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MONASH University
MONASH ADDICTION RESEARCH CENTRE

# Enhancing Hepatitis C Care in Community Pharmacies in Australia

A national roundtable summary report

## Introduction

Australia is working to eliminate hepatitis C as a public health threat by 2030. This elimination goal is in line with global targets set by the World Health Organization and targets included in Australia's National Hepatitis C Strategy 2018–2022. It is estimated that approximately 50% of people living with hepatitis C in Australia were treated between the end of 2015 and 2020, but the number treated each year is declining.[1]

As progress towards elimination slows, the remaining people who may benefit from treatment are likely to be those who are either not engaged with existing models of care or those whose needs are not being met by the healthcare services they are engaged with, as well as those who face greater social, cultural, economic, geographic, educational, and other equity-related barriers to care.[2, 3] Furthermore, given elimination efforts to date have targeted priority populations, particularly people who inject drugs, the remaining untreated population are increasingly those who are undiagnosed and may not be considered as "at risk".[4] Going forward, if Australia is to reach its elimination goal, more nuanced approaches are needed to identify and meet the care needs of the remaining people living with hepatitis C.

Pharmacies present a potentially untapped resource which could be harnessed to bridge some of these gaps. There are over 5,800 pharmacies across Australia, including over 2,400 pharmacies dispensing Opioid Agonist Therapy (OAT) to approximately 47,500 people, who may have a history of injecting drug use and may therefore be living with hepatitis C.[5-7] Unfortunately, due to multiple systemic barriers, many people on OAT are not tested or treated for hepatitis C through their prescriber.[2, 8] Over 2,900 pharmacies across Australia participate in the Needle and Syringe Programs (NSPs) and the pharmacy sector altogether distributes an estimated 6 million needles and syringes per annum to people, many of whom inject stimulants rather than opioids and may not be receiving treatment for substance use.[6, 9, 10] While people who inject drugs and people on OAT are generally supportive of community-pharmacy models of hepatitis C care, not all people have positive experiences with their pharmacist, therefore stigma and discrimination remain a major barriers to healthcare utilisation.[2, 3, 11-13] Studies from overseas and within Australia show with training and education, community pharmacists and pharmacies can enhance hepatitis C care provision to people who may be living with or at risk of hepatitis C.[14-17]

On the 26th August 2022, Burnet Institute, Hepatitis Australia and Monash Addiction Research Centre convened a cross-sectoral round table with approximately 55 representatives from community organisations, academia, professional organisations, and government to discuss opportunities for enhanced hepatitis C care in community pharmacies. A list of organisations and stakeholders represented is provided in the appendix. Guest speakers presented on current research, existing programs for pharmacy-based hepatitis C care in Australia and internationally, and other pharmacy-based care programs in Australia. Participants

discussed core themes during facilitated breakout rooms before an open discussion with a cross-sectoral panel. The roundtable and chat function were recorded and notetakers were allocated to breakout rooms and the panel to best capture the discussions. This report summarises key findings from the breakout room and panel discussions and has been prepared and reviewed by representatives from organisations that convened the roundtable.

### Roundtable Objective

The objective of the roundtable was to identify key barriers and enablers to enhancing hepatitis C care in Australian community pharmacies with a view to guide the development of a hepatitis C program of care in pharmacies which could be implemented nationally.

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## Key Questions

- Where and for whom is this a priority?
- What could the model(s) of care in the program look like?
- What are the best strategies to implement it?

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## Key Findings

### Person-centred care

Providing different options for care delivery is important in overcoming multiple barriers to testing and treatment faced by many people living with hepatitis C. Placing the person at the centre, treating them with care, dignity, and respect in a culturally safe environment as well as having flexible models of care that cater to the needs of individuals and communities will be key to success. This may include, where possible, offering multiple options for testing, referral and follow up, as well as both walk-in and appointment-based services. People living with hepatitis C may also have health and social needs related to their hepatitis C such as substance use disorders, mental health disorders, homelessness, unemployment, limited transport options, language difficulties, telecommunication difficulties, and low health literacy. Integrating pharmacy-based care with other services that can best support individuals and communities to overcome these access barriers will better enable them to progress through the hepatitis C care cascade.

Incorporating financial incentives for clients such as cash, gift cards or other rewards for testing, bringing a friend for testing, or attending follow up appointments is an evidence-based strategy that may help to overcome some barriers clients may face. This may also help build the profile and legitimacy of the program. Incentivising treatment would need to be done within an ethical framework. Any testing would also need to be of no cost to the client. This would need to be clear for them as some clients, particularly clients on OAT, can incur considerable financial hardship and sometimes debt with their pharmacy.

