Abstracts of the Australasian Viral Hepatitis Elimination Conference: poster presentations

P1

Hepatitis C CALD community outreach

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Introduction: Culturally and linguistically diverse (CALD) communities have always been recognised as a high priority population for hepatitis C, particularly, in countries of origin where there is a high risk of medically acquired hepatitis C via unsterile medical treatment, which includes spread through vaccination programs and infected medical blood supplies. It is estimated that more than 11 per cent of people in Australia who have been exposed to hepatitis C are from CALD backgrounds. This project aims to address the issue by engaging with CALD communities via educational workshops.

Methods: Literature reviews were undertaken to determine hepatitis prevalence rates among CALD populations (including Chinese, Vietnamese, Italian and Egyptian communities) in country of origin and in Australia. Following that, comprehensive community consultations were conducted to ensure education content regarding hepatitis C; liver cancer and general liver health is culturally informed and effective. Subsequently, educational workshops were delivered to the communities in their native languages to help increase knowledge of liver health, hepatitis C transmission, testing and treatment.

Results: The project aims to achieve results including increased testing and treatment of viral hepatitis in high priority CALD communities, improving knowledge of the connection between liver cancer and hepatitis, supporting community members to share their knowledge and encourage others to seek testing and treatment. In addition the project will developing sustainable relationships within each community that will serve the ongoing awareness and community education opportunities and create a range of multi-lingual viral hepatitis educational resources. A robust evaluation of project activities and outcomes will be conducted to report final results comprehensively.

Conclusion: There is a lack of rigorous research and programs that address hepatitis C issues among CALD communities in Australia. Hence, further studies and interventions similar to this outreach project that aim to increase hepatitis C education, testing and treatment are critical.

Disclosure of interest statement: None to disclose.

P2

An immunochromatographic test for measurement of alanine aminotransferase (ALT) at point-of-care

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Background: Alanine Aminotransferase (ALT) is widely used for detection and management of liver disease, but current ALT tests rely on laboratory instruments, limiting their availability especially for patients in resource-poor settings who represent the majority of the global burden of chronic HBV and HCV as well as metabolic liver disease. We have developed a rapid, point-of-care test (POCT) that provides a visual, semi-quantitative measure of ALT protein in plasma or whole blood in 20 minutes with potential for full quantitation of ALT levels using an optional instrument.

Methods: We determined the correlation between the ALT POCT and 'gold standard' enzymatic ALT activity using coded plasma samples from the Alfred Hospital, Melbourne (n=48; range: 10-276 ALT U/L) and the Jiangsu Provincial Hospital, Nanjing, China (n=174; range: 9-774 ALT U/L).

Results: ALT levels measured in plasma using the ALT POCT at both sites showed high levels of correlation with standard clinical laboratory enzymatic ALT (R^2=0.86 p<0.0001 Melbourne; R^2=0.97 p<0.0001 Nanjing). In the Melbourne patients where APRI data was available, the ALT Rapid Test also showed surprisingly good correlation with this marker R^2=0.64, p=0.0001.

Conclusion: An in-house laboratory evaluation of the ALT POCT on clinical samples demonstrates high correlation with standard enzymatic ALT across the relevant clinical ranges. The measurement of ALT protein provides a robust and accurate POCT that is not temperature or instrument dependent, can be deployed in the field and be useful in expanded efforts to improve management of liver disease worldwide.

This novel approach using protein detection of enzymes or cell associated molecules has potential for direct measurement of APRI following modification to detect AST rather than ALT and incorporating platelet count by detecting platelet specific cell surface molecules.

P3

Successful treatment of hepatitis C among homeless and socially marginalised clients in primary care

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Background: The prevalence chronic hepatitis C infection is high in socially disadvantaged groups including those affected by housing instability and those in drug rehabilitation. Direct acting antiviral (DAA) treatments which are effective and well tolerated could enable these patients to access therapy in primary care. Homeless Healthcare is an urban not-for-profit general practice that primarily services such clients. We commenced treating chronic hepatitis C patients once DAA drugs from March 2016.

Methods: We audited all prescriptions for DAAs in 2016. We reviewed complications and defaults on therapy, and evidence of virological response.

Results: Fifty-seven people were prescribed DAA after remote consultation with a tertiary liver service. Of these, 11 were Aboriginal (19%), 17 were women (30%); 30 were genotype 3 (53%) and 27 (47%) were genotype 1. Twenty-five people (44%) reported active injecting drugs and 14 (25%) were in a drug rehabilitation. Fifty-five of 57 patients initiated treatment, 3 of whom remain on treatment. End of treatment PCR was tested on 42 of 52 completed patients, all of whom were negative. Of the 10 remaining patients, 9 were lost to follow up and one died on therapy. Thirty of 42 completed patients also had a HCV PCR 12 weeks after completion; 29 had a sustained virological response (SVR12) and 1 did not. Of the other 12 completing patients, 6 are not yet 12 week's post completion, 5 have been lost to follow up, and 1 has died.

Conclusion: Almost two-thirds of patients commenced on DAA therapy (30 of 46) had a confirmed SVR12 with 2 deaths and only 1 confirmed virological failure. General practices that regularly service socially marginalised clients are well placed to manage their chronic hepatitis C alongside their other health problems.

Disclosures: None.

P4

Acceptability of point of care finger-stick and venepuncture hepatitis C virus testing among people who inject drugs and homeless people

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Background: Hepatitis C virus (HCV) testing remains inadequate globally. Simplified point of care tests are urgently needed to enhance HCV diagnosis and elimination. The aim of this study was to assess the acceptability of finger-stick whole-blood and venepuncture HCV testing among people who inject drugs (PWID) and homeless people in Australia.

Methods: Participants were enrolled in an observational cohort study with recruitment at six sites in Australia between May and December 2016. Capillary whole-blood collected by finger-stick and plasma collected by venepuncture were obtained from participants for Xpert® HCV viral load testing. Participants completed a questionnaire on acceptability of blood collection methods.

Results: Among 297 participants enrolled (mean age, 45 years; 70% male), 39% self-reported as HCV positive and 40% tested HCV RNA positive. Overall, 70% reported ever injecting drugs, 51% injected in the last month, and 35% were receiving opioid substitution treatment. Prior to the study, 67% of participants reported having ever been tested for HCV by venepuncture and 46% by finger-stick. Sixty-seven percent preferred to get HCV test results on the same day. Ninety-four percent of participants indicated that they would be willing to wait up to 120 minutes for results. A high proportion of participants reported that taking a sample of blood by finger-stick testing was somewhat or very acceptable (83%). The majority of participants preferred finger-stick compared to venepuncture (68%), with 70% of these preferring to receive results in 60 minutes. The most common reason for preferring finger-stick testing was that it was quick (55%) or the nurse usually has trouble taking my blood (9%).

Conclusion: Finger-stick whole-blood collection is highly acceptable by PWID and homeless people. The further evaluation of simplified point of care HCV testing as a single-visit opportunity to engage people in care is crucial for HCV treatment scale-up to achieve HCV elimination.

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P5

Primary care-based viral hepatitis clinic in rural NSW: outcomes from the first 15 months of direct acting agents

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Introduction: Primary care based chronic hepatitis C (HCV) treatment is vital to rapidly up-scale treatment numbers in Australia. The PBS listing of Direct Acting Agents (DAA's), in March 2016, enabling all primary care practitioners to prescribe via S85 authority scripts was a landmark moment. In February 2016, a viral hepatitis clinic was established, one day per week, in a busy rural NSW general practice by an experienced S100 GP prescriber working closely with local gastroenterologists. Her scope of practice includes co-managing many complicated cases with cirrhosis and advanced liver disease due to the sparsity of gastroenterology services in the region.

Methods: Prospective data has been collected on all new HCV cases seen since March 2016 including source of referral, age, gender, genotype, viral load, prior treatment, significant medical problems, APRI, fibroscan, FIB4, cirrhosis status, DAA regime, treatment uptake, adverse events, sustained virological response (SVR), opiate replacement and Aboriginal and Torres Strait Islander (ATSI) status.

Results: Preliminary data review from the first 14 months reveal 117 cases have commenced on DAA treatment with approximately 33 % having cirrhosis pretreatment,14 % prescribed opiate replacement and 18 % identifying as ATSI. To date 51 cases achieved an SVR, 4 have relapsed (2 decompensated cirrhosis pre-treatment and 2 non-cirrhotic, GT3a, treatment experienced, null or partial responders to pegylated Interferon treatment), 36 have completed treatment are awaiting 12-week post treatment testing, and 22 are currently on treatment. Detailed data from the first 15 months of operation will be presented.

Conclusion: Chronic HCV treatment with DAA's is ideally suited to primary care but outcome data is sparse in Australia. This data will assist to compare treatment outcomes with other models of care and be valuable as it includes rural primary and shared care data including many cirrhotic patients.

Disclosure of interest statement: None to disclose.

P6

Phylogenetic clustering of recent hepatitis C virus infection between 2004 and 2015

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Background: Little is known about hepatitis C virus (HCV) transmission among people with recent infection and in particular among gay and bisexual men with HIV co-infection. Phylogenetic methods can provide useful insights into transmission. The aim of this study was to identify phylogenetic pairs and clusters among people with recent HCV infection in Australia.

Methods: Data and specimens from five studies of recent HCV in Australia recruited between 2005 and 2015 were used for this study. Viral RNA was extracted from samples and HCV Core-E2 region sequenced. Phylogenetic trees were inferred using maximum likelihood analysis and 1000 bootstrap replicates. Clusters were identified using ClusterPicker (90% bootstrap threshold, 5% genetic distance [GD] threshold). Pearson's chi-squared test was performed in STATA (version 14.1).

Results: In total, 352 participants were eligible for inclusion in this study from ATAHC (2004–2007, n=167), RAMPT-C (2009–2013, n=70), ATAHC II (2011–2015, n=82), DARE-C I (2013–2015, n=14), and DARE-C II (2014–2015, n=19). The proportion with HIV/HCV co-infection was 43% (151/352). Core-E2 sequences were obtained from 274 participants. HCV genotype (GT) prevalence among sequences obtained was: GT1a/b: 64% (n=176), GT3a: 32% (n=89) and GT2/4/6: 3% (n=9). Overall, 30% of participants were in a pair or cluster (GT1a 44% [71/162], mean maximum GD [MMGD]=3.0; GT1b 43% [6/14], MMGD=0.26). Among HIV/HCV co-infected participants, 35% (48/138) were in a pair or cluster, compared to 21% (29/136, p=0.013) of participants with HCV mono-infection. Among those with GT1a/1b, 44% (42/96) and 35% (28/80) of HIV/HCV and HCV subjects were in a pair/cluster.

Conclusion: In this study of recent HCV infection in Australia from 2004–2015, a high proportion of participants demonstrated phylogenetic clustering. The greater proportion of clustering found among HIV/HCV co-infected participants highlights the need to

provide broad DAA access and rapid uptake, together with ongoing monitoring of the phylogeny.

Disclosure of interest statement: None to declare.

P7

No wrong door: do current referral pathways capture those at risk of onward HCV transmission?

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Introduction: Albury Community Health (ACH) is a regionally based service offering treatment for people who have Hepatitis C Virus (HCV).Its clients are referred via GPs, Opiate Treatment Program (OTP), Mental Health (MH), Aboriginal Medical Service (AMS), Drug and Alcohol (D&A), Needle Syringe Program (NSP), Justice, Sexual Health (SH) or self-referral. Recent research suggests treating those with the highest risk of onward transmission could significantly reduce future HCV cases. This prompted ACH to audit past and present clients of the service to identify first if they fall into the category of being high risk and second whether current referral pathways sufficiently capture those high risk clients. It is suggested that those who continue to share injecting drug equipment are those at highest risk

Methods: All client files from those who engaged with service since August 2014 were reviewed to determine referral pathway and injecting drug history. Those who indicated intravenous drug use (IVDU) within the last three years and were referred via NSP, Justice or D&A services were determined to be of the highest risk. Data were descriptively analysed using Xcel.

Results: 159 people had engaged with ACH since August 2014, of these 84 indicated IVDU in the last three years, 70 were determined not to be high risk and 5 had unknown status. Referral pathways for the high risk cohort was OTP 25, GP 18, self-referral 10, previously known to service 10, D&A 6, AMS 4, SH 3, NSP 3, MH 2, Justice 2, Other 2

Conclusion: Review of routinely captured data indicates that ACH HCV treatment program is not capturing clients who are of the highest risk of onward transmission. Strategies to enhance NSP, Justice & DA referrals and service promotion avenues need to be explored that are regionally appropriate.

