly asymptomatic with a 20-30 year chronic infection phase, many cases of HCV remain undetected or previously diagnosed (often many years ago before simple treatments were available) but not linked to hepatitis C care. To reach the next 180,000 people still living with hepatitis C, considerable efforts will be needed to increase testing and treatment uptake across key services, including high caseload services such as drug and alcohol community services, homeless services, mental health services, and in general practice where people may be unaware of their infection.

The national progress report identified an important risk for our elimination efforts which is the declining trends in both the number of people receiving hepatitis C RNA testing for treatment work up and a subsequent slowing of treatment uptake, indicating the need to enhance efforts to facilitate diagnostic testing and linkage to care. We believe that this decline in numbers is a combination of not enough routine testing in high caseload services, low awareness about the new treatments among the affected community and health providers and a lack of prioritisation of hepatitis C within busy general practice health services. If this trend continues, we won't reach the numbers that are needed to ensure the elimination of hepatitis C by 2030. Ensuring more

health care providers are aware of the treatment and can routinely offer and test people for hepatitis C, as well as reduce the barriers to accessing care through outreach and peer models, is critical to reaching the next 2/3rds of the population living with hepatitis C.

Aware of these issues, the EC Australia program is focusing on supporting efforts to reverse the falling levels of hepatitis C testing and treatment within the next 12 months and expanding the reach and coverage of engaged health services. Given the nature of funding cycles in government (often the budget cycle takes over 12 months to fund projects) and the reliance of the Community Sector on this funding, EC Australia support re-invigorates the response and will be faster and more focussed on reaching the next 180,000 people still living with hepatitis C, which may not necessarily occur if we wait for Government and the Community Sector to self-coordinate.

Even with the support of EC Australia there is potential that testing and treatment numbers will continue to decline in 2020, but we believe that the level of decline will be reduced compared with doing nothing at all and we anticipate broader reach and coverage into health services that have yet to be engaged in the hepatitis C response so far. In addition, the EC Australia structure and coordinated approach to enable continued impact and increases in hepatitis C testing and treatment uptake beyond the life of the project.

The investment in workforce development projects through the EC Australia program in particular, will have the ability to demonstrate outputs and outcomes of testing and treatment numbers. The projects are in the process of being funded and should come into effect in late 2019/early 2020. However, the natural lag between starting an intervention and the interventions impact means we are unlikely to observe the impact of these projects until later 2020 and into 2021. However, we believe these projects will have a significant effect on Australia's hepatitis C elimination effort. In addition, the national hepatitis C campaign planned for roll out early to mid-2020 will provide another boost to these efforts, focussed on driving people into engaged and trusted health services.

Year 1 – Key Activity Reporting

Updated inclusive of Year 1: Q 1, 2, 3 & 4

Year 1 – Key Activity Reporting			
Phase	**Key Activities**	**Deliverable(s)**	**Progress**
Year 1	**Program Management**	Q1: Contract Execution	Completed
	Program Management	Q1: Governance structure formalised	Completed
	Health Promotion	Q2: National Campaign plan developed Q4: Update on National Health Campaign implementation submitted with Annual Report	Completed
	Education and workforce development	Q2: Priority educational programs & jurisdictional work plans developed Q4: Jurisdictional educational program work plans submitted with Annual Report	Completed
	Implementation research	Q2: Identification of major implementation research project and small pilot project submitted Q4: Ethics Application for implementation research project submitted with Annual Report	Completed
	Surveillance and Evaluation	Q2: Identification of priority Surveillance and Evaluation projects	Completed
		Q4: Hepatitis C elimination Surveillance Report and progress reports ACCESS, REACH-C, Ophelia and ANSPS submitted with Annual Report	Completed
		Q4: Established core team to work on liver disease & liver disease/HCC database and protocol submitted to ethics	In progress
	Annual Report	Q4: Annual Report submitted	Completed

Governance and Project Monitoring

Progress Q3 & 4 of Year 1: April – September 2019

The EC Australia Governance structure (detailed in the previous report) was utilised throughout the recent six-month period as all components shifted from priority setting and planning to implementation. An overview of these meetings is listed below:

Technical Working Group Committee meetings

Health Promotion – Core Reference Group planning workshops

- 4th July 2019, Sydney: The Core Reference Group held a planning workshop to discuss priority areas for the health promotion campaign and review previous campaigns and the recent evidence around barrier and enablers. Meeting Participants = 10
- 25th Sept 2019, (via ZOOM video conferencing): The Core Reference Group held follow up meeting where key findings from NSW Health campaign development were shared and discussed, and media agencies were reviewed for invitation to submit to an expression of interest. Meeting Participants = 10

Workforce Development – Review meetings and Peer-review workshop

- May – August 2019, ongoing meetings were held with each key partner organisation and the EC Australia team to refine the scope of proposals, aims and evaluation frameworks.
- 1st August 2019, Adelaide (and via phone conference): Key partner organisations from each state & territory were invited to present their proposals to the group for discussion and peer-review feedback. We also included an afternoon workshop on data collection systems and evaluation to help strengthening the evaluation plan and outcomes monitoring. Meeting Participants = 46

Implementation Research – Key Stakeholder meeting

- 6th August 2019, Sydney (and via phone conference): Key stakeholders including state departments of health, research institutes, community organisations were convened to discuss current activities for following up notifications, issues to consider and sharing of the qualitative research protocol. Meeting Participants = 22

Evaluation and Surveillance – Planning and data collation meetings

- Feb – August 2019, ongoing meetings were held with the four key partner organisations that provided access to over 23 separate data sources across Australia, to form the first report on Australia's progress towards hepatitis C elimination.

EC Australia Executive Committee meetings

- 24th June 2019, Melbourne (and via ZOOM video conferencing): Update from the State Consultation Project Development and information about partner contracts. Meeting Participants = 16
- 7th August 2019, Sydney (and via phone conference): Review and approval (if granted) of Workforce Development proposals from jurisdictions. *See Work Force Development section for more details of proposals.* Meeting Participants = 17

EC Australia Advisory Committee meetings

- 14th August 2019, (via ZOOM video conferencing): Update from State Consultation Process, discussion on Advocacy Points arising from state consultations and presentation of Workforce Development proposals for the purpose of feedback and input prior to roll-out. Meeting Participants = 22

The next major meeting planned is for the Annual National EC Australia meeting which is planned to take place in Melbourne on the 27th of November 2019; where we will provide an update of year 1 activities, present the EC Australia Aboriginal Heath Strategy for wider consultation and progress the national review and evaluation of surveillance systems for enhancing follow up and linkage to care of people recently and historically notified of hepatitis C.