### Pharmacists as a workforce

Many, but not all, pharmacists have strong relationships and rapport with their clients, in particular clients accessing OAT. Where strong relationships exist, these could be harnessed to engage previously unreached people living with and at risk of hepatitis C. With adequate training on pathophysiology, testing and treatment, as well as authentic education on stigma, discrimination and cultural safety, pharmacists could expand their role in hepatitis C care. This may be particularly beneficial in rural pharmacies where there may not be sufficient human resources for in-reach workers or access to traditional care pathways.

Pharmacists would need to be to be remunerated appropriately for their skills and time performing potential activities in their expanded role, such as risk assessments, testing, providing a diagnosis, referring, and following progress. A key barrier in the present context of the ongoing covid-19 pandemic is the limited capacity of an already overworked and burning out pharmacy workforce. However, the program could work in pharmacies with sufficient human resources and a distributed workload if financed appropriately.

### Pharmacy as a setting

Pharmacies are one of the most frequented primary healthcare services and are available without the need for an appointment. Hepatitis C care in pharmacies has the potential to engage previously unreached populations including:

- People living in locations where there is a pharmacy available but limited access to General Practitioners (GPs) or specialist hepatitis services.
- People currently prescribed OAT, who, due to multiple systemic barriers, may not be receiving hepatitis C care through their OAT prescriber.
- People transitioning out of custodial settings and are disconnected from community healthcare.
- People from cultural and linguistically diverse communities and with low health literacy who may not be accessing GP services.
- People who feel uncomfortable disclosing sensitive information to their family GP.

Importantly, as the progress toward hepatitis C elimination continues, the remaining people who may benefit from treatment may not fit into the traditional priority populations. Through education and health promotion initiatives pharmacies may help to find people not previously identified as at-risk. This may be particularly valuable in pharmacies that do not have capacity for higher-level activities such as testing.

Different pharmacies would have different capacities for and interest in hepatitis C care. There may be limits on space, time, and human-resources. A program with multiple models of care that is adaptable to pharmacies' capacities rather than one-size-fits-all is more likely to succeed. Proving in-reach workers, such as nurses and peer-workers, may help to overcome barriers for pharmacies with limited capacity, as well as linkage to outreach and other community-based services. Furthermore, training pharmacy assistants and distributing workload may ease pressures.

### Testing

Different types of tests offer different advantages and disadvantages depending on the pharmacy and the individual, as well as regulatory, access and funding barriers (see section on regulation):

- Rapid antibody testing is affordable and quick, however its utility in detecting active infection is diminishing as more and more people are cured of hepatitis C but remain antibody positive. This test would be particularly useful as a screening test in people who have never tested or have previously tested negative. The short time to result (<15min) makes it more useful for people less likely to return to the pharmacy for a result.

- Dry Blood Spot Testing (DBST) has the advantages of being low cost, simple to perform, and able to test for active infection with hepatitis C RNA, in addition to testing for other infections such as HIV and hepatitis B. The long processing time of up to week may be suitable for regular visitors or where there is a robust follow up system.

- GeneXpert RNA testing is relatively high maintenance but can accurately detect active infection. The 60-90minutes time for results and high expense of the equipment would make it more suitable for short term placement in high case-load pharmacies with regular contact with people at risk. The short-term placement could be carried out by in-reach workers.

- Self-testing is a convenient option for individuals but would require extensive pre-test counselling and a strong system for follow up.

### Co-ordinating efforts

The program would need to be integrated into a multi-directional system of support and collaboration, whereby other health services such as drug and alcohol services, general practitioners, mental health services, social services and specialist hepatitis services are mutually supportive of each other, the pharmacy, and the individuals and communities as they progress through the hepatitis C care cascade, acknowledging that hepatitis C may be just one of the challenges an individual is facing in their life.

The program would need strong systems for follow up and linkages to further testing, assessment, and treatment. There are multiple options for linkage to care such as out-reach workers, community-based nurse practitioners, referral to the patient's preferred GP, referral to GPs experienced in hepatitis C treatment, remote/telehealth follow up with a hepatitis nurse, nurse practitioner or specialist physician. Roles and responsibilities would need to be clearly defined to be consistent with skillset and scope of practice and to ensure a clear duty-of-care. As much as possible referral and follow up options would be flexible to the needs of clients and should simplify the pathway to cure by minimising the steps from diagnosis to treatment.

### Financial and human resourcing

Appropriate funding would be crucial to initiate and continue the program for as long as is needed. There have been many trials done in pharmacy settings which demonstrate the benefit of community pharmacists and pharmacies in managing chronic disease but, to date, these have often not translated into sustained practice change due to lack of demonstrated cost-effectiveness or funding beyond a trial or pilot.

Government funding grants, community pharmacy agreements, philanthropic grants, and industry partnerships could present opportunities to fund the program. The program may only be required for a limited number of years in the push to elimination by 2030, which may help to secure the funding needed. A strong commitment from government to support the program over several years period would be needed to demonstrate its effectiveness.