Disclosure of interest statement: None to disclose.

P8

Using 'teach-back' with clients who live with chronic hepatitis B: does it improve understanding?

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Background: The low rate of diagnosis and access to clinical management amongst patients with chronic hepatitis B (CHB) can partly be attributed to poor disease-related knowledge. Limited health literacy has been noted to be disproportionately common in minority communities, the elderly, individuals with limited education level and also people with low English proficiency. Nearly 2/3 of people living with CHB come from marginalised communities and share these demographic features.

Client-clinician communication plays a particularly important role in patient education as the way information is presented and delivered has great impact on engagement and the learning process. Research demonstrates that there are gaps in patients understanding of CHB and that these should be addressed to improve health outcomes. The aim of this study was to evaluate the efficacy of the teach-back communication method for improving participants' understanding of CHB, compared to a standard clinical consultation

Methods: Clients living with CHB and attending outpatients were invited to participate. Participants were randomized into the standard consult or teach-back group. A pre and post-questionnaire was administered to all participants to collect information on demographics and to assess the baseline knowledge of CHB.

Participants then attended their allocated standard outpatient consultation or teach-back session. The teach-back session was a one-on-one discussion between the investigator and the participant. Participants were asked to participate in a second evaluation 4 weeks after the initial educational intervention (teach-back vs. standard clinical consultation).

Results: The research will be complete in June 2017. More than 60 clients have participated to date. Preliminary results indicate that 'teach-back' improves client understanding of CHB.

Conclusions: Teachback may be a useful tool for clinicians to adopt so that clients increase their understanding of CHB and what they can do themselves to improve their own and family's health.

P9

Youth at risk: increasing youth workers' knowledge and confidence to talk with young people about hep C and injecting

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Introduction: The 'Youth at Risk' training package aims to reduce the transmission of hepatitis C and other blood borne viruses among young people though increasing the knowledge and confidence of youth workers already in contact with young people who may be exposed to injecting drug use. Youth workers are ideally placed to provide vital harm reduction information for young people at risk of injecting who may not be accessing health services.

In 2014, there were almost 350 notifications of hepatitis C in people under 25 in NSW.

An estimated 90% of all new hepatitis C cases in Australia are linked to injecting drug use.

Evidence suggests the average age of initiation into injecting drug use is around 19 and that hepatitis C is acquired less than two years after the onset of injecting.

Methods: The training program is delivered as a flexible, three module package consisting of:

- Hepatitis C in the context of young people
- Harm Reduction and the Needle and Syringe Program
- Engaging with young people around injecting drug use and harm reduction services.

Pre and post course and 3-month follow-up evaluation data has been collected and analysed.

Results: A total of 12 workshops have been delivered (with an anticipated 20 in total), to 117 participants, from 22 NSW organisations. All participants agreed or strongly agreed the Youth at Risk training was relevant to their job role and could identify at least one aspect of the training to implement into their workplace. Self-reported knowledge of hepatitis C increased from 37.5% at baseline to 78.5% post-workshop. Three-month follow-up data show increases in knowledge and confidence reported after the workshops are maintained, and workplace changes are implemented.

Conclusion: Participants of the workshops leave more equipped to engage with young people at risk of injecting, and therefore prevent transmission of hepatitis C in a vulnerable population.

Disclosure of interest statement: Nothing to Disclose.

P10

Injecting risk behaviours among people who inject drugs in an Australian prison setting, 2005–2014: the HITS-p study

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Background: HCV transmission remains high in Australian prisons. Understanding injecting risk behaviours in prisons is crucial to effectively develop and implement programs to work towards HCV elimination. This study investigates injecting risk behaviours in the Hepatitis Incidence and Transmission Study in prisons (HITS-p) cohort.

Methods: HITS-p is a cohort study which enrolled people with a history of injecting drug use from 23 prisons in NSW from 2005–2014. Participants completed a survey at enrolment and follow-up visits to determine recent injecting behaviours. Generalized estimating equation (GEE) methods were used to assess injecting risk behaviours prior to and following prison entry and to investigate injecting risk behaviours in prison.

Results: Overall, 499 participants with a history of injecting drug use were included (mean age, 28 years; 65% male). Recent injecting drug use decreased from 71% in the three months prior to prison entry as compared to 27% since entering prison. Among people reporting recent injecting, needle/syringe sharing increased from 19% prior to entering prison to 73% since entering prison. At enrolment, the proportion reporting any injecting, ≥weekly injecting, and needle/syringe sharing in prison was highest among younger individuals. In GEE analyses, participants were significantly less likely to inject drugs following incarceration. Among injectors, participants were less likely to inject ≥weekly but more likely to share a needle/syringe. Among continuously imprisoned participants, younger age was associated with increased odds of any injecting, ≥weekly injecting, and sharing a needle/syringe.

Conclusion: These data indicate that upon entry to prison, injecting drug use decreases, but syringe sharing increases among injectors. Younger individuals are more likely to exhibit high-risk injecting behaviours in prison. These data highlight the need for improved HCV prevention strategies (including improved needle/syringe access and scale-up of HCV therapy) for those at increased risk of HCV transmission in prison, including younger individuals.

Disclosure of interest: We recognise the need for transparency of disclosure of potential conflicts of interest by acknowledging these relationships in publications and presentations.

P11

Far North Queensland aboriginal and Torres Strait Islander hepatitis B project

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Introduction: In July 2016, Queensland Health funded a 12 month pilot to improve clinical hepatitis B (HBV) services to Far North Queensland (FNQ) Aboriginal and Torres Strait Islander people living in Cairns and Hinterland, Cape York and the Torres Strait. This talk outlines the completed project outcomes after six month (Jan-June 2017) work: FNQ HBV cascade of care data (with estimated gaps), Queensland's first HBV clinical data program and referral system, and steps taken to improve the chronic HBV clinical management protocols. The talk considers managing a short-term project within historical structural barriers of limited timing, bureaucratic channels and uncertain linkages between key organisations. Lastly, the presentation showcases the diversity of FNQ HBV health services and health promotion activities that enhance stronger organisational partnerships, communication and goodwill.

Achieving better FNQ HBV outcomes belongs to those delivering hepatitis B services: the Aboriginal Community Controlled Health Organisations (Apunipima, Gurriny Yealamucka, Mamu, Mulungu and Wuchopperen Health Services); Cairns and Hinterland Hospital and Health Services (Sexual Health Service, Gastroenterology, General Medicine, Midwifery, Paediatrics, Adult Community Health; Tropical Public Health Service); Torres and Cape Hospital and Health Service; Northern Queensland Primary Health Network; Royal Flying Doctor Service, and Hepatitis Queensland.

The Hepatitis B Project Team involved a collaboration of key Queensland Health staff: Dr Peter Boyd, Collette Cashman, Tracey Cuthbertson, Morgan Dempsey, Yvonne Drazic, Penny Fox, Carla Gorton, Dr Josh Hanson, Dr Sam Jones, Dr Jowita Kozlowska, Rhondda Lewis, Yoko Nakata, Rohan Pratt, Dr Annie Preston-Thomas, Dr Darren Russell and Norma Sullivan. The Queensland Health funded HBV team included: Dr Glen Curran (Clinical Nurse Consultant) and Robyn Wilson (Data Manager).

Disclosure of interest statement: None.

P12

Revitalising hepatitis B health promotion responses in Western Sydney: exploring new opportunities

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Introduction: There is a substantial burden of hepatitis B in Western Sydney Local Health District (WSLHD), with the Auburn area having the highest prevalence in New South Wales (NSW). In order to implement the NSW Hepatitis B Strategy 2014–2020, WSLHD HIV and Related Programs, Storr Liver Centre, WentWest (Western Sydney Primary Health Network) and ASHM convened a working group in early 2016 to revitalise health promotion responses to hepatitis B epidemic.

Methods: The working group established a revitalised health promotion project based on the original 'Jade Fan Project' of the former Sydney West Area Health Service. The partnership was extended to WSLHD Multicultural Health and Hepatitis NSW. Reinvigorated strategies include project governance, capacity building for primary care providers, culturally appropriate resource development and community engagement.

Results: The project has been strengthened by the partners' commitment and diversity of expertise. Training sessions were developed to up-skill General Practitioners and Practice Nurses. Support of a web-based portal for clinical pathways has assisted in seamless referrals to specialist services. It has had 137 views since July 2016, with 'Routine Liver Assessment' being the most viewed section.

Culturally appropriate resources were updated and disseminated. Community education events targeting hot spots for hepatitis B were delivered to raise awareness and encourage access to screening and care. A community survey conducted at the Auburn event during Hepatitis Awareness Week 2016 showed participants had poor knowledge of hepatitis B; 50% believed it is symptomatic, and that it can be transmitted by sharing cutlery or food. Half of participants had never tested and half had not been vaccinated for hepatitis B.

Conclusion: Effective partnerships are vital in revitalising health promotion efforts on hepatitis B in Western Sydney. Continued collaboration with affected communities and primary care providers will address knowledge gaps in communities and support testing and immunisation uptake.

Disclosure of interest statement: Nothing to disclose.

P13

Call: community assessment and liver liaison, a liver clinic provided to homeless men in their community

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Aim: Early identification and management of chronic liver disease among marginalised populations through a community based model of care.

Methods: Viral hepatitis Screening and Liver Assessment are provided in an outreach setting, onsite to communities 'at risk' of liver disease. This involved blood collection for viral hepatitis and fibrosis scoring using a mobile fibroscan. Recently patients have been able to access hepatitis C treatments on sited.

Results: So far 293 clients screened and diagnosed: HBV 2.3%, HCV 10.23%, cirrhosis 6.52%. These subjects were linked with a multidisciplinary care plan (GPs and liver clinic) delivering integrated cutting edge care for liver disease.

Conclusion: Assessing and diagnosing hepatitis and liver disease early to marginalised communities improves health outcomes and reduces cost to the health system.

Disclosure of interest statement: The conference collaborators recognise the considerable contribution that industry partners make to professional and research activities. We also recognise the need for transparency of disclosure of potential conflicts of interest by acknowledging these relationships in publications and presentations.

P14

Stigma and discrimination: an exploration of need and potential responses in Victoria, Australia

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Background: Stigma and discrimination towards people living with viral hepatitis are identified as issues of national and state significance in Australian government strategy papers, and not least, by people living with or affected by viral hepatitis (and associated advocacy bodies). Stigma and discrimination, or the fear of, have been well established as barriers to care, and as having significant impact on other quality of life measures, for those living with various blood borne viruses. Hepatitis Victoria has been funded to investigate potential systemic and individual approaches to reducing stigma and discrimination towards those living with viral hepatitis. The first step in this project is to conduct consultations with affected communities, to establish potential peer-identified interventions.

Methods: Victorian based consultation via online survey, focus groups, and key informant interviews with those living with viral hepatitis (B and/or C), and those who work with, or have personal relationships with people living with viral hepatitis. These consultation methods will be delivered in English, and other community languages including Mandarin, Vietnamese, and Dari.

Results: Consultation currently in progress.

Conclusion: Results of this initial consultation will be available by end June. This presentation will discuss these results, identifying whether, and how, the major issues and needs identified in relation to stigma and discrimination, differ for those living with hepatitis B and/or C. Consultation methods are designed to identify whether and how, other social identities impact on identified needs and issues, including for example cultural membership, gender, and age. Potential intervention strategies identified as a result of these consultations will also be discussed.

While this consultation is Victorian based, we would anticipate that the methods used, results gained, and consequent conclusions reached, will be of practical and theoretical interest and broadly applicable in multiple contexts.

Disclosure of interest statement: None to disclose.

P15

Engagement of the notorious mongrel mob and their knowledge of hepatitis C

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Introduction: Hepatitis C remains a considerable health issue with at least 1% of the New Zealand (NZ) population infected. Risk factors (RF) include tattooing, piercing, IV drugs. High risk population groups are IV drug users, prisoners, gang members; the latter are thought of as difficult to reach and study.

HCV prevalence in gang populations and knowledge of routes of infection and treatments are important for infection prevention and efficient provision of health care. This has not been studied in NZ.