EC Australia Logo

Another key outcome from this period was the **development of a logo for the EC Australia program**. It was determined that a logo was needed to identify and unify the program, outside of both the Paul Ramsay Foundation and the Burnet Institute as activity increases. Options for logos were developed by an independent designer, and then voted on by the EC Australia Executive Committee at the 7th August meeting in Sydney. The finalised EC Australia logo variations are:

EC Australia State Contracts – Workforce Development projects

The State level contracts for workforce development projects with key partner organisations have been progressed, *see Workforce Development sections for more details of proposals.* The current identified key partner organisations for which EC Australia contracts have updated since the last report. The current list is below:

- South Australia: Royal Adelaide Hospital and Hepatitis SA
- Western Australia: Peer Based Harm Reduction WA, Hepatitis WA, WANADA and WA Aboriginal Health Council.
- Queensland: University of Queensland
- National Programs: Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) & Australian Injecting & Illicit Drug Users League (AIVL)
- NSW: NSW Health and Liverpool Hospital
- Tasmania: *to be confirmed* (Potentially TAS Hospital or University of Tasmania)
- Victoria: VHHITAL Consortium and Doherty Institute
- ACT: *to be confirmed*

Health Promotion

Progress Q3 & 4 of Year 1: April – September 2019

The focus of the Health Promotion component of EC Australia to date has been on collating the evidence on successful awareness raising activities and understanding the current barriers and enablers for accessing hepatitis C care to inform the National Health Promotion campaign. This involved a review and synthesis of flagship campaigns developed by state-based organisations, gathered during the EC Australia state consultations. The consultations have involved state and national drug user associations, hepatitis councils, existing state-based hepatitis steering committees, health service providers, clinical training providers and peak professional bodies. We have included an updated summary of the State Consultations – See Appendix 1.

Informed by the state consultations and current surveillance data which clearly identifies lower uptake of hepatitis C treatment among PWID, the EC Australia national health promotion campaign has established it will focus on engaging PWID in the first phase. The goal of this campaign will be to increase testing and treatment for hepatitis C among PWID – and we have developed a detailed outline about the process for the campaign development and implementation timelines – see Appendix 2.

A phase 2 of the health promotion campaign is in planning and aims to increase testing and treatment among Aboriginal and Torres Strait Islander people. More details of the Phase 2 campaign is included in the newly drafted '**EC Australia Aboriginal Strategy'** that will guide future steps for the development of a health promotion campaign for this community group (for more information on the strategy refer to page 16 of this report and Appendix 8).

To guide and coordinate the campaign a National Reference Group has been created. It includes key partner organisations including Australian Injecting and Illicit Drug Users League (AIVL), NSW Users and AIDS Association (NUAA), Peer Based Harm Reduction WA, Harm Reduction Victoria, Hepatitis NSW, Centre for Social Research in Health, and EC Australia; and national group of peers (with lived experience of injecting drug use and hepatitis C) from the AIVL National Peer Network with members from each state/territory drug user organisation.

The National Reference Group are currently completing their evidence generation and collation phase and have identified several key priorities to ensure campaign impact:

- A focus on PWID and led by PWID, from campaign development through to delivery
- Based on evidence regarding current barriers and enablers for accessing hepatitis c care
- Informed by existing materials and learning's from previous campaigns
- Includes an explicit call to action and promotes access points
- Includes complimentary service readiness interventions
- Utilises an appropriate media agency
- Ensures interventions and messages are tailored to each state and territory

A creative/media agency will be engaged to work together with the National Reference Group to develop a communication strategy that targets PWID as the primary audience for the national

campaign and the health and community workforce who regularly engage with PWID and can promote and support them to access hepatitis C treatment, as the secondary audience for the national campaign.

Opportunely, the NSW Ministry of Health has funded Hepatitis NSW and NUAA to develop a state-wide health promotion campaign targeting PWID. The process being undertaken in NSW closely aligns with what has been envisaged for the national campaign, which has involved focus groups with different populations of PWID to explore knowledge and experience with hepatitis C treatment (barriers, facilitators, influences and history). NSW Health have provided approval to access all the campaign materials and formative work for the National Campaign, and EC Australia plans to leverage the NSW campaign and integrate evidence from other jurisdictions ensure national campaign.

The campaign development process and timelines is as follows:

1. Establishing governance and planning (May-July 2019)
2. Evidence generation and collation (July-Oct 2019)
3. Development of campaign strategy and materials (Oct 2019-Feb 2020)
4. Development of campaign implementation and evaluation plan (Jan-Feb 2020)
5. Campaign Implementation (March 2020 onwards)

The implementation of the campaign in March 2020 has been timed to complement and utilise the networks of organisations and additional workforce that will be funded through EC Australia Workforce Development and Health Service Delivery activities. Furthermore, the National Reference Group wanted to ensure the release of the NSW hepatitis C campaign prior to the National campaign to enable lesson to be shared and to pilot peer-peer education and messaging as a viable communication channel. Refer to Appendix 2 for a detailed outline about the proposed process for the campaign development and timelines.

Lessons Learned to date

Previous Hepatitis C campaigns have focussed largely on increasing awareness about the new DAAs and have used positive messages to motivate behaviour changes. During the evidence generation and collation phase, a review of current barriers and enablers for accessing hepatitis c care has identified the need to dispel persistent myths and misconceptions around restrictions to treatment and severe side effects that were related to the old interferon treatments. Current research also suggests that among communities of drug users, there is a perceived non-urgency to access treatment, and limited understanding of the short-long term risk/benefits of not-curing/curing their hepatitis C. Throughout the literature there is strong support for peer-driven education and messaging and a clear need to deliver workforce development around reduce stigma and discrimination in healthcare settings. We have summarized and presented these findings from evidence generation and collation phase in the attached poster – '*Tailoring Hepatitis C Health Promotion for People Who Inject Drug*s' Appendix 3.