The program would need to be considered in the context of other community-based initiatives. There is already a limited and stretched hepatitis workforce with limited funding. Co-ordinating with and complementing rather than competing with other community-based initiatives such as hepatitis C care in mental health and drug treatment settings will help ensure sustainability of the workforce through sharing of limited resources such as education, training, hepatitis nurses and peer-workers.

### Advocacy

Strong advocacy would be needed to initiate and sustain the program. To ensure clarity around professional roles and support interprofessional collaboration, it would be ideal to achieve cross-sectoral consensus from community, pharmacists, and other health professions regarding how such a program would operate before presenting the idea to government. Where models of care are demonstrated to have interdisciplinary and cross-sectoral support they are more likely to be funded and successfully implemented.

A strong business case would aid in advocacy for funding from government for implementation. Such a business case would need to demonstrate the cost-effectiveness of preventing transmission through treatment as prevention, as well as prevention of hepatitis-C related co-morbidities such as hepatocellular carcinoma, cirrhosis, and liver transplant, and hepatitis C-related mortality. A business case could be built for both micro-elimination and large-scale elimination efforts.

The next iteration of the National Hepatitis C Strategy 2023-2030 presents an opportunity to prioritise government support for pharmacy-based initiatives. Inclusion of community pharmacists and pharmacies in the next national strategy, as a key workforce and setting to enhance hepatitis C elimination efforts would be an important step to begin the advocacy effort for funding allocation.

### Implementation logistics

There are many possible strategies for roll out of the program such as focusing on OAT and NSP pharmacies and pharmacies located near prisons, correctional services, mental health services, drug and alcohol services and pharmacies associated with Aboriginal Community Controlled Health Organisations. The Doherty Institute Mapping report could also be used to target geographic areas that are underperforming. It would be prudent also to “start small” and evolve and expand the program through an evaluation and continuous quality improvement process.

Pharmacies would need to be supported to ensure they are ready to participate in the program. This will require not only training and education of the staff, but also ensuring pharmacies have a private area for consultation. Owing to the cost of DAAs, consideration of financial barriers to stocking the medication is warranted, particularly in perceived low prevalence settings. Overcoming this barrier would reduce steps between prescribing and dispensing. Systems to track test results and progress through the care cascade could support patient follow up and potentially collect outcome data to monitor progress against program aims.

### Regulation

Potential regulatory barriers should be explored to determine if they are relevant to different models of hepatitis C care in pharmacies. This may include regulatory barriers to expanding the scope of practice for pharmacists, nurses and the skill set of peer-workers; insurance requirements for peer-workers; lack of Therapeutic Good Administration approvals for self-testing; restrictions on use of Dried Blood Spot testing and Point of Care testing beyond research settings; and requirements for doctors and nurse practitioners to undertake a consultation before ordering venepuncture pathology. Developing the models of care with input from a range of disciplines would help to ensure they represent good clinical practice.

### Next steps

In keeping with the key finding of the need to develop cross-sectoral consensus, the steering committee guiding this project will be expanded to provide broader representation. This committee will guide activities, including:

- Design of a program for enhanced hepatitis C care in community pharmacies.
- Further research initiatives the enhance the program.
- Building cross-sectoral consensus.
- Formation of strategic partnerships.
- Lobbying for regulatory changes.
- Development of a business case for pharmacy-based care as an effective model.
- Advocacy for appropriate funding as a priority.
- Exploration of new or novel funding options.
- Implementation and evolution of the program.
- Incorporation of the program within other community- and hospital-based systems of care.

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## Appendix

### Organisational Representation

The following organisations and stakeholders were represented at the round table.

Community and multidisciplinary organisations:

- Hepatitis Australia
- Hepatitis South Australia
- Hepatitis Western Australia
- Harm Reduction Victoria
- National Aboriginal Community Controlled Health Organisation
- Community Restorative Centre NSW
- Australian Alcohol and Other Drugs Council
- Australasian Professional Society on Alcohol and Other Drugs

Pharmacy organisations and stakeholders:

- Pharmacy Guild
- Pharmacy Society of Australia
- Community Pharmacists

Nursing organisations and stakeholders:

- Australian Hepatology Association
- Nurse Practitioners

Medical Organisations and stakeholders:

- Gastroenterological Society of Australia
- Australasian Society of Infectious Diseases
- Royal Australian College of General Practitioners
- Australasian Chapter of Addiction Medicine
- Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine

Academic organisations and stakeholders:

- Burnet Institute
- Kirby Institute
- Monash Addiction Research Centre, Monash University
- Academic pharmacists from Curtin University, University of Sydney, Deakin University and La Trobe University

Government:

- Commonwealth Department of Health and Aged Care
- SA Health, Government of South Australia
- Department of Health and Human Services, Government of Victoria
- Supercare Pharmacies Initiative, Government of Victoria
- North Western Melbourne Primary Health Network
- Brisbane South Primary Health Network

Industry:

- AbbVie
- Gilead
- Cepheid