Methods: We collected data on HCV prevalence, liver health, knowledge and RF in a considered high-risk, difficult-to-approach gang population. We held a series of educational Health Hui (meetings) throughout NZ with the Notorious Mongrel Mob, their whānau (extended family) and affiliates. The hui was advertised via word-of-mouth. Data was collected on demographics, gang affiliation, HCV-related knowledge using a validated questionnaire; FibroScan, liver function test, anti-HCV and anti-HBs antibody tests. Participants were educated on HCV RF and symptoms at the end of the events.

Results: We enrolled 53 gang members, family and affiliates (72% Maori, 53% Male). No cases of HCV (2 HBV) were identified. There was poor knowledge of HCV – average questionnaire score was 40.7% vs. 59.4% in a previous general population survey. The study group was high risk with 70%, 32% and 9% exposed to uncertified tattoo and piercing outlets, and IV drugs, respectively. 19% consumed alcohol 3–7 times per week with 70% of them consuming >4 units/session. 10 (19%) had evidence of fibrosis or cirrhosis (F2-F4). ALT was mostly in normal range. 53% considered themselves overweight.

Conclusion: We were successful in reaching this group – an encouraging outcome for future initiatives. We did not identify HCV; liver health was relatively good. We found high levels of RF and poor associated knowledge that is likely to be an under-representation of the population features.

Disclosure of interest statement: Authors have nothing to disclose.

P16

SOF/VEL/VOX for 8 or 12 weeks results in high SVR12 rates: an integrated analysis of the POLARIS-1, POLARIS-2, POLARIS-3 AND POLARIS-4 studies

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Background and Aims: The once-daily fixed-dose combination tablet of sofosbuvir/velpatasvir/voxilaprevir (SOF/VEL/VOX) was evaluated for the treatment of genotype 1–6 HCV infection in four Phase 3 studies in direct acting antiviral (DAA)-experienced POLARIS-1 and POLARIS-4) and DAA-naïve (POLARIS-2 and POLARIS-3) patients with and without compensated cirrhosis. DAA-experienced patients received treatment for 12 weeks and DAA-naïve patients received treatment for 8 weeks. Overall SVR12 rates were >95% across all the studies. This post-hoc analysis assesses efficacy in patients with and without traditional negative predictors of response.

Methods: This was a retrospective analysis of data from 1,056 patients treated with SOF/VEL/VOX in the Phase 3 studies.

Results: Overall, 38% of patients had cirrhosis, 70% had HCV RNA ≥800,000 IU/mL, 59% of the DAA-experienced patients had received an NS5A inhibitor-containing regimen, 20% of the DAA-naïve patients had prior treatment failure with pegylated interferon+ribavirin, 12% were ≥65 years old and 10% were black. SVR12 rates for the DAA-naïve SOF/VEL/VOX 8 week and DAA experienced SOF/VEL/VOX 12 week subgroups were overall 95% & 97%; cirrhosis 94% and 95%; HCN RNA ≥800K 94% & 97%; age >65 96% and 99%; black 90% & 93% respectively. SVR12 rate for the DAA-naïve SOF/VEL/VOX 8 week prior PEG+RBV subgroup was 92%. SVR12 rate for the DAA experienced SOF/VEL/VOX 12 week prior NS5A Inhibitor subgroup was 96%.

Conclusions: The POLARIS program enrolled a diverse patient population, including many with factors historically associated with treatment failure. Overall SVR12 rates for the DAA-naïve SOF/VEL/VOX 8 week and DAA experienced SOF/VEL/VOX 12 week subgroups were 95% and 97% respectively and in those with cirrhosis were 94% and 95% respectively.

Disclosure of Interest: S Roberts: Consultant: Gilead, AbbVie, and MSD, C Cooper: Grant: Gilead Sciences, Abbvie, Merck, Consultant: Gilead Sciences, Abbvie, Merck, Sponsored Lectures (National or International): Gilead Sciences, Abbvie, Bristol-Myers Squibb, Merck, E Lawitz: Grant: AbbVie, Achillion Pharmaceuticals, Boehringer Ingelheim, Bristol-Myers Squibb, Enanta Pharmaceuticals, Gilead Sciences, GlaxoSmithKline, Janssen, Merck & Co, Roche, Salix, Santaris Pharmaceuticals, Tacere, Theravance, Consultant: AbbVie, Achillion Pharmaceuticals, Bristol-Myers Squibb; Enanta, Gilead Sciences, Janssen, Merck & Co, Novartis, Santaris Pharmaceuticals, Regulus,Theravance, Sponsored Lectures (National or International): AbbVie, Bristol-Myers Squibb, Gilead, Janssen, Merck & Co, KR Reddy: Grant: Gilead Sciences, Inc, BMS, Abbvie, Merck, Janssen, Consultant: Gilead Sciences, Inc, Abbvie, Merck, A Thompson: Grant: Gilead Sciences, Abbvie, BMS, MSD, Springbank, Consultant: Gilead Sciences, Abbvie, BMS, MSD, Sponsored Lectures (National or International): Gilead Sciences, Abbvie, BMS, MSD, S Zeuzem: Consultant: Gilead, AbbVie, Bristol-Myers Squibb Co, Janssen, Merck & Co, I Jacobson: Grant: AbbVie, Genfit, Gilead, Intercept, Merck, Consultant: AbbVie, Bristol-Myers Squibb, Gilead, Intercept, Janssen, Merck, Trek, Sponsored Lectures (National or International): Gilead, Intercerpt, Merck, P Ruane: Grant: Gilead Sciences, Inc, Abbott, B-MS, Boehringer, Idenix, Jannsen, Consultant: Gilead Sciences, Inc, Abbott, B-MS, Boehringer, Jannsen, Viiv, Sponsored Lectures (National or International): Gilead Sciences, Inc, Abbott, B-MS, Boehringer, Jannsen, Merck, , VIIV, Stockholder: Gilead Sciences, Inc, R Hyland: Stockholder: Gilead Sciences, Inc, Employee: Gilead Sciences, Inc, L Stamm: Stockholder: Gilead Sciences, Inc, Employee: Gilead Sciences, Inc, L Han: Stockholder: Gilead Sciences, Inc, Employee: Gilead Sciences, Inc, D Brainard: Stockholder: Gilead Sciences, Inc, Employee: Gilead Sciences, Inc, N Bräu: None Declared, T Asselah: Consultant: : Gilead Sciences, Inc, AbbVie, B-MS, Janssen, Merck, Roche, B Willems: Grant: Gilead Sciences, Inc, Vertex, Boehringer-Ingelheim, Merck, Cangene, Abbvie, Consultant: Gilead Sciences, Inc, Vertex, Boehringer-Ingelheim, Abbvie, Roche, Janssen, Sponsored Lectures (National or International): Gilead Sciences, Inc, Janssen, S Flamm: Grant: Gilead Sciences, Inc, AbbVie, and Intercept Pharmaceuticals, Inc, Consultant: Gilead Sciences, Inc, AbbVie, Bristol-Myers Squibb, Intercept Pharmaceuticals, Inc, Merck & Co, Inc, and Salix, M Bourlière: Consultant: Gilead, AbbVie, GSK, Janssen, MSD, Sponsored Lectures (National or International): Gilead, AbbVie, GSK, Janssen, MSD, G Foster: Consultant: Gilead, GSK, Merck, Abbvie, Janssen, Sponsored Lectures (National or International): Gilead, GSK, Merck, Abbvie, Janssen, E Gane: Consultant: Gilead Sciences, Inc, AbbVie, Achillion, Janssen, Merck, Sponsored Lectures (National or International): Gilead Sciences, Inc, AbbVie, Alnylam, Merck, M Manns: Grant: Gilead Sciences, Abbvie, Achillion, Alios, Bristol-Myers-Squibb, Roche, Boehringer Ingelheim, Novartis, Merck/MSD, Janssen, GlaxoSmithKline, S Gordon: Grant: Gilead Sciences, Inc, Cymba Bay, AbbVie, BMS, Conatus, Exalenz, Intercept, Merck, Consultant: Gilead Sciences, Inc, AbbVie, CVS Caremark, Intercept, Merck, Sponsored Lectures (National or International): Gilead Sciences, Inc, Intercept, K Kowdley: Grant: Gilead Sciences, Inc, Abbvie, Evidera, Galectin, Immuron, Intercept, Merck, NGM Biopharma, Novartis, Tobira, Trio Health, Consultant: Gilead Sciences, Inc, Abbvie, Enanta, Intercept, Merck, Novartis, Trio Health, Verylx, Sponsored Lectures (National or International): Gilead Sciences, Inc, Intercept.

P17

The impact of hepatitis C-related uncertainty on self-reported stress in people who inject drugs living with hepatitis C

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Background: People who inject drugs (PWID) are the population most at risk of hepatitis C virus (HCV) infection in Australia. The landscape of HCV care is rapidly changing. The introduction of FibroScans and new treatment will likely alter the experience of living with HCV. This qualitative study aimed to explore positive and negative influences on wellbeing among PWID living with HCV.

Methods: The Treatment and Prevention (TAP) study examines the feasibility of treating a community-based cohort of HCV mono-infected PWID. A purposively recruited sample from TAP was identified, stratified based on age and gender. In-depth interviews were conducted with 16 participants. Participants were aware of their HCV seropositive and fibrosis status (measured by FibroScan) prior to interview. Questions were open-ended, focussing on the impact of health status on wellbeing, social functioning and stability. Interviews were voice recorded, transcribed verbatim and thematically analysed. Analysis was guided by Mishel's (1988) theory of Uncertainty in Illness.

Results: All participants reported HCV-related uncertainty, particularly mis-information or a lack of knowledge surrounding liver health and FibroScan. Those with greater fibrosis experienced an extra layer of prognostic uncertainty. This was particularly stressful and affected behaviour, relationships and everyday life. For all participants HCV-related uncertainty was a key motivation to seek treatment, which was seen as a way to regain some stability in life. Those who had completed treatment not only reported treatment as alleviating HCV-related stress, but promoting feelings of empowerment and confidence in navigating other challenges in their lives.

Conclusion: Despite advances in diagnostic tools and treatment, the HCV experience is shrouded in uncertainty, which may result in increased personal stress. This suggests the need for simple and direct education programs, resources and information on liver health targeted towards PWID living with HCV, to reduce potential mental health harms in this group.

Disclosure of interest statement: The TAP Study is an investigator-initiated study supported by a research grant from Gilead Sciences.

P18

Treating the mob: providing hepatitis C treatment in an aboriginal community controlled health service is a successful model of care

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Introduction: The Victorian Aboriginal Health Service established a Liver Clinic in September 2015 in anticipation of the release of the new Hepatitis C treatments.

Individual community members with chronic Hepatitis C had previously been identified and reviewed clinically.

The Liver clinic was then able to engage over 80 people in the first year to successfully treat them and they are now 'cured'.

Methods: The Victorian Aboriginal Health service established a Liver clinic to manage high rates of Hepatitis C within the community. The Leadership of the clinic was taken by the Aboriginal Health/AOD worker (AHW) who had a strong relationship with many community members diagnosed with Chronic Hepatitis C.

A formal relationship was established with the Gastroenterology Department from a major Melbourne Hospital for support and guidance. They provided a visiting 'Liver Nurse' weekly for as long as it was required to build the capacity of the service.

The AHW, STI/BBV Nurse and General Practitioner all worked together to support the individuals to access and follow through with treatment.

Health Promotion Resources were developed 'Word of Mouth' or the Koori Grapevine seemed to be the best promotion.

Results: All Community members who were offered treatment participated. All those who were prescribed the medications completed the program and were 'cured'.

Side effects were minimal and short lived.

Many people reported an improvement in their focus on maintaining their overall health.

Conclusion: Providing Direct Acting Antiretroviral Treatment for Chronic Hepatitis C in an Aboriginal Community Controlled Health Service is a successful model.

Disclosure of interest statement: None of the authors have a conflict of interest to report.

P19

An innovative way to increase ongoing care for Chinese patients living with chronic hepatitis B

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Background: CALD communities have been significantly affected by chronic hepatitis B in Australia; the Chinese community is one of the most affected communities. Ethnic Communities Council of Queensland (ECCQ)'s Blood Bore Viruses (BBV) and STI Program has been reaching the Chinese community through multiple strategies, including local Chinese media, Chinese social media, appropriate Chinese resources, health promotion events and face to face education sessions. However, due to very strong stigma attached to hepatitis B, very few people with chronic hepatitis B actively seek help.