Workforce Development and Health Service Delivery

Progress Q3 & 4 of Year 1: April – September 2019

Since completing the national consultation in May 2019, the focus of the Workforce Development and Health Service Delivery (WDHSD) component of has been on identify jurisdictional priorities which will support the transition of hepatitis C testing, linkage to care and treatment from tertiary to primary-based care and contribute to the goal of hepatitis C elimination by 2030. Upon completion of the consultation, jurisdictions submitted proposals that reflected the local priorities. All the jurisdictions submitted proposals by 14th June 2019. Proposals were initially assessed, internally, by the ECA team and initial feedback about the project aims, outcomes, budget and evaluation strategy were provided to the proposal holders by mid-July.

Proposals were assessed against the WDHSD guiding principles:

1. Potential for scale up
2. Assist with prioritising Hepatitis C care
3. Utilise evidence-based approaches
4. Avoid duplication
5. Ensure equity addressing gaps via response to data
6. Enhance sustainability

Overall, 22 proposals were received; the proposals were reviewed internally Two proposals were subsequently withdrawn due to duplication. The remaining 18 proposals were categorised into three themes (see table 1):

1. Models of care (10 proposals)
2. Education / workforce development (7 proposals)
3. Enhanced linkage to care (3 proposals)

A national meeting of all ECA proposal holders was convened on 1st August. Each proposal was presented and details regarding an overview of the aims of the proposal, the intended activity and the intended outcomes and evaluation, was presented for discussion. Participants worked in the themed groups to identify relevant data systems and consistent evaluation metrics that could be utilised to provide evidence of impact for the proposals.

The proposals were subsequently presented by the ECA team to the executive committee and the advisory committee in August 2019 for feedback and input on the scope of work, intended outcomes and evaluation framework. Feedback was then fed back to proposal holders on 20th August with request for further detail and enhancements where indicated. Nine proposals were subsequently approved by the ECA committees and shifted into contract staging while seven proposals are still completing approval processes. Six of the seven proposals are from QLD and were delayed at the request of the Queensland steering committee, however, appear on track for approval by mid-October. Contracts are in the process of being executed with 15 organisations (for 20 projects).

Workforce Development and Health Service Delivery Jurisdictional Proposals

Jurisdiction	Organisation	Proposal title	Budget	Timeline
Theme 1: Models of care				
Tasmania	Department of Health	Tasmanian EC Australia Outreach Project	$400,000	2 years – 2019-2021
Northern Territory	Royal Darwin Hospital and the Menzies	A partnership approach to enabling access to hep C treatment without visiting the hospital in a remote setting	$451,742	2 years – 2019-2021
South Australia	Royal Adelaide Hospital	SA EC Australia Outreach Project	$452,634	2 years – 2019-2021
Western Australia	Hepatitis WA	Regional Workforce Development Project	$180,000	2 years – 2019-2021
Western Australia	Peer-based Harm Reduction	Hepatitis C PHRE project	$200,000	2 years – 2019-2021
Queensland	Hepatitis QLD	Probation and Parole Community (PaP-C) Project	$350,200	2 years – 2019-2021
Queensland	Queensland Injectors Health Network	Prison Transition Support	$100,000	1 year (time period tbc)
Queensland	Queensland Injectors Health Network	Hepatitis C Community Peer Support Project	$237,000	2 years – 2019-2021
Queensland	University of Queensland	Incentives for People Who Inject Drugs	$10,000	1 year (2020)
Queensland	Cairns Sexual Health Service	Cairns Hep C Free incentive program for PWID	$5,000	1 year (2022)
Theme 2: Education / workforce development				
Victoria	Victorian HIV Hepatitis Integrated Training and Learning	A whole of practice approach to increasing the capacity of primary care to positively impact the cascade of care in hepatitis C in Victoria	$241,000	2 years – 2019-2021
South Australia	Hepatitis SA	GP-led in-practice primary care education and support	$35,000	2 years – 2019-2021
Tasmania	Tasmanian Council on AIDS, Hepatitis and Related Diseases	Tasmanian ECA Community Education Project	$80,000	2 years – 2019-2021
New South Wales	Ministry of Health	Treatment in the NSW Needle and Syringe Program	$205,000	2 years – 2019-2021
Western Australia	WA Network of Alcohol and other Drug Agencies	Increasing access of AOD services users to testing and treatment	$200,000	2 years – 2019-2021
Western Australia	Aboriginal Health Council of WA	Workforce Development and Health Service Delivery	$210,000	2 years – 2019-2021

National	Australasian Society for HIV, viral hepatitis and sexual health Medicine (ASHM)	Creating champions of change: galvanizing the healthcare workforce to support elimination	$151,577	2 years – 2019-2021
Theme 3: Enhanced linkage to care				
New South Wales	Liverpool Hospital	Screening consecutive emergency admissions at risk of hepatitis C (SEARCH-2)	$194,500	2 years – 2019-2021
Victoria	The Doherty Institute	Coordinated hepatitis responses to enhance the cascade of care by optimising existing surveillance systems: CHECCS	$199,000	2 years – 2019-2021
Queensland	Department of Health	Notification follow up	$157,000	2 years – 2019-2021

Additional activities completed include:

- EC Australia funded 16 scholarships (14 nurses and 2 peers) to attend the Viral Hepatitis Nurse-led Models of Care forum, which was held the day before the Australasian Viral Hepatitis Elimination Conference. Scholarship holders were required to blog or formally feedback via ASHM social media on nursing-related content. The Nurse-led Models of Care forum was attended by 49 nurses for across Australia and was very well evaluated. The evaluation report will be available in October 2019.*This project was funded out of the Contingency budget line.*
- EC Australia is partnering with Tasmania Health, who are implementing an GP education project that is funded through AbbVie. A nurse has been employed and is enrolling primary care practices; collecting baseline data, providing education over three visits and then reassessing the numbers of people tested and treated for hepatitis C to assess the impact of in-practice education. So far, 9 primary care practices have been enrolled and an evaluation report will be available in March 2020.
- EC Australia is partnering with the National Prisons Hepatitis Network to Education Project targeting Prison Settings. They have secured additional funding from Gilead Sciences and Abbvie to support this work and EC Australia are contributing to this funding pool which will aims to increase capacity of prison staff including clinicians and correction officers to promote and delivery hepatitis C care, and increase awareness of hepatitis C treatment programs in prison to prisoners. *This project is being funded out of the Contingency budget line.* The project timelines include:
    - Phase 1: Needs assessment of clinicians, correction officers and prisoners (2019)
    - Phase 2: Educational resources development for Clinical Staff, Correctional Officers and Prisoners (Jan – May 2020)
    - Phase 3: Program Delivery (June 2020- Dec 2021)
    - Phase 4: Evaluation and Report Delivery (Dec 2021)

Lessons Learned to date

A number of key learnings from the state consultation and proposals development phase, identified by the ECA team, have helped address challenges in implementing a national program and shape the implementation plans. The first key lesson learnt was that the difference in each jurisdiction's health system structure significantly impact on how health priorities are set within states/territories and how health programs are delivered. The governance structure of the health systems are largely centralised as in the case of Victoria, Tasmania, WA, NT and ACT or largely decentralised through the Local Health Districts in NSW, Hospital and Health Services in QLD and Local Health Networks in SA. These structures drive differences in coordination and funding allocation to the hepatitis C elimination approach. However, there were shared barriers across all jurisdictions including lack of a coordinated response which often resulted in service duplication, and inadequate funding to respond to hepatitis C in an evidence-informed approach, particularly in jurisdictions with limited health budgets (Tasmania, NT and ACT).

Each jurisdiction (except the ACT) has a hepatitis C elimination steering committee or implementation working group, which were central to the prioritization process. The EC Australia team attended a steering committee meeting in every jurisdiction between March and June 2019 to socialise the committee and key stakeholders of the ECA Australia aims and to initiate the prioritisation of state/territories activities. Other stakeholders consulted during the jurisdictional visits included: harm reduction and hepatitis organisations, clinicians and nurses, Aboriginal health organisations, Alcohol and Other Drug (AOD) organisations, Primary Health Networks (PHN), education and research organisations.
The national consultation sought to explore the following key questions:

- What models of care / initiatives are working?
- Which workforces need to be targeted to increase coverage of hepatitis C care?
- What capacities/skills are needed to drive increase in uptake of hepatitis C care?
- Where are the gaps in workforce development and health service delivery?
- What does "success" look like? How is it measured?

The ACT are in the process of convening a steering committee in November 2019 and the ECA team will attend the inaugural meeting to discuss the ECA priorities and invite ACT to submit proposals for funding.

Workforce development

Overall, there was national consensus that multiple approaches to workforce development are needed to engage and support the broad range of workforces that are potentially involved in hepatitis C testing and treatment, as well as accurate evaluation of existing programs to determine their reach and impact. The ECA team identified several reoccurring themes regarding hepatitis C workforce development activities across Australia including:

- A predominant focus on GP education to the detriment of other health workforces, in particular, limited workforce development activities for nurses, Nurse Practitioners (NP), Alcohol and Other Drug (AOD) workers, prison health staff, Needle and Syringe Program (NSP) workers, Aboriginal health workers, mental health workers, social workers, homelessness services, pharmacists, community health workers and practice managers

in primary care settings. All these latter professional groups were considered critical to identifying people for testing and linking them to care, however to date have not been well targeted for training, education and workforce development opportunities. The focus on GPs to date has somewhat been driven by funding made available through Pharmaceutical companies which target prescribers, and ECA as identified a need to broaden education and training opportunities to include other key workforces that are often tasked with patient support and responsible for undertaking hepatitis C HCV testing and treatment workup. This broad focus on other key workforces is strongly support key finding from the national progress report, that identified the need to enhance efforts to facilitate diagnostic testing and linkage to care in order to drive treatment uptake.

- The state consultations identified a range of educational activities being implemented yet there was a lack of evidence and understanding about which activities resulted in greatest impact on hepatitis C testing/treatment uptake. There was inconsistency regarding the evaluation metrics being collected to evaluate these activities and a limited collection of robust outcome indicators to effectively evaluate these programs, including linkage care and testing and treatment numbers.
- While it is widely acknowledged among clinical workforce that hepatitis C care is now easier than ever, the transition from hepatitis C care being predominantly delivered through specialists in tertiary settings to delivery by GPs in primary care has meant that hepatitis C care is now just one of many competing health priorities in the primary care space. As a result, service providers have identified the need to move beyond one-off educational activities which are largely clinical knowledge-based, to a model of workforce development that provides support for increasing clinical capacities through professional mentoring models and in-practice support models, to drive testing and treatment uptake outcomes. In addition, availability of “just in time” resources to support busy, time-poor providers with in-practice clinical and patient support and information on how to utilize patent management systems was to identify and link patients into care was identified as a current gap.
- To better support in-practice education and training models, there was significant interest in scaling up the EC Victoria Toolkit (https://ecpartnership.org.au/toolkit) to support a whole of practice approach to hepatitis C in primary care settings across Australia. The ECA team is in the process of working with the jurisdictional steering committees to adapt the content of the Victorian toolkit for a jurisdiction-specific audience. It is anticipated that the revised toolkits will be available in October 2019 at the commencement of the ECA WDHSD projects.

Health service delivery

Many innovative and adaptive hepatitis C, community-based models of care were identified throughout Australia. Nurse-led models of care have been the backbone of the Australian outreach approach to offering hepatitis C care in primary care settings.
Nurses are working in a variety of roles including:

- Hepatitis C capacity building with primary care and community health services

- Specialist outreach models where nurses have direct patient contact and deliver hepatitis C clinical care including testing, liver disease assessment and treatment access and monitoring
- Service blitzes which focus on testing in high prevalence settings such as mental health and homelessness services.

An adaptation of these models have evolved to include a partnership approach between nurses and peers (people with lived experience of injecting drug use and/or lived experience of hepatitis C and/or treatment), working in AOD settings and NSPs, where peers are the initial point of contact with the consumer and build trust in the service, with the ultimate goal of referral to the nurse-led clinic and linkage to care. Integral to several nurse-peer partnership models is the role of incentives as an engagement strategy for people with or at risk of hepatitis C. Unfortunately, evaluation data to support the role of nurses, peers and incentives, is limited, however, building this evidence based is an explicit interest and aim of the EC Australia Implementation Research Component.