Methods: ECCQ has started to provide Fibroscan tests at selected GP clinics with high hepatitis B caseloads. The majority of them are Chinese patients. A trained Chinese bilingual health worker (BHW) from ECCQ presents at the Fibroscan clinic to assist and help patients. As there is no language and cultural barriers, the Chinese BHW is able to identify and discuss issues with individual patients around chronic hepatitis B management and treatment at the clinic, and provides intervention immediately if needed.

Results: The presentation will report details on numbers of patients, main issues and responses from patients, and discuss why people are lost in follow-ups.

Conclusions: Health workers have been working hard to keep people with chronic hepatitis B in care. However, trying hard is not always enough. The presentation will give a new perspective in effectively engaging with affected patients to increase ongoing care for CALD people affected by chronic hepatitis B.

Disclosure of interest statement: The conference collaborators recognise the considerable contribution that industry partners make to professional and research activities. We also recognise the need for transparency of disclosure of potential conflicts of interest by acknowledging there are relationships in publications and presentation.

P20

Monitoring the uptake of hepatitis C: direct acting antiviral treatment in Australia

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Background: Interferon-free direct-acting antiviral (DAA) regimens for HCV infection have been government-subsidised in Australia since March 2016. This study monitored treatment uptake during March-December 2016, the first 10 months of the universal DAA access.

Methods: Data on dispensed DAA prescriptions for a longitudinal cohort of individuals, representing a 10% random sample of the Pharmaceutical Benefits Scheme (PBS) database, were used for analysis. The proportion of the chronic HCV population treated was estimated utilising previous modelling-based estimates.

Results: An estimated 32,400 people initiated DAA treatment during March-December 2016 (14% of chronic HCV population), including 11,310 (14%) in New South Wales, 8,400 (15%) in Victoria, 6,430 (14%) in Queensland, 2,270 (11%) in Western Australia, 2,000 (17%) in South Australia, 830 (23%) in Australian Capital Territory, 770 (17%) in Tasmania, and 360 (10%) in Northern Territory. Prescribed DAA regimens included sofosbuvir/ledipasvir (56%) sofosbuvir+daclatasvir (39%), sofosbuvir+other agents (4%), and paritaprevir/ritonavir/ombitasvir+dasabuvir (1%). Among those initiating DAA therapy, 66% were men, 43% were ≤50 years old, and 16% were prescribed by general practitioners (GPs; vs. 62% by specialists, and 22% by other physicians). The proportion of individuals prescribed by GPs increased from 6% to 29% and the proportion of individuals ≤50 years old increased from 32% to 61% between March and December. An estimated 70% of total patients with HCV-related cirrhosis received DAA therapy from 2014 to 2016 through PBS, clinical trials, early-access programs or generic supply.

Conclusions: Rapid treatment scale-up was observed in the first 10 months of DAA therapy in Australia. The proportion of prescriptions by GPs increased over time, crucial for broadened access. Further evaluations will include assessment of treatment uptake within jurisdictions, among indigenous Australians, and among sub-populations at a greater risk of HCV, including, people who inject drugs, people on opioid substitution therapy, prisoners, and HIV-infected men who have sex with men.

Disclosure of interest statement: The Kirby Institute is funded by the Australian Government Department of Health and is affiliated with the Faculty of Medicine, UNSW Sydney. The views expressed in this publication do not necessarily represent the position of the Australian Government.

P21

An ehealth model of care for community hepatitis C management: the HealthElink project

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Background: The advent of new generation highly effective direct-acting antiviral (DAA) therapy has presented an ambitious but achievable opportunity to eliminate the virus by 2030. These remarkably effective treatments, combined with a modest side-effect profile have now enabled management of most patients in a primary care setting. The achievement of the lofty elimination goal demands development of alternate models of care to support General Practitioners (GPs) whilst maintaining a patient-centred approach. Limited pre-DAA studies suggest equivalent sustained virological response (SVR) rates with community HCV therapy via telehealth models, however loss to follow-up may be higher than tertiary settings. Digital health technologies represent a new opportunity to facilitate timely, coordinated, participatory medicine and potentially address many of the roadblocks preventing both GP initiation of HCV treatment and ensuring adequate follow-up.

Methods: HealthElink is a custom made, web-based portal intended to promote patient centred chronic disease management. Patient, nurse, GP and specialist specific interfaces allow development and delivery of custom treatment plans, direct messaging capabilities between each party, electronic reminders, progress indicators and streamlined task management for tertiary teams. The HCV specific module allows the GP to enter clinical and demographic characteristics to allow instant assessment of the degree of liver fibrosis and the generation of an appropriate treatment regimen based on Australian

Liver Association consensus via an inbuilt algorithm. This includes automated calculation of surrogate markers of fibrosis and incorporation of the University of Liverpool hepatitis drug interaction checker.

A prospective, multicentre pilot of HealthElink across primary care and prison services in South Australia, Victoria and the Northern Territory is scheduled to begin in June 2017. The primary outcome is Sustained Virological Response (SVR12). Secondary outcomes include patient, doctor and nurse satisfaction, cost and number of treatment initiations per practitioner. We anticipate preliminary results to be presented in mid 2018.

Disclosure of interest statement: The project has received grant funding from the Royal Melbourne Hospital, Bristol-Myers Squibb and Merck Sharp and Dohme.

P22

'No closed door' to HCV treatment in the era of fully funded DAAs: access to a peer navigator is essential

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Background: Historically, Australia has had a poor record of access to hepatitis C (HCV) treatment with only 22% of people living with chronic HCV (PLWHCV) ever treated and rates of death due to HCV-related illnesses rapidly increasing. In March 2016, the Australian Government funded direct acting antivirals (DAA) with no restrictions on access to adults with chronic HCV infection, and a small co-payment ($AUS 7–38/month). Roll out has been swift with an estimated 14% of PLWHCV treated at the end of 2016. The New South Wales (NSW) government has an equity focus with the NSW Users and AIDS Association (NUAA) funded to provide peer-support for HCV treatment access to affected community members. This paper presents the results of a peer navigator program trialled by NUAA to support engagement in HCV testing and treatment among community members.

Methods: In July 2016, NUAA developed a 'buddy system' in which a peer who has undergone DAA treatment and training in HCV supports community members through HCV treatment. People who 'graduate' are then offered the opportunity to 'buddy' their peers. Small incentives are provided for each stage of testing and treatment including hepatitis B vaccination.

Results: To date, a total of 85 people have been tested for HCV via the 'buddy system' with 64% (n=55) having chronic HCV with detectable RNA+. Of these 55 people, 73% (n=40) had liver disease assessment performed with transient elastography (FibroScan). Overall 33% of all participants and 51% (n=28) of RNA+ (70% of those scanned) commenced treatment. To date, 20 participants have completed DAA treatment via the program. A total of XX participants have also had at the first dose of HBV vaccination.

Conclusion: The 'buddy system' demonstrates that populations typically considered 'hard to reach' have a high level of HCV uptake within a flexible, person-centred model of HCV care. The success to date can be attributed to tailored peer support and multiple points of treatment access that suit the individual seeking treatment. It is essential that access to similar models is expanded if we are to achieve HCV elimination.

Disclosure of interest statement: No conflict of interest.

P23

Strategies towards the elimination of viral hepatitis in Queensland

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Background: Prior to 2016, treatment for hepatitis B and C in Queensland had been largely limited to tertiary settings. This model of care contributed to long wait times at some tertiary outpatient clinics, particularly in metropolitan centers. On the 1st of March 2016, new Direct Acting Antiviral treatments (DAAs) were listed under schedule 85 on the PBS in Australia, meaning general practitioners (GPs) and other services could now treat patients for HCV in the community.

Methods: A telephone survey of all public hospital outpatient hepatology clinics, infectious disease units, most sexual health, alcohol and other drugs (AOD) services and Corrective Services Health Centers across Queensland was conducted from March 2016 – October 2016. Respondents were surveyed on the treatment services they currently provided to patients for hepatitis B and C, any outreach clinics they conducted and what facilities were available to them for the assessment of liver disease.

Results: Since the introduction of HCV DAAs and revised PBS guidelines in November 2016, many sexual health and some AOD services have embraced the opportunity to treat patients with HCV. A number of outpatient hepatology clinics have created special fast tracks to treatment for patients with HCV, including shared care arrangements. Some regional services have worked in partnership with Corrective Services to successfully implement DAA treatment. However, there are still gaps where cooperative relationships have not yet been established, and there has been little change to improve processes for management of chronic hepatitis B (CHB).

Conclusion: The elimination of viral hepatitis in Queensland is only achievable if treatment is widely accessible to the affected community. The expansion of the provision of treatment services for HCV in Queensland over the past year has been impressive, but more work must be done to engage GPs in the treatment of both HCV and CHB.

Disclosure of interest statement: This work was originally commissioned by Queensland Health.

P24

What GP prescribers need to treat hepatitis C: results of an online survey

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Introduction: ASHM conducted 15 comprehensive direct acting antivirals (DAA) training courses around Australia from March 2016 to February 2017. Little is known about the support needs of GPs who have undertaken DAA training.

Methods: In April 2017, ASHM invited 271 course attendees to complete a 28 question on-line survey to evaluate the uptake of DAA prescribing and the support needs of prescribers.

Results: 53 doctors completed the survey, of whom 77% identified as GPs. Survey respondents reported a wide patient load with 73% seeing 5 or less patients with for hepatitis C (HCV) per week. 73% of respondents reported screening and assessing more patients following the training. 87% of respondents had not prescribed treatment for HCV prior to DAA listing in 2016. Following training, 58% indicated that they were confident or very confident in prescribing HCV treatment. Since attending training, 64% reported prescribing DAA therapy in consultation with a specialist. Of the 36% who had not prescribed, the commonest reason was 'no patient load'. Following the PBS changes on 1/11/16 allowing experienced GPs to prescribe independently, 34% indicated that they had done so for over 100 patients in total. A wide range of support needs were identified by the respondents, with the most common being 'ready access to specialist support' followed by 'access to Fibroscan' and 'more training needed'.

Conclusion: Following training, the majority of survey respondents reported confidence in DAA prescribing. The survey identified some opportunities to support primary care prescribing, including increased specialist support, improved access to Fibroscan and additional training.

Disclosure of interest statement: ASHM has received funding in the form of unconditional education grants to provide hepatitis C training from Gilead, BMS, Abbvie and MSD.

D Baker received funding from Gilead and BMS for educational events, Advisory Board membership and clinical trials.

P25

Integration of hepatitis C assessment and treatment in a unique residential drug and alcohol treatment facility for women

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Introduction: The up-scaling of hepatitis C treatment to primary care and community based centres is pivotal in working toward elimination of chronic hepatitis C and the reduction of the projected burden of disease in Australia. Residential drug and alcohol treatment facilities provide an opportunity for individuals with drug and alcohol dependency to DETOX and stabilise in a safe and supportive environment. Jarrah House is the only non-government residential facility in Australia that offers a medicated withdrawal treatment program; an opioid substitution program and the capacity to accommodate women and their children. The integration of hepatitis C treatment within a unique residential drug and alcohol treatment program contributes to the vision of the holistic model of care of the facility and demonstrates the possibilities for partnership models of care to contribute to the elimination of hepatitis C in Australia.

Methods: A partnership model of care has been developed between the Women's Alcohol and Drug Advisory Centre (Jarrah House), visiting General Practitioners and Community Hepatitis Clinical Nurse Consultant (CNC) to assess for hepatitis C and initiate treatment for residents with chronic hepatitis C. We report on the processes involved in planning, negotiating and implementation of treatment, challenges and acceptability of the program.

Results: The phases of planning and negotiation prior to implementation of the hepatitis C clinic identified roles and responsibilities for the organisation, the general practitioner and the clinical nurse consultant. A number of benefits to this model have been identified and can be characterised as benefits to the clients treated for hepatitis C, the organisation, the general practitioner and the clinical nurse consultant.

Conclusion: The development of a model of care to suit individual settings enhances access to assessment and treatment for hepatitis C. This partnership model of care optimises the opportunity for treatment to be provided in a supportive environment and enhances the holistic model of care established at Jarrah House.

Disclosures: None to disclose.