Implementation Research

Progress Q3 & 4 of Year 1: April – September 2019

Following the completion of the state consultations in May 2019, the focus of the Implementation Research component has been on identifying and supporting priority workforce development proposal that incorporate the use of rapid testing and peer-based models to increase the uptake of hepatitis C testing and treatment. These include:

- SA EC Australia Outreach Project – which will pilot rapid point of care testing in prison and community settings delivered through nurse-led models.
- WA Hepatitis C PHRE peer education program – which will demonstrate the effectiveness and impact of using peer-education for increasing awareness of DAA treatment and provided assisted referral into a nurse-led hepatitis clinic.
- NSW Enhancing NSP Service Delivery in NSW – which will scale up NSP-based, peer-supported hepatitis C care in NSW NSP services to provide on-site Dried Blood Spot testing and linkage to care pathways at NSP sites in NSW.
- NT Partnership approach to deliver hepatitis C treatment in remote setting - which will embed peers within a clinical outreach nurse-led model in Darwin and Alice Springs to engage and support patients to access hepatitis C care.
- QLD Hepatitis C Community Peer Support Project - which will provide peer-support to a range of health services including alcohol and drug services, community GPs, NSPs services to engage and support patients with complex health needs to access hepatitis C care.

The Implementation Research component has been providing technical assistance to these projects specifically relating to the program design and implementation strategy to ensure these projects can demonstrate impact clearly and also guidance with the evaluation plans to support a

robust evaluation of these programs. Data and outcomes of these studies will collectively contribute to the body of evidence around the impact and utility of these new technology innovations and innovative approaches to increasing access and uptake of hepatitis C testing and treatment.

An area of interest and importance for Implementation Research but not identified in the original application is the potential to use surveillance systems to increase uptake of hepatitis C care and treatment. The aim is to provide enhanced linkage to care to individuals recently diagnosed with hepatitis C and notified to jurisdictional surveillance systems. Using surveillance systems to follow up infectious disease notifications is not a new approach. Known as - contact tracing, the follow-up of infectious by Department of Health has precedence for a number of infectious diseases including HIV, sexually transmitted infections, tuberculosis and meningococcal meningitis in Australia and elsewhere globally.

Historically in Australia, this approach has not been adopted for hepatitis C except in the setting of an outbreak following a contaminated medical procedure. However, during the state consultations, it was identified that a number of jurisdictions were using their surveillance systems to trial various approaches to link person recently notified with hepatitis C to care and treatment, by providing enhanced follow up either by contacting individuals treating clinicians and in some cases by contacting patients directly. Also, the EC Australia team were aware of work being undertaken in the United Kingdom and in some states in the USA using surveillance systems to link people with hepatitis C infection to care and treatment.

Accordingly, the EC Australia team organized a meeting with key stakeholder in August 2019 (Sydney), including Department of Health representatives, community representatives and key research institutes to discuss existing approaches being piloted across the different jurisdictions. This meeting reviewed examples from both Australia and overseas and discussed early outcomes from these pilot studies to assess if current approaches were likely to be a viable and sustainable across jurisdictions. Also, there was discussion about what additional interventions utilizing the surveillance systems were likely to enhance linkage of people notified as having hepatitis C to treatment, and ultimately assist Australia's elimination efforts. There was agreement across the group to support a national review and evaluation of surveillance systems for enhancing follow up and linkage to care of people recently and historically notified for hepatitis C, to provide robust evidence for the effectiveness, impact and cost-effectiveness. As a result, the Burnet Institute will lead NHMRC Partnership grant submission in November 2019; which will include all jurisdictional Department of Health representatives and other key community, clinical, laboratory partners.

A key concern raised by key community organisations was the acceptability of such an approach to the affected populations such as people who inject drugs and Aboriginal and Torres Strait Islander people. Would people feel uncomfortable with being contacted by the Government about their hepatitis C status, due to concerns around privacy and confidentiality and also fear of further stigma and discrimination that was so often associated with both being hepatitis C positive and also an illicit drug user? It was agreed that an initial piece of qualitative research was needed to explore the acceptability of such approaches from both the community and government

perspectives. In response, a research project to investigate *"Using notification data to increase access to the hepatitis C cure"* was developed and has since received ethics approval from Alfred Health.

This qualitative study aims to identify the acceptability, and most effective method of using hepatitis C notification data held by state and territory governments to source and inform people diagnosed with hepatitis C, who have not accessed treatment, that a cure is available, and how to access this cure.

The objectives of this study are to identify:

1. Whether people with hepatitis C will find it acceptable to be contacted by a third party (to be determined) to promote access to hepatitis C treatment using information provided to state and territory health department notification systems,
2. Review the regulation, systems and processes used by state and territory health departments to collect and store notification data, including the implications of privacy legislation within each jurisdiction; and
3. Identify potential legislative and procedural barriers to contacting people previously notified as having hepatitis C infection.

Stakeholder interviews as part of this research has commenced and this will inform the larger national evaluation that will be submitted as a NHMRC Partnership grant submission in November 2019.

Lessons Learned to date:

South Australia is the first jurisdiction to pilot a state-wide pilot of using their Hepatitis C Notification System to provide enhanced follow up to ensure they are linked to care.

Key outcomes of their pilot and evaluation:

- SA implemented a six month pilot where all Communicable Disease Control Branch notifications of HCV were directly referred to the viral hepatitis Nurses for follow up and the efficacy and efficiency of the pathway was evaluated.
- Each month, the Disease Surveillance and Investigation Section, generated a report containing the first name, surname, date of birth, and the contact details of the diagnosing clinician for all HCV cases notified during the preceding month.
- Notifications were then referred to the viral hepatitis nurses who followed up all cases not already known to the service by contacting the diagnosing clinician in the first instance. The viral hepatitis nurses then discussed options available to the diagnosing clinician for optimal management of the patient. Cases who had already tested HCV ribonucleic acid (RNA) negative do not have active infection and received no further follow up at this point. The remaining cases were then offered follow up according to the doctor's preference.