P26

HealthPathways Melbourne: assisting general practitioners and practice nurses to provide optimal care for patients with hepatitis C

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Introduction: HealthPathways is a web-based platform containing clinical advice for conditions treated commonly in general practice. Central to the process of developing pathways is the bringing together of general practitioners (GPs), specialists and other relevant stakeholders to develop and build consensus on the published advice. The pathways are designed for use during a consultation to prompt the GP to important aspects of the patient assessment and treatment journey. This content incorporates localised referral information.

The introduction of direct-acting antivirals (DAAs) for chronic hepatitis C (HCV) treatment to the PBS General Schedule means that some GPs may require additional and ongoing support to confidently manage and treat their patients. More than 33,000 Australians have initiated DAAs since the 1st of March 2016, including 12% of the Victorians living with HCV.

Methods: North Western Melbourne Primary Health Network (NWMPHN) recognised the important role that HealthPathways could play within the HCV treatment space. In collaboration with Eastern Melbourne Primary Health Network (EMPHN), the review of the HCV HealthPathway began in December 2016. The updated and completed pathway was made available on the HealthPathways Melbourne website from the 1st of March 2016. Promotion of the pathway was made directly to GPs (during practice visits), in newsletters and during viral hepatitis education events.

Results: From the 1st March 2016 to the 28th February 2017 there were 1499 views to the HCV pathway. This was a substantial increase when compared to the 144 views in the year prior to the introduction of DAAs. HCV is now the most frequently accessed pathway of the 405 available on HealthPathways Melbourne. The pathway continues to be updated as new medications and resources become available.

Conclusion: Continuing to support GPs to treat as many patients with HCV as possible, with resources such as HealthPathways, remains an important component of achieving the goal of elimination by the year 2030.

Disclosure of interest: We acknowledge the significant contributions made by all who assisted in the development of the HCV pathway.

P27

Hepatitis B outreach to people who inject drugs (PWID)

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Background: Hepatitis B Virus (HBV) is the leading cause of liver cancer. People who inject drugs (PWID) are at substantial risk for the transmission of HBV, through both unsafe injecting and sexual activity. In Australia, 40% of new HBV infections occur among PWID.

Methods: The staff in primary healthcare settings are in a prime position to facilitate HBV testing, vaccination and treatment but they need to increase their knowledge of this high risk priority population. Collaborations which endeavour to facilitate increased understanding of HBV for staff in primary care and drug and alcohol settings are needed.

Between 2016–2018 we aim to increase awareness of HBV vaccination and prevention in PWID, who access HealthWorks, a primary health centre in Footscray; Victoria. We aim to also develop health education materials for organisations who have daily contact with PWID including needle syringe programs.

The project will be planned and delivered in close consultation with affected community members, representatives and the partner organisations. Peer participation will be a focus of the resource development including pre and post knowledge testing, focus groups and peer education sessions during health promotion months at HealthWorks.

Results: It is expected that the project will educate the PWID community in Footscray and have the following outcomes:

- The PWID community and their partners and families will have an increased awareness of HBV testing, treatment and vaccination options.
- A written resource for PWID at risk of HBV will be developed in consultation with affected community members.
- A brief intervention for staff will be developed to assist build their capacity around HBV.

Conclusion: It is hoped these resources will outlast the project along with clarifying access to vaccination and testing pathways. Engagement of the PWID community will be central to the success of this project.

Disclosure of interest statement: None to disclose.

P28

Queensland injectors health network (QuIHN) treatment management program (TMP): hepatitis C virus (HCV) direct acting antivirals (DAA) full access for people who inject drugs

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Background: In March 2016, DAA HCV treatment became available to ALL Australians living with chronic HCV. QuIHN's TMP offers community treatment prescribing, prioritising people who inject drugs (PWID) who have HCV, using a Treatment as Prevention framework to cure HCV. TMP utilises a multi-disciplinary approach (Needle Syringe Program (NSP), General Practitioner (GP), Case Managers, Hepatologists, Nurse Practitioner), where clients primarily refer through the NSP,GP or word-of-mouth.

Methods: Clients complete an initial screen to determine eligibility (PWID, Opioid Substitution Therapy (OST), Counselling, Rehab), with client-focused discussions around treatment readiness, HCV diagnoses and history, drug and alcohol use, support, mental health, housing and financial needs are recorded. Clients are determined a level of social support required ranging from no/minimal support through to face-to-face and telephone calls as required/medication reminders, liaison with external service providers.

Case mangers work in collaboration with GP's and Hepatologists whilst continuing to support and advocate for clients. Key to success is the provision of harm reduction education around drug use (i.e. minimize re-infection risks, ensure access to clean equipment pre, on and post treatment).

Results: January 2016 to March 2017, 418 screened (161 level 1 support, 201 level 2 support, 56 level 3 support) with 220 clients completed HCV treatment. Of those 220, 116 have cured at SVR12, 50 have missed the SVR12 test, 54 are pending SVR12. Of those completed treatment, 10 clients discontinued treatment early. A further 198 clients have been screened and are either on treatment, in work-up, or are uncontactable.

Conclusion: QuIHN has seen a significant increase in the number of people living with HCV, accessing and successfully completing treatment. Using a multi-disciplinary care coordination approach, including clinical and case management staff, TMP aims to play a significant role in the elimination of HCV infection among Queensland populations of PWID.

Disclosure of interest statement: QH funding.

P29

Treating hepatitis C virus infection (HCV) with direct acting antivirals (DAAs) through the existing infrastructure of opioid agonist therapy (OAT)

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Introduction: The introduction of Direct Acting Antivirals (DAAs) in Australia, with their improved efficacy and tolerability, has simplified the treatment of chronic hepatitis C virus infection (HCV). This presents the opportunity to treat more patients in more settings. Expansion of HCV treatment through alcohol & drug services is of particular interest due to the high concentration of patients with HCV already engaged with the existing infrastructure. In our Local Health District the skills and experience to manage HCV have been nurtured amongst addiction medicine specialists. This, coupled with access to a mobile Fibroscan machine and training in its use, have allowed DAA treatment to be rolled out in a variety of opioid agonist therapy (OAT) clinics in the district. This poster details the model of care and presents case series data of our experience.

Methods: Preliminary clinician-lead assessment of HCV treatment readiness occurs opportunistically in the OAT service setting. This includes education around transmission risks, provision of pathology requests and collation of results. Suitable patients are flagged, and at their next OAT review the addiction medicine specialist undertakes a comprehensive assessment of HCV and liver disease, along with medical, psychosocial and alcohol and drug assessments. At the same visit a Fibroscan is performed, drug-drug interactions are screened, medication adherence discussed and a prescription for DAA treatment is written. Directly observed therapy or take-home self-dosing are possible.

Results: Between 1/3/2016 and 1/4/2017, 59 patients commenced DAA treatment (39 through a major city OAT public dosing clinic, 14 through a regional city OAT public dosing clinic, and 6 through a regional non-government organisation that provides OAT). Updated completion and response rates will be provided.

Conclusion: Rapid expansion of DAA treatment can be achieved through OAT settings if targeted training of addiction medicine specialists occurs alongside access to a mobile Fibroscan machine.

Disclosure of interest statement: None to disclose.

P30

Scaling up or holding back? Contemplating treatment as prevention in the prison setting within Australia's current policy frameworks

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Background: Hepatitis C (HCV) is a global public health concern. There is a global prevalence of 15% of the world's prisoner population, making those incarcerated a priority population for treatment. New therapies, known as directing-acting antivirals (DAAs), became available under Australia's universal healthcare scheme on 1 March 2016 without restrictions (e.g., injecting drug history, liver disease stage, incarceration status). This creates an opportune time to trial treatment as prevention (TasP) as an elimination strategy for HCV in prison settings. But do Australia's policies support treatment scale-up to achieve elimination among this priority population?

Methods: A systematic search was conducted using Google and other web-based search functions to locate all publicly available policies in each Australian state and territory related to HCV health and HCV-related prison health. Inductive and deductive analyses were conducted for each jurisdiction, with documents being assessed against a set of five *a priori* criteria. Documents included in the analysis were current at 28 Aug 2016, or 6 months following treatment availability.

Results: A total of 18 documents were located, including both health (n=10) and prison health (n=8) documents relevant to HCV. Jurisdictions ranged in their commitments and consistencies for delivering HCV harm reduction strategies and treatment availability within the prison setting. Both reinfection and treatment as prevention were mentioned in only two policies.

Conclusion: Few jurisdictions have updated or published HCV-related health or prison / prisoner health policies following availability of DAAs. Current policies do not provide effective support for implementing treatment scale-up that could be possible under universal access to HCV treatment among this priority population.

Disclosure of interest statement: The authors have no competing interests to declare.

P31

Treatment as prevention in the prison setting: prisoners' perspectives

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Background: Hepatitis C virus (HCV) is a global public health concern. Inmates within the prison system are particularly affected, with a global

prevalence estimated to be 15%. On 1 March 2016, Australia provided universal access to new direct-acting antiviral therapy, thus providing a promising setting for trialling treatment scale-up efforts. The Surveillance and Treatment of Prisoners with hepatitis C (SToP-C) study is implementing the first real-world trial of treatment as prevention (TasP) for HCV.

Methods: Participants were recruited from four correctional centres in New South Wales, including one women's prison and across security classifications (minimum, medium, and maximum). Thirty-two prisoners with a history of injecting drug use (i.e., risk of exposure to HCV) participated in qualitative interviews prior to prison-wide treatment roll-out. All participants had been screened for HCV within the previous six months; n=16 HCV positive, n=14 HCV-negative, and n=2 awaiting test results.

Results: Most participants indicated support for treatment scale-up and perceived prison officers as supportive of treatment interventions. However, prisoner movement was consistently raised as a major challenge for TasP elimination efforts; i.e., prisoners moving between prisons or coming in from community (who have not yet been treated) may join injecting networks of those already treated. Others described TasP as 'fighting a losing battle'. Participants worried about resistance to treatment should they become reinfected. Suggestions for harm reduction measures to assist TasP effectiveness (and reduce risk of re-infection) included education, increasing access to opioid substitution therapy and prison needle syringe programs.

Conclusion: There are a number of challenges in HCV treatment scale-up efforts in the prison setting. TasP in the prison setting is likely to reduce transmission rates. However, prisoners remain concerned about long-term effectiveness of TasP efforts (and treatments) without access to effective prevention measures.

Disclosure of interest statement: The authors have no competing interests to declare.

P32

Laws prohibiting peer distribution of injecting equipment in Australia

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Background: Despite Australia's formal policy stance, most states in Australia have laws that hinder hepatitis C prevention. One example is laws that allow only 'authorised persons' within 'approved programs' to distribute injecting equipment. This is known as the prohibition on 'peer distribution.'

Methods: Taking the laws governing distribution of injecting equipment in New South Wales as a case study, we use Bacchi's approach to policy analysis to critically consider the assumptions underpinning these laws, with a focus on examining their discursive, subjectification and lived effects.

Results: Legislative prohibitions on the distribution of injecting equipment except by 'authorised persons' within 'approved programs' constitute people who inject drugs (PWID) as irresponsible and untrustworthy and re-inscribe a familiar stereotype of the drug 'addict'. These constructions of PWID fundamentally constrain how the provision of injecting equipment may be thought about in policy and practice. Prohibitions on the distribution of injecting equipment among peers may also have other, material, effects and may be counterproductive to various public health objectives. However, the actions undertaken by some PWID to distribute equipment to their peers may disrupt and challenge these constructions, through a counter-discourse in which PWID are constituted as active agents with a vital role to play in blood-borne virus prevention. Such activity continues to bring with it the risk of criminal prosecution, and so it remains a vexed issue.

Conclusions: These insights have implications of relevance beyond Australia, particularly for other countries that prohibit peer distribution, but also for other legislative practices with material-discursive effects in association with injecting drug use.

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P33

The living well program: bringing hepatitis C treatment to marginalised people in residential rehabilitation centres

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Background: The *Living Well* program works with key partners to dramatically improve access to hep C testing and treatment for people in residential rehabilitation centres. The program has built an innovative model that brings hep C testing, FibroScans, and treatment into residential rehabilitation centres so that we continue to reach marginalised people living with hep C where they're at. The program aims to engage and empower 160 people a year to access testing and treatment.

Methods: Peer facilitators run 4 week courses focusing on engaging people in residential rehabilitation centres with hep C information, testing and treatment. *Living Well* sessions provide information about hep C, testing, treatment, and liver health as well as bringing in specialists such as dieticians and clinical nurse consultants.