- Key Results included:
  - 303 notifications received from CDCB.
  - 247 (82%) successfully followed up.
  - 142 (57%) HCV RNA positive (remaining cases were HCV RNA negative or had not been tested*).
  - 110 (77%) followed up for further assessment and consideration of treatment:
    - 56 (51%) by GP or specialist without support
    - 23 (21%) by GP with VHN support
    - 31 (28%) through VHN direct referral
    - 9 (6%) refused any further follow up or treatment at this point

The South Australian Viral Hepatitis Model of Care Reference Group endorsed a recommendation to continue the HCV notification referral system in its current format, noting that the system provides utility in ensuring consistency and quality of care offered to all new HCV diagnoses, and in providing targeted support to clinicians who are diagnosing HCV rather than those who self-select for HCV professional development opportunities. The system offers opportunities to contribute to enhancing treatment uptake among people living with HCV, and will be a valuable contribution to the progress towards HCV elimination targets.

We have included a copy of their **South Australian Hepatitis C Notification Referral Trial Evaluation Report** in Appendix 6.

Evaluation and Surveillance

Progress Q3 & 4 of Year 1: April – September 2019

National report on progress towards the elimination of hepatitis C

The Evaluation and Surveillance component has prioritised the delivery of the first national report on progress towards the elimination of hepatitis C virus in Australia as a key output for EC Australia.

EC Australia, in partnership with the Kirby Institute, published the first national report on progress towards the elimination of hepatitis C virus in Australia and launched the report at the 2019 Australasian Viral Hepatitis Elimination Conference, on the 5th of August, in Sydney. The report provides an overview on progress towards eliminating hepatitis C in Australia. The report presented data from 23 separate sources across Australia, including data including targeted analysis previously unreported hepatitis C virus surveillance data (e.g., from the ACCESS surveillance system), publicly available data (e.g., DAA treatment PBS claims) and new and previously published mathematical modelling. EC Australia will continue to work with research and other partners on future annual reports to include some data not unavailable for the inaugural report and expanding the coverage and analyses of existing datasets to provide the most comprehensive picture possible.

The first report highlights the great strides Australia has made towards hepatitis C elimination over the past two to three years, with over 70,000 Australians having accessed curative therapies

known as direct acting antivirals (DAAs) by the end of 2018. The report also highlights the declining numbers of new hepatitis C infections occurring each year.

However, the report also highlights threats to hepatitis C virus elimination. With approximately two-thirds of the estimated population living with hepatitis C is yet to be treated, a key concern is the decline in the number of people receiving HCV ribonucleic (RNA) testing for treatment work up and a subsequent slowing of treatment uptake. The report therefore highlights areas for targeted action, including enhancement of efforts to facilitate diagnostic testing and linkage to care. Mathematical modelling based on the most recent testing and treatment data suggests that without efforts to significantly increase testing of at-risk populations to prevent further treatment declines, Australia's progress towards elimination of hepatitis C will slow.

Key points from the report: Australia's progress towards hepatitis C elimination:

- Over 70 000 Australians have accessed DAAs, highly effective and curative hepatitis C treatments;
- Treatment uptake peaked in the months following the listing of DAAs on the PBS but has subsequently slowed;
- The uptake of treatment has been accompanied by declines in new hepatitis C infections among PWID and gay and bisexual men as key risk populations;
- There is declining hepatitis C incidence among PWID, HIV-positive gay and bisexual men and lower prevalence of infection among recent injectors suggesting early evidence of a treatment as prevention benefit;
- Linked hepatitis C virus notification data also indicates a decline in advanced liver disease complications and liver-related deaths, and further declines in morbidity and mortality outcomes from hepatitis C are expected given the uptake of treatment in recent years;
- Stigma and discrimination towards PWID and people living with hepatitis C remains prevalent, raising concerns about how this may be affecting individuals' access to healthcare;
- Reports of receptive sharing of needles and syringes has remained stable in recent years and there remains a need to focus on primary prevention. However recent declines in incident infections suggest evidence of a treatment-as-prevention benefit;
- Mapping of treatment uptake across Australia shows inequity in treatment uptake and highlights a need ensure there is a focus on ensuring access to treatment in rural and remote areas; and
- Updated simulation models highlight that increasing testing and diagnosis among people at risk of hepatitis C virus infection (and subsequent linkage to care) is essential for Australia to achieve elimination of hepatitis C.

In summary, while Australia has made great strides towards hepatitis C elimination over the past two to three years most of the estimated population living with hepatitis C prior to the introduction of DAAs are yet to be treated. Increased efforts to engage hepatitis C-affected populations in testing, treatment and prevention remains a priority, and without significant increases in the testing of at-risk Australia's progress towards elimination will slow.

The most recent data compiled in the first national report on progress towards the elimination of hepatitis C virus in Australia underscores a pivotal moment time in the effort to eliminate hepatitis C in Australia, signalling the need to review, renew, and refocus efforts. Future annual reports will aim to fill gaps in our knowledge on the hepatitis C epidemic and response among all priority populations and settings and update progress made.

We have included a full copy of the report '**Australia's progress towards hepatitis C elimination'** in Appendix 7.

Identification of priority surveillance and evaluation projects

The evaluation and surveillance team has identified two priority surveillance projects and three priority evaluation projects that will be supported to ensure robust and translational outcomes of national relevance. The two surveillance projects will be implemented in Queensland and Victoria and will compare different approaches to optimising and enhancing surveillance systems to facilitate timely hepatitis C treatment access for recently notified hepatitis C cases. Monitoring and evaluation of these projects will aim to refine and maximise their effectiveness in improving rates of treatment and translate lessons learned to guide similar efforts being undertaken in other jurisdictions. The three priority evaluation projects will be implemented to help evaluate and refine hepatitis C virus testing and treatment programs in the prison, probation and parole settings in South Australia and Queensland. Data monitoring systems being implemented for these projects will assess the impact of a new models of hepatitis C care, provide a mechanism to enhance patient follow-up in prison, and support the evaluation of prison transition assisted referral and probation and parole outreach hepatitis C virus clinical pathways.

Cirrhosis/liver cancer screening database

An initial planning meeting was held in Victoria in July 2018 to review current practices for managing and monitoring people with cirrhosis who have been treated and cured of their hepatitis C. The meeting laid the groundwork for a national review and survey of Departments of Gastroenterologist/Hepatology to better understand current practices and challenges in standardising the monitoring and screening of people with cirrhosis for liver cancer. The review will help inform the development of clinical guidelines, as well as best-practice models for establishing a centralised cirrhosis/liver cancer database in each jurisdiction. Options for using the centralised databases to ensure routine follow-up and ongoing liver cancer screening using hepatitis C and B treatment as a point of engagement will be explored in this work.

Cost effectiveness/resource mapping models

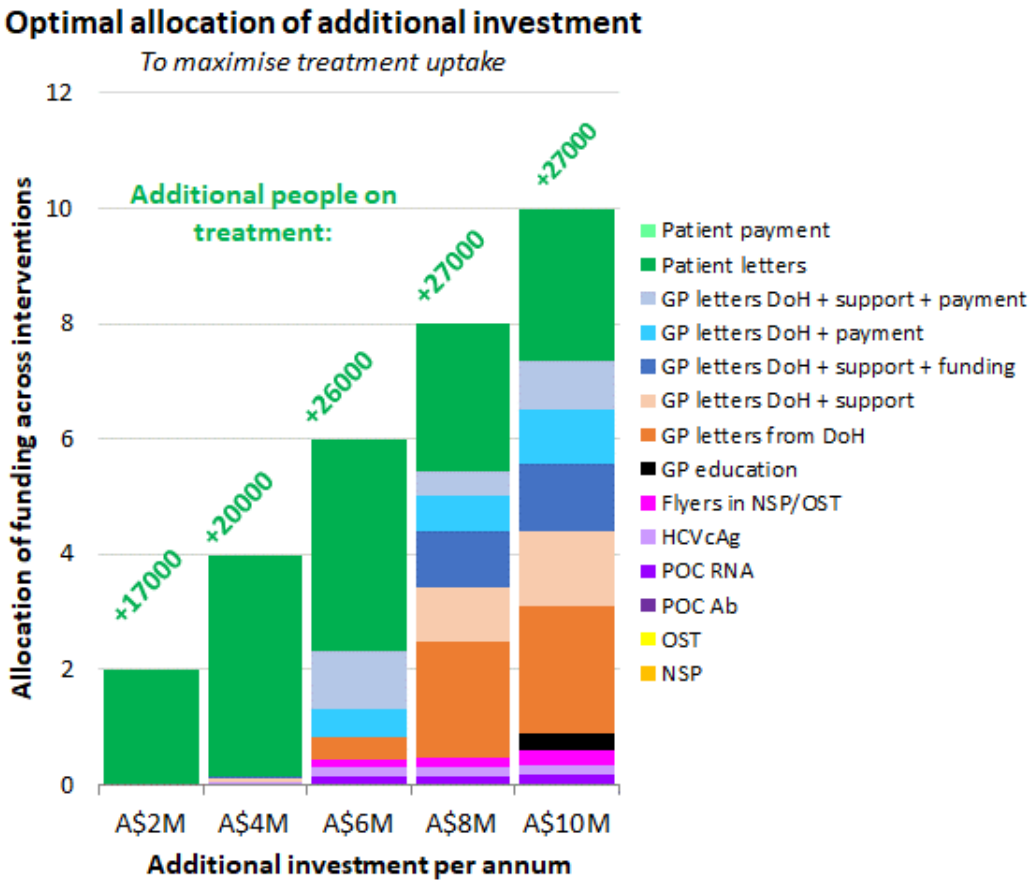
Initial modelling work which fed into the first national report on progress towards the elimination of hepatitis C virus in Australia has since been extended to further understand variation in treatment uptake across geographical areas. A specific model has been calibrated to hepatitis C epidemiological and clinical data from 89 geographic regions across Australia and will provide crucial information to inform implementation of targeted interventions based on specific local epidemiological and health service constraints. Localised models will project the elimination impact of continuing current trends in testing, linkage to care and treatment to identify gaps in the overall response.

Models will also examine the impact of a series of interventions implemented locally on improving testing, retention in care and treatment uptake. Modelled interventions will include rapid point-of-care testing, hepatitis C core antigen (HCVcAg) testing, GP education, support services for GPs, funding for GPs, letters from the Department of Health to diagnosed but untreated patients and/or their GPs, and financial incentives for patients and/or their GPs for treatment completion. Interventions will be assess in terms of: (1) their cost-effectiveness for improving treatment uptake; (2) the optimal allocation of different levels of funding across interventions at a national level to achieve the maximal number of people treated; and (3) the optimal allocation of different levels of funding across geographical regions, and interventions within those regions, to achieve the maximal number of people treated.

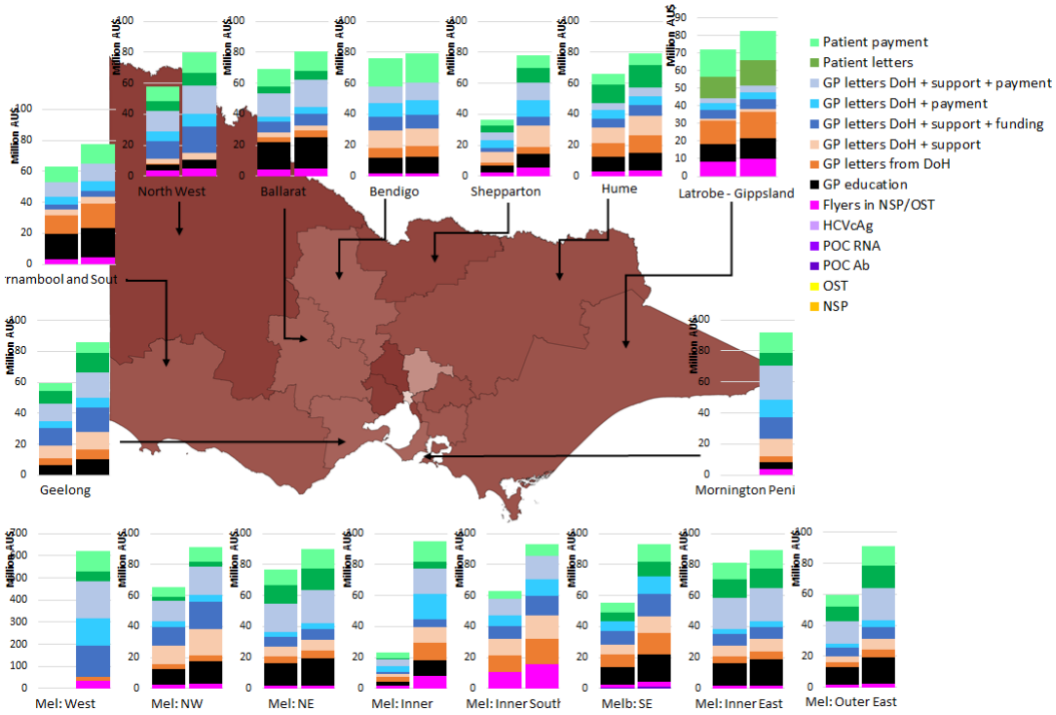
Outcomes to date:

Projections were run from 2018 to 2030 for the main outcomes of total number of people treated, the projected hepatitis C care cascade in 2030, and the total costs (split by tests and treatment, other interventions, and disease management). We have included below selected outputs from the models as examples only, displayed for both national and sub-national levels. A full draft of this model will be provided in the next reporting period.