Results: *Living Well* has been met with great enthusiasm by participants and is strongly supported by the residential rehabs who ask the *Living Well* program to come in every 6 months. Getting a FibroScan and hep C test has been eagerly taken up by participants and treatment offered to all those living with the virus.

The first ever hep C treatment was commenced and completed at *Phoebe House*, a women's rehabilitation centre in Sydney, in partnership with St. George Liver Clinic.

Jarrah House has, for the first time, set up a hep C clinic and commenced treatment within a partnership between Hepatitis NSW and South Eastern Sydney LHD.

Testing and FibroScans are being arranged at *Guthrie House* and *Foundation House*, both services linked into Royal Prince Alfred Hospital's Liver Clinic.

Two other large services, WHOS and Ozanam Learning Centre, are hosting *Living Well* and expected to reach over 100 people tested and treated during the program.

Conclusion: *Living Well* evolved from a chronic disease self-management model into one that facilitates access to testing, FibroScans and access to DAA treatment, and effectively supports better health outcomes for marginalised populations.

Disclosure of interest statement: None to disclose.

P34

Expanding access to treatment for patients with hepatitis C through the use of the remote access request form

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Introduction: The expansion of treatment delivery including community prescribing is essential to achieving the elimination of hepatitis C (HCV) in Australia. The Remote Consult Request Form (RCRF) was implemented to assist General Practitioners (GPs) prescribe HCV therapy in consultation with Liver Specialists. The uptake, efficiency and impact of the RCRF were assessed.

Methods: All RCRFs from April 2016 – February 2017 were collated excluding duplicate and incomplete forms (n=11). Usage,

demographics and turn-around time were assessed. Patient characteristics were compared to hospital patients (chi-square, t-test). Hospital referrals April – December 2016 were compared to previous 9 months (t-test).

Results: 205 Remote Forms were received from 94 GPs (18.6 forms/month). Mean age 45, 55% genotype 1, 9.3% treatment experienced, 3.9% diabetic. 48.3% resided within the hospital catchment, 21.5% were rural.

305 hospital patients commenced therapy during the same period. Hospital patients were older (mean 52 versus 45 years, p<0.01) and more patients were treatment experienced (37.0% versus 9.3%, p<0.01).

93.7% (192/205) of RCRFs were approved. 13 were rejected and appointed at the hospital, primarily due to cirrhosis (n=6). Drug-drug interactions identified in 17.6% (36/205) patients, medication changes recommended for 4.4% (9/205) patients. Essential information was omitted in 17.1% (35/205) of RCRFs; nurses liaised with GPs to resolve.

Mean turn-around time for all RCRF was 6.9 weekdays (mode 2.0).

Referrals to the hospital Liver Service decreased from 48 to 29 per month (p<0.01). Mean wait-time for appointment decreased from 220 to 74 days (p<0.01).

Conclusion: The vast majority of RCRFs were approved for community therapy. A small number of cirrhotic and complex patients were redirected to the hospital. Hospital referrals and wait-time decreased significantly. The RCRF is an effective and innovative collaborative tool improving access to HCV treatment and will continue to be a useful tool for GPs who are inexperienced with the treatment of HCV.

Disclosure of interest statement: None to disclose.

P35

Treatment access for hepatitis C across Australia: mapping need and capacity

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Introduction: Since the introduction of highly effective treatments for chronic hepatitis C (CHC) with broad eligibility criteria in Australia, a key focus is ensuring access for those affected and maximizing uptake, particularly in areas with a higher burden of disease or limited access to specialist services. We assessed relative burden of infection and availability of potential hepatitis C prescribers by Primary Health Network (PHN), in the context of current treatment trends and elimination goals.

Methods: We estimated the geographic distribution of CHC using the established national prevalence applied proportionally to notifications data obtained from the National Notifiable Diseases Surveillance System. Health workforce registration data, including specialty type (for gastroenterology/hepatology, general medicine, infectious diseases, addiction medicine, and sexual health specialties, and GPs), job setting, PHN of primary practice, and hours worked, were extracted from the Australian Institute of Health and Welfare National Health Workforce Dataset.

Results: The estimated prevalence of CHC in PHNs varied from >1.5% in rural NSW and the Northern Territory to <0.6% in Northern Sydney and in Western Queensland. The estimated number of people living with CHC per potential specialist hepatitis C prescribers varied widely, from 67 to >800 per PHN. GP workforce distribution was less variable, with the number of people living with CHC per GP varying from between 4 and 12. Some PHNs had fewer than 5 potentially eligible specialists. Forthcoming treatment data available through the National Viral Hepatitis Mapping Project will allow comparison of these estimates with treatment uptake.

Conclusion: Our analysis demonstrates that the number specialist prescribers, currently the predominant group of practitioners prescribing CHC treatment, is severely limited in a number of geographic areas. Expanding prescribing beyond traditional specialist practitioners is essential to meet elimination goals, particularly in areas with a high estimated burden of infection.

Disclosure of interest statement: None to disclose.

P36

Outcomes of general practitioner prescription of direct acting antiviral therapy utilising a remote consultation referral pathway in Western Victoria

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Introduction: To increase treatment access, the pharmaceutical benefits scheme enabled general practitioners (GPs) to prescribe direct-acting antivirals (DAA) to treat hepatitis C virus (HCV). For GPs inexperienced in the management of HCV, a consultation with a specialist was required. Barwon Health and Western Victoria Primary Health Network developed an HCV remote consultation referral pathway, accessed through HealthPathways online portal. The pathway enabled GPs to remotely consult with a specialist. This study describes the development of the pathway and evaluates its outcomes.

Methods: GP engagement with the referral pathway was measured by; number of GPs who referred patients and number of unique page views on HealthPathways.

A retrospective review was undertaken to determine the cascade of care including: the number of patients referred, proportion of patients approved for GP treatment, proportion that started GP treatment (defined as a script being written), and the rate of cure (defined as sustained virologic response; SVR12).

Results: In ten months, 137 patients were referred by 63 GPs, of whom 38% were opioid substitution therapy prescribers. The median number of unique page views of HealthPathways was 81/month (range 51–132).

Of the 137 patients the median age was 48 years (range 21–71), 64% were male; 98 (72%) patients were approved for GP treatment. The most common reason for non-approval was that further investigations for cirrhosis were required. Outcome data has been collected for 38 patients; 35 have started treatment. Thirteen patients were eligible for SVR12 assessment and have had an SVR12 test – all have been cured. Data collection from GP clinics for the remaining 60 patients is ongoing.

Conclusion: A high proportion of referrals were approved for GP DAA treatment, with available SVR12 data showing 100% cure rate. To eliminate HCV, it is critical to increase access to treatment by engaging GPs in HCV management.

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P37

An integrated approach to viral hepatitis management in the community: tackling hepatitis B and C using a model of shared care

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Background: With mutual goals to reduce the number of chronic hepatitis infections and increase the number of people receiving antiviral therapy as part of the NSW hepatitis B and C strategies, there is a need to extend the reach of current health service delivery. Traditionally, patients infected with either hepatitis B or C were referred to hospital specialist services for management and treatment. However

as treatment has become more accessible and less complicated, it is now possible to treat these patients in the community.

Method: In 2014 we implemented a model of shared care which exclusively focussed on supporting general practitioners (GPs) in the Western Sydney LHD to manage hepatitis B. This model of care relies on a strong relationship between GPs, Hepatology nurses, Liver Specialists and patients. A nurse-led Fibroscan clinic provides additional assessment toward appropriate care planning according to current management guidelines. A program specific registry facilitates disease management and HCC surveillance. The model provides culturally appropriate, in-language health information to a diverse patient population with variable health literacy. We have now integrated this model to include hepatitis C management.

Results: We currently have 10 primary health centres engaged in the model of shared care. This has resulted in an increase in the number of patients receiving guideline-based care for their hepatitis B or C infections. The service allows individualised GP support, tailored to practitioners' prescribing needs and their patients. In excess of 300 patients have been enrolled in the disease registry. The nurse led Fibroscan clinic has provided assessment for both hepatitis B and C patients, supporting the initiation of antiviral medication. Further results will be available over time.

Conclusion: The model enhances timely patient referral and management according to guidelines, increasing treatment uptake. Treatment is prompt, and delivered in a familiar and accessible environment for the patient.

Disclosure of interest statement: None to disclose.

P38

Hepatitis NSW's specialised counselling service: professional support for people undertaking DAA treatment for viral hepatitis C

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Introduction: Hepatitis NSW's specialised counselling service is training, coordinating and supervising professional volunteer counsellors to deliver regular cost-free hepatitis-informed counselling to individuals preparing for or accessing treatment for hepatitis C. Service assists in addressing and preventing the development of long-term emotional and mental health issues.

This service continues to show that since the rollout of new DAA treatments, receiving counselling can be central to improving adherence to treatment and addressing health-related emotional issues in individuals.

Methods: This service provides person-centred, and solution-focused counselling support to clients affected by hepatitis C.

The service supports clients dealing with different stages of hep C. Provides emotional support to newly diagnosed clients, assists informed decision-making and preparing for treatment, provides support during treatment, encourages treatment adherence, and contributes to post-treatment recovery. This service also supports clients with advanced liver disease and those preparing for or living with a liver transplant.

Counsellors provide clients with an informed, non-judgemental environment, helping to gain insights and encourage informed decision making over their health issues. Clients receive weekly telephone appointments and the service is reviewed after 9 sessions.

Results: Feedback surveys from clients accessing the counselling service have shown a sense of improved well-being as well as positive health outcomes. Results of evaluation will be included in this presentation.

Since July, 2016 this service delivered 320 sessions to 42 clients, averaging 30 sessions per month. Delivering hepatitis-informed support to affected individuals complements the work of medical professionals, particularly for marginalised individuals and residents of regional NSW. Clients identify working through issues including concerns around treatment, isolation, stigma and discrimination, and the psychosocial impact of hepatitis C.

Conclusion: Hepatitis NSW's counselling program has been shown to be effective in improving adherence to DAA treatment, supporting clients' overall feeling of improved well-being, informed decision making, and decreased sense of isolation and stigma. The service can be essential to improving health outcomes when complements hep C treatment.

Disclosure of interest statement: None to disclose.

P39

Does the cure for hepatitis C start at moment of diagnosis? An analysis of Canadian women's experiences

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Background: Approximately 95,000 Canadian women are living with hepatitis C (HCV). Within this population rates of acute HCV are increasing more rapidly in young women than any other group. Good care at the point of diagnosis has been shown to enhance women's access to HCV treatment and healthcare services.

This presentation will focus on a group of Canadian women's experience of HCV diagnosis to identify recommendations to improve care at diagnosis, that will in turn, enhance women's access to treatment and a cure.

Methods: This qualitative study using a narrative methodology approach was conducted across three Canadian provinces and explored women's experience of receiving an HCV diagnosis and factors contributing to attendance for care. Through purposive sampling, 24 women were recruited and interviewed

Results: The analysis revealed the diagnosis experience was significant for the women, their journey into care and access to treatment. Significant variation in the diagnosis experiences was noted, which were influenced by the role of drug use, type of services delivered, the context of women's lives and the information/health education received at diagnosis. The absence of accurate information post-diagnosis magnified the psychological distress that can follow a HCV diagnosis.

Conclusion: Women's experiences of diagnosis had significant implications for their access to HCV care and overall health. As new treatments become more accessible, their success in elimiating HCV will rely on engaging women into care. Our findings provide a clear and compelling case for interventions/supports to improve HCV diagnosis that will in turn, enhance women's access to new highly effective treatments and provide a much greater chance of cure for all those affected.

Disclosure of interest statement: None to disclose.

P40

Initial outcomes of integrated community-based hepatitis C treatment for people who inject drugs: findings from the Queensland injectors' health network

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Introduction: Integrated treatment and harm reduction services provide a unique opportunity to facilitate direct-acting antiviral (DAA) therapy for hepatitis C virus (HCV)-infected people who inject drugs (PWID). We examine outcomes of community-based delivery of DAA therapy for PWID.

Methods: The Queensland Injectors' Health Network (QuIHN) is a community-based agency providing harm reduction and treatment services. Administrative data from QuIHN's HCV Treatment and Management Program (TMP) were analysed. The TMP uses a case

manager support framework. We used intent-to-treat analysis to examine treatment completion and efficacy.