Optimal investment at a national level



Optimal investment at a sub-national level



Lessons Learned to date:

Current gaps in our knowledge of the epidemic among some priority populations and settings exists, limiting our ability to accurately assess progress towards hepatitis C virus elimination among some priority populations including:

- Aboriginal and Torres Strait Islanders;
- Prison populations; and
- People living in rural and remote areas.

We need to better understand the hepatitis C epidemic among these priority populations so as to identify their needs and prioritise appropriate responses. We have identified and will prioritise the inclusion of new data sources in future reports:

- ATLAS: The Aboriginal and Torres Strait Islander Sexual Health Surveillance Network - a national sentinel surveillance network designed to track and interpret patterns of STI and blood-borne virus testing and treatment, monitor trends, evaluate interventions and inform policy development;
- GOANNA: A national study of young Aboriginal people that involved every state/territory Australian health department and peak Aboriginal health organization; and
- The compilation and integration of prisons hepatitis C testing and treatment data collected by state/territory governments and through the National Prisons Hepatitis Network.

EC Australia is also discussing with the Kirby Institute support for the establishment of a new national blood borne virus prisons surveillance and monitoring project.

EC Australia Aboriginal Health Strategy

EC Australia is currently developing an **Aboriginal Health Strategy** that focuses on supporting accessible hepatitis C care among Aboriginal and Torres Strait Islander Peoples. The strategy aims to raise awareness about and uptake of the hepatitis C treatments and address ongoing stigma relating to hepatitis C and injecting drug us within the Aboriginal and Torres Strait Islander communities. It will also focus on supporting mainstream health services to strengthen or develop culturally safe hepatitis C care for Aboriginal and Torres Strait Islander people living with hepatitis C, assist Community Controlled Organisations to expand and develop models of hepatitis C care and facility opportunities to strengthen and develop partnerships and referral networks between Community Controlled Organizations and mainstream health services.

EC Australia has prioritised accessible hepatitis C care for Aboriginal and Torres Strait Islander Peoples due to the inequitable rates of hepatitis C notifications. A strategy is currently being developed to inform and guide activities across the four key components of EC Australia.
Guiding principles for the EC Aboriginal and Torres Strait Islander strategy:
1. Values of self-determination, spirit and integrity, cultural continuity, equity, respect, reciprocity and responsibility are embedded throughout the project and beyond;
2. Aboriginal and Torres Strait Islander people, communities and organisations will be involved in all aspects of the project. This will include project priority setting, design, implementation, evaluation and dissemination;
3. Support capacity-strengthening opportunities for Aboriginal and Torres Strait Islander health care providers and organisations;
4. Enhance the sustainability of activities and their outcomes beyond the project.

Currently, a working group is being formed that will comprise individuals and organisations working in Aboriginal and Torres Strait Islander health. Once the working group is established a wider National Reference Group will be developed, ensuring representation from all areas of health service delivery and geographical jurisdictions. The National Reference Group will contribute to the development of EC Australia activities focussing on Aboriginal and Torres Strait Islander communities.

Lessons Learned to date

During the state consultations, the EC Australia team recognized that the existing structures of the state steering committees in each jurisdiction and the short timelines for prioritization and funding of activities through EC Australia, may have unintentionally disadvantaged some Aboriginal health services from appropriately participating in the process. While each state steering committee has named representatives from Aboriginal health organizations on them, competing health priorities and the critical advisory role Aboriginal health services play on many different steering committees resulted in an under-representation at important jurisdictional meetings. As a result, Aboriginal communities were often not represented, which may have further contributed to a de-prioritization of program planning and funding allocations to hepatitis c

programs that focussed on Aboriginal and Torres Strait Islander peoples. It was determined that a specific EC Australia component that focuses on and engages with Aboriginal people would help address this need, by developing a structure to support meaningful involvement and leadership within the aboriginal health sector and ensuring dedicated resources and expertise.

Advocacy Implications for EC Australia

Progress Q3 & 4 of Year 1: April – September 2019

Advocacy implications coming from State Consultations

Updated from previous report, inclusive of Year 1: Q 1, 2, 3 & 4

- Timely access to PBS/MBS Data at State/Territory level is limited
- Genotype requirement is unnecessary since pan-genotypics
- Nurse Practitioners in prison not able to prescribe DAAs due to PBAC restrictions
- Standardization of Reflexive Testing @ Laboratories is important
- HCV Case definition for Notifiable System – based still:
    - Detection of anti-hepatitis C antibody OR
    - Detection of hepatitis C virus by nucleic acid testing
- How to treat "in-patients"? – particular long-stay in mental health units
- Quality Improvement Programs – support for PDSA Cycles through PHNs
    - Potential for Hep C Practice Incentive Programs
- Limited evaluation capacity within the clinical and community sector

Revised Workplan

- Complete Partner Contracts for **Workforce Development** projects – **October 2019**
- Establish monitoring and reporting framework for **Workforce Development** project rollout - **November 2019**
- Annual National EC Australia meeting – **27th November 2019**
- **Health Promotion –** Continuation of evidence generation and collation and then development of campaign strategy and materials – **September 2019 – February 220**
- **Implementation Science –** Complete stakeholder interviews for the *"Using notification data to increase access to the hepatitis C cure"* research piece – **December 2019**

Evaluation and Surveillance – support the development of monitoring and data collection metrics for the workforce development projects and canvas for feedback on the National report on progress towards the elimination of hepatitis C virus in Australia, in preparation for 2020 report development.