Results: By the end of February 2017, 127 treatment clients who consented for research had completed therapy and were due for post-treatment sustained virological response (SVR) testing. In an intent-to-treat analysis, 96% of clients completed treatment and 80% had confirmed SVR. There were no confirmed cases of treatment non-response. The remaining clients (20%) had not attended their SVR test at the time of data extraction. There were no significant predictors of SVR, but there was a trend suggesting that clients who reported injecting on a less than daily basis were more likely to have a confirmed SVR than clients reporting no current injecting.

Conclusion: PWID can be effectively treated for HCV and comply with DAA therapy in a community-based integrated care facility. However, strategies are required to support client retention until SVR is confirmed.

Disclosure of interest statement: The QuIHN Treatment and Management Program (TMP) is funded by the Queensland Government, Department of Health through the Communicable Diseases Unit (Project ID: 70251).

P41

Advancing the development of community-based models to access marginalised populations for hepatitis C treatment incorporating assessment, outreach and case management

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Introduction: Much of our discourse is now around how we reach those most marginalised populations in the viral elimination of Hepatitis C. This will increasingly require services to think outside the square and develop new user-friendly and innovative models of care. Our current reality is that most individuals can potentially be treated in primary care. The HIV Outreach Team (HOT) is well placed to meet this challenge, as we provide a range of services for people with HIV and Hepatitis C co-infection using a case management approach.

Methods: HOT is exploring options to pilot a community-based model working with an aboriginal population in Sydney to provide targeted case management around access, assessment, transport, service linkage and referral to primary care and/or specialist treatment. We plan to hold a series of community conversations using the Harwood methodology to explore challenges, myths and perceptions and are a partner in the Integrated Community Hepatitis C Assessment and Treatment program which supports general practitioners to become familiar with prescribing direct acting anti-viral therapy. Jointly funded with the Central and Eastern Sydney Primary Health Network, this program engages an experienced Hepatitis C Clinical Nurse Consultant to build capacity around assessment, management and treatment.

Results: This program will not only acknowledge Aboriginal people as a key priority population but help build an evidence base of community awareness and knowledge and work towards coproducing services with our consumers. Ultimately we plan to demonstrate that new and innovative services can remain cost effective, provide scope for staff to expand their roles, draw on existing clinical expertise and develop models of care to suit individual and population group settings.

Conclusion: If Australia is on target to eliminate hepatitis C within the next 10 years we must experiment with everything in our armoury and that includes being innovative and supporting new service delivery programs.

Disclosure of interest statement: None to disclose.

P42

Hepatitis C treatment in a community needle and syringe program as a method of engagement for injecting drug users

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Background: Most people with hepatitis C who actively inject drugs have not been treated using the oral direct acting antiviral regimens. This is directly related to the vulnerability experienced by this hard to reach population. A Nurse Led Hepatitis C Treatment Program offered treatment within a community Needle and Syringe Exchange Program.

Methods: Patients attending a Needle and Syringe Exchange Program were informed about the new direct acting antivirals (DAA) oral therapies by peers and invited to participate in treatment. Pre-treatment assessment, on treatment management and follow up was undertaken by a nurse practitioner. Patients received treatment according to current Gastroenterological Society of Australia guidelines. Clinical outcomes were ascertained and self-reported compliance was assessed. Patients with advanced liver disease were referred to a tertiary specialist liver clinic.

Results: Currently, 17 (70% male, median age at baseline 47) have commenced hepatitis C treatment. All patients were treatment naïve. 70% were actively injecting at commencement of treatment, 30% had not injected for more than 12 months. Of the 17 people who initiated treatment, 3 people continue on the treatment program with 92% of the intention to treat (ITT) population reaching the end of treatment visit (EOT). Adherence was assessed every 4 weeks. An EOT response was achieved by 92% of the ITT population. Of those who have reached the 12-week post treatment visit, 7 (100%) achieved a sustained virological response (SVR).

Conclusion: Hepatitis C treatment offered to clients attending a Needle and Syringe Exchange Program provides an effective and alternative method of access to treatment for those people who are marginalised, are substance users and who have limited access to health services.

P43

FIB-4 is superior to APRI and identifies HCV patients with less significant fibrosis who could be managed in primary care

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Introduction: Hepatitis C virus (HCV) affects approximately 230000 Australians. Increased access to directly acting antivirals (DAA) offers the opportunity of eradicating HCV from Australia. The need for fibrosis assessment to determine need for secondary care and treatment duration using Fibroscan could represent a barrier to access. 60% of patients referred for HCV management do not have severe fibrosis (=<F2) as determined by Fibroscan in our centre. We hypothesised that use of simple non-invasive tests (APRI, FIB-4) may identify a subgroup of HCV patients that do not require assessment with Fibroscan in secondary care.

Methods: From our HCV DAA treatment database we identified patients with complete data that had undergone Fibroscan in secondary care. We calculated FIB-4 and APRI and correlated this with the presence of fibrosis. From ROC curves we determined cut offs for F3/4 and <=F2 and calculated sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) for each.

Results: 499 patients were analysed (68% male, 40% F3/4). FIB-4 and APRI were calculated as per published formula. FIB-4 outperformed APRI in all analyses. The AUROC for FIB-4 for detection of F3/4 was 0.862. Optimal cut offs for sensitivity and specificity showed FIB-4 had a sensitivity of 77.2%, specificity of 80.6%, PPV 73.6%, NPV 83.5%. AUROC for the detection of milder fibrosis was 0.823. Choosing an optimal cut off with high sensitivity for detection of mild fibrosis. FIB-4 had a sensitivity of 90.4%, specificity 48.3%, PPV 78.9% and NPV 70.2%. The frequency of patients below our sensitive cut off for detection of mild fibrosis was 27% (N=131).

Conclusion: FIB-4 can identify a significant proportion of patients without severe fibrosis who could avoid secondary care referral for fibrosis assessment thus easing access to DAA therapy.

Disclosure of interest statement: No conflict of interest to declare.

P44

Maximising access to hepatitis C (HCV) treatment: the Sunshine Coast experience

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Introduction: Maximising access to directly acting antiviral agents (DAA) is central to achieving eradication of HCV from Australia. Treatment models based in secondary care represent a barrier to access due to resources, geography and expense. To improve access, the Sunshine Coast Hospital and Health Service (SCHHS) has explored new models of DAA therapy.

Methods: SCHHS Hepatology service offers 3 models of care for HCV patients. 1. Traditional secondary care where treatment is initiated and monitored by hospital staff, 2. high throughput rapid evaluation liver clinic (RELIC) where a treatment recommendation is made and treatment is initiated and monitored in primary care. 3. Nurse led regional Fibroscan based assessment clinics with a treatment recommendation by MDT and initiation and monitoring in primary care (Hepatology partnership). The aim of these models of care is to maximise access to HCV therapy whilst identifying patients with advanced fibrosis who require follow up in secondary care.

Results: Since March 1st 2016 598 patients have been initiated on DAA therapy. 482 hospital based secondary care, 91 through RELIC and 25 through the Hepatology partnership. Mean age 51 yrs (18–69), 50% Genotype 1, 40% Genotype 3. 30% F4 and 26% treatment experienced. SVR 12 data is available for 242 patients (203 Hospital based, 39 RELIC). Overall SVR rate is 96.7%. In the hospital cohort SVR rate was 97% and in the RELIC treated cohort SVR was 94.9%. (P=NS). No SVR data is available yet for patients treated in the Hepatology partnership.

Conclusion: RELIC facilitates the initiation and monitoring of DAA treatment in primary care whilst also identifying patients with advanced fibrosis who require secondary care. SVR rates are similar and this model is being further evaluated in the Hepatology Partnership program.

Disclosure of interest statement: No conflict of interests to declare.

P45

Frequency of HCV resistance associated substitutions at baseline and relapse

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Introduction: Amino acid changes in the HCV NS3, NS5A and NS5B regions can confer resistance (known as resistance associated substitutions or RAS) to direct acting antivirals (DAAs). RAS likely pre-exist and are observed in patients who relapse after DAA therapy. There are few data describing the baseline prevalence of HCV RAS in Australia or their on-treatment emergence following failure of DAA therapy. Such information may be beneficial in the selection of initial DAA regimen and for the planning of salvage therapy.

Methods: Baseline samples and samples from patients experiencing relapse after DAA therapy were assessed for the presence of HCV NS5A RAS by PCR and population-based sequencing. A proportion of these samples were tested to identify known HCV RAS in the NS3, NS5A and NS5BB regions using the *Sentosa* NGS (Next Generation Sequencing) HCV genotyping assay (Vela Diagnostics, Singapore).

Results: More than 500 samples were available for assessment with the majority from patients infected with HCV genotype 1a (50%) or HCV 3a (35%). In samples from patients experiencing treatment failure, the prevalence of HCV NS5A RAS approached 90%. The predominant HCV NS5A RAS from HCV 3a relapsers was at position Y93 whereas for HCV 1a relapsers RAS where found at Q30, L31 and Y93. Overall baseline prevalence of HCV NS5A RAS was <10% and greater for HCV 3a (11.7%) than HCV1a (7%). RAS in the HCV NS3 and NS5B regions were uncommon.

Conclusion: Our preliminary data indicate that the prevalence of baseline HCV NS5A RAS is lower than that found in overseas studies. Most treatment failure could be attributed to the presence of HCV NS5A RAS. The low prevalence of baseline HCV RAS makes it difficult to justify the cost of pre-therapy screening but resistance testing may be a useful tool for identifying HCV RAS in those patients considering re-treatment.

Disclosure of interest statement: None to disclose.

P46

Yes I want to be tested: what next? Warning! Another obstacle course soon to begin … experiences of the community and bilingual workers

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Background: This project took into consideration the timelines, resources, experience, and community needs and opted for an inductive – exploratory approach to enhance testing and treatment uptake.

The pilot project found the uptake of the testing was favourably received with surprisingly good results. Limitations of services and several other barriers were noted. It draws on its iterative approach to better understand the process of testing and makes recommendations for making the process more compatible to the needs of the CaLD communities.

Objectives: Working towards better approaches that make testing, treatment and prevention more accessible and user friendly for people from CaLD communities.

Methods: Interactive Groups sessions were used to raise awareness of getting tested and treated for viral hepatitis and participants encouraged to sign up for testing. 220 people attended the information sessions and 181 went through the testing and treatment process.

In the initial information sessions 121 people participated. The iterative approach helped a revised and an enhanced approach with another 99 people attending over 3 days.

Results: Of the initial 121 participants, 82 people went through the actual testing process.10% of the people were HBV positive. All 99 participants from the next group went through the testing process and 6 were HBV positive and 4 HBC positive. Again a 10% positive rate was noted. A total of 181 were tested and 10% overall were antigen positive. 13 (HBV) and 4 (HBC).

The qualitative data suggested knowledge of the process, timing, convenience, cost, importance of the exercise at hand, dependence and support, ignorance and lay concepts as key variables that made the uptake challenging.

Discussion: The underestimation of the barriers for CaLD communities was noted. Several enablers were identified and recommendations made to enhance the testing uptake.

Disclosure of interest: None.

P47

A pilot study to inform, test and treat people from non-english speaking backgrounds living with chronic hepatitis in Western Australia

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Background: Available treatments for hepatitis B virus (HBV) and hepatitis C virus (HCV) are highly effective however treatment uptake in Australia is low resulting in further spread of the viruses and poor health outcomes including cirrhosis of the liver. For people from non-English speaking backgrounds living in Australia the prevalence of HBV and HCV is higher than for Australian-born residents. This

pilot study sought to establish a pathway to address barriers to accessing information, testing and treatment for people from non-English speaking backgrounds (NESB).

Methods: Small group information sessions were delivered to more than 90 people from NESB. 14 general practitioner (GP) practices were invited to participate in testing and treatment services. Strategies were implemented to resolve the barriers encountered at each stage in accessing care.

Results: Participants were motivated to seek testing and treatment following the information sessions. Patients often attended GP appointments with their whole family and were reliant on public transport and the assistance of bilingual workers. More than 90% participants had an unfavourable experience when they tried to access health care. GPs were not always available at the time of the appointments and the available GPs had no knowledge of the study leading to miscommunications between patients and Patients who saw GPs not linked to the study were not always followed up for treatment.

Discussion: Barriers to accessing care need to be addressed or may inhibit timely testing and treatment uptake or future health seeking behaviour. Developing relationships between service providers and tertiary treatment clinics is time and effort intensive but critical to facilitating health care access for people from NESB.

P48

Implementing an elimination program for hepatitis C: a partnership approach from Victoria

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Background: Modelling suggests WHO targets for hepatitis C virus (HCV) elimination by 2030 can be achieved if treatments are targeted towards people who inject drugs (PWID). In Australia, universal access to direct-acting antivirals (DAAs) for all patients chronically infected removes key policy impediments making elimination targets achievable. However, to achieve these targets a major shift from tertiary- to community-based services is required to reach and treat PWID. This shift requires an integrated approach from providers, policy makers, community organisations and drug user networks.

Methods: The 'Eliminate Hepatitis C (EC) Partnership' is implementing an elimination program utilising a health systems framework, delivered through five key components; health promotion and demand generation activities, training and education, clinical pathways, data systems and surveillance and research and evaluation (including financing), with a governance structure to provide leadership and strategic direction. Community-integrated hepatitis C nurses are central to achieving the population coverage needed to realise elimination targets by providing support and outreach services within high-caseload community sites and prisons. The scale-up of key interventions, including rapid point-of-care testing and pharmacy-led treatment will ensure enough treatment demand for treatment-as-prevention to be effective and sustainable. A surveillance system will allow ongoing monitoring and assessment of achieving elimination targets.

Results: Between 2017–2021, the EC Partnership will provide tailored support to 28 community and prison services, to maximise the quality, efficiency and uptake of HCV treatment among PWID. Treating a minimum of 4500 PWID with HCV over a three-year period will provide meaningful reductions in community prevalence (21%) and incidence (12%). If successful this approach will enable the State of Victoria to meet WHO's 2030 elimination targets.

Conclusion: Australia is uniquely placed to demonstrate impact of an innovative model that will strengthen local health systems and provide real-world evidence for HCV elimination aspirations.

Disclosure of interest statement: The Eliminate Hepatitis C Partnership is supported by an investigator-initiated research grant from National Health and Medical Research Council and Gilead Sciences. JD, MH, and AT receive investigator-initiated research funding from Gilead Sciences, AbbVie and BMS. JD's institution has received honoraria from Merck, Gilead and BMS. WS's institution has received honoraria from Merck, Gilead, BMS and AbbVie. No pharmaceutical grants were received in the development of this study.

P49

MAGELLAN-1, PART 2: glecaprevir and pibrentasvir for 12 or 16 weeks in patients with chronic HCV genotype 1 or 4 and prior direct-acting antiviral treatment failure

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Background: Currently, there are no treatments specifically indicated for patients with Hepatitis C virus (HCV) infection who fail treatment with an NS5A inhibitor. This study evaluated the efficacy and safety of glecaprevir (GLE) and pibrentasvir (PIB) for 12 or 16 weeks in HCV-infected patients with prior virologic failure to at least one NS5A and/or NS3/4A protease inhibitor containing therapy.

Methods: In Part 2 of MAGELLAN-1, patients with chronic HCV GT1 or GT4 infection and prior treatment failure to NS5A and/or NS3/4A protease inhibitors, with or without compensated cirrhosis, were randomized 1:1 to receive 12 or 16 weeks of coformulated GLE/PIB (G/P; 300/120 mg). The primary endpoints were safety and the percentage of patients achieving sustained virologic response (HCV RNA<15 IU/mL) at post-treatment week 12 (SVR12).

Results: A total of 91 patients were enrolled: 44 received 12 weeks of G/P and 47 received 16 weeks. 74% of patients had HCV GT1a, 21% had GT1b, and 4% had GT4 infection. Thirty percent of patients had compensated cirrhosis, and baseline demographics were well distributed between study arms. Overall, SVR12 was achieved by 89% (39/44) and 91% (43/47) of patients who received 12 and 16 weeks of G/P, respectively. The majority of adverse events (AEs) were mild in severity, and no patient discontinued due to AEs. No patients had serious AEs considered related to study drug. Headache was the only AE that occurred in ≥10% of patients. No treatment emergent grade 3+ elevations in alanine/aspartate aminotransferases or bilirubin were observed. Viral resistance data will be available upon presentation.

Conclusions: G/P retreatment of HCV GT1 or GT4 infected patients, with or without compensated cirrhosis, who experienced prior DAA therapy failure resulted in high overall SVR12 rates. The regimen was well tolerated with no relevant laboratory abnormalities and no discontinuations due to adverse events.

Disclosure of interest statement: AbbVie sponsored the study (NCT02446717), contributed to its design, collection, analysis, and interpretation of the data, and participated in the writing, review, and approval of the abstract. All authors had access to relevant data. This abstract contains information on the investigational products glecaprevir and pibrentasvir.

A Asatryan, CW Lin, Y Lei, TI Ng, J Kort, T Pilot-Matias, and F Mensa: employees of AbbVie and may hold stock or stock options.

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M Buti: Advisory board/Speaker: Gilead, AbbVie, Merck, Janssen.

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S Pianko: Investigator: AbbVie. Advisory board and speaker bureau Gilead, Abbvie, Merck.

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P50

Acceptability of hepatitis C treatment in community settings: qualitative part of a mixed method systematic review

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Background: A successful community-based model of care for patients with hepatitis C virus (HCV) infection, should be acceptable to both patients and care providers as well as effective and efficient. The aim of this presentation is to identify what is currently known about the acceptability of community-based models of care for HCV treatment. This presentation focusses on the experience of patients and care providers who have participated in community-based HCV treatment.

Method: The study involved a systematic review of publically available information which involved searching seventeen databases and organisational websites. Analysis using meta-aggregation was undertaken of qualitative publications to identify themes. ConQual approach was used to evaluate synthesised findings.

Results: Six studies fulfilled the inclusion criteria for the qualitative part of the review. Positive changes in daily life were mentioned by patients as a result of treatment initiation. The key themes mentioned by patients as catalysts to commencing treatment included: accessibility of the clinics, level of support provided, high levels of trust and experience of being listened to in the initial appointment. Group HCV treatment and long-standing relationships between patients and providers were key factors associated with adherence to treatment. Familiarity with individual service providers; providing convenience, safety and personal care; feeling guided and supported were valued by patients.

Some patients reported a barrier to trust resulting from the co-location of HCV care providers with opiate substitution treatment (OST) prescribers. However reduction in travel costs and offsite referrals, the familiarity of the settings were mentioned as positive aspects of HCV and other services co-location.

Staff commented that the new models improved patients' engagement. The opportunity to be connected with specialists and researchers was also valued by providers who generally indicated satisfaction with co-located HCV treatment.

Conclusion: Providing HCV care in the community settings by familiar providers makes patients more willing to initiate, continue and complete the treatment. However, when services are collocated then power relationships inherent in addiction service provision should be considered.

Disclosure of interest statement: None to disclose.

P51

Advanced liver disease nurse education program in NSW

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Background: With the improved efficacy and ease of use with new hepatitis C treatments, hepatitis C nurses could develop new skills and play a significant role in managing patients with advanced liver disease. Nurses need to be suitably skilled to take up this role. There is limited international and Australian experience in developing hepatology focused education programs which involve assessment of nurse skills and practice. The purpose of this study was to determine whether a mentorship based program is beneficial and feasible. We also describe the uptake of the program until May 2017.

Methods: Seven hepatologist mentors (five from one of two tertiary teaching hospitals in Sydney and 1 from a regional setting) and seven nurses (five rural/regional and two Sydney-based) engaged in an 9 month program that included 6 modules comprising face-to-face teaching, skills workshop, clinical placement, on-line learning, mentoring and assessment. Hepatology nurses and hepatologists developed the advanced liver disease curriculum in collaboration with nurse academics from the University of Sydney. A mixed-method evaluation was developed including paper-based surveys and in-depth qualitative interviews with nurses and the hepatologist mentors.

Results: The face-to-face teaching, skills workshop, clinical placement and on-line learning were rated as highly beneficial and relevant to practice. Under mentorship nurses have begun to develop policies to improve care in their local services. The course has received credit recognition for a Primary Healthcare subject from the University of Sydney.

Conclusion: We have developed a program which is acceptable, feasible and effective for nurses and their mentors and could be utilised

in other jurisdictions. This education program has facilitated an extended scope of practice for nurses to improve access to care for people with advanced liver disease.

P52

'Behind closed doors, no one sees, no one knows': stigma and treatment as prevention in prison

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Introduction: Globally, the burden of the hepatitis C virus (HCV) is disproportionately borne by those in prison. In Australia, over 30% of prisoners tested seropositive in recent survey data and prisoners are designated a priority population for treatment in the current national HCV strategy. Last year, Australia listed the new direct-acting antivirals (DAAs) under the national health-care scheme, ensuring universal treatment access.Together these factors make prison a promising setting for the SToP-C study (Surveillance and Treatment of Prisoners with HCV): the first real-world trial of HCV treatment as prevention in prison. While highly effective DAAs have removed many of the clinical and social barriers associated with interferon-based treatment, one of the primary roles of the study's qualitative component is to explore ongoing barriers, including the impact of HCV-related stigma.

Methods: Participants were recruited from four correctional facilities in New South Wales, including one women's prison and all three security classifications (minimum, medium, and maximum). Thirty-two prisoners with a self-identified history of injecting drug use (i.e. risk of exposure to HCV) participated in qualitative interviews prior to prison-wide treatment roll-out. All participants had been screened for HCV within the previous six months: HCV-positive (n=16), HCV-negative (n=14) and awaiting test results (n=2).

Results: Participants reported perceptions of HCV-related stigma operating among both inmates and prison officers. Reports included fears associated with contagion ('they think you can catch it from coughing') and image management ('he's got hep C, he's dirty, he's a junkie'). Interestingly, however, several participants emphasised a historical *diminution* in HCV-related stigma within prisons: 'It was very hush, hush … now it's a very open thing.'

Conclusion: HCV-related stigma is enacted variously across the prison system. While its presence does not appear to be universal, contending with its impact may prove crucial to effecting treatment as prevention within the prison system.

Disclosure of interest statement: The authors have no competing interests to declare.

P53

Hepatitis C diagnostic testing trends in Victoria, 2010–2015

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Introduction: Treatment scale-up is central to HCV elimination. The recent introduction of direct-acting antivirals (DAAs), available to all those living with chronic HCV, provides the setting for elimination in Australia. Acknowledging the importance of diagnosis as the first stage of the HCV cascade of care, WHO's HCV elimination targets include 90% of people living with HCV knowing their status. A major focus of the Victorian 2016–2020 HCV strategy is to increase testing; here we explore Victoria's baseline HCV screening and follow-up trends for 2010–2015.

Methods: Through the Australian Collaboration for Co-ordinated Enhanced Sentinel Surveillance (ACCESS) laboratory network, de-identified HCV diagnostic test records were extracted from four Victorian laboratories using GRHANITE™ software. Patient records within a laboratory were linked on hashes of names, date of birth, sex, postcode, and Medicare number. Annual screening numbers were counted using the first antibody test per individual per year. Follow-up testing was classified as a PCR test record following a positive antibody test within 12 months. Proportions positive were calculated.

Results: The annual number of HCV antibody tested individuals increased by 51% over five years, from 81,661 in 2010 to 123,132 in 2015. The proportion positive ranged between 3.1% and 4.1% in all years. There was a decline in the proportion of positive antibody tests that were followed by a PCR test within 12 months, from 44.4% in 2010 to 41.7% in 2015 ($p<0.001$). The proportion positive of these PCR tests ranged between 63.3% and 66.2%.

Conclusion: HCV antibody screening in Victoria has increased over time since 2010; however follow-up PCR testing remains low. To achieve HCV elimination by 2030, increasing PCR testing will be important to ensure HCV infected people are linked to DAA treatment. We will continue monitoring these trends to evaluate the success of Victoria's plan to increase testing in 2016–2020.

Disclosure of interest statement: Funding received from the Victorian Department of Health.

P54

Treatment adherence among people who inject drugs taking directly observed direct acting antiviral therapy at Kirketon Road Centre

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Introduction: The Kirketon Road Centre (KRC) is a primary health care service in Kings Cross, Sydney, providing prevention, treatment and care of viral hepatitis for people who inject drugs (PWID). KRC developed an individualised adherence support program for direct-acting antiviral (DAA) therapy, with those assessed as requiring maximum support receiving daily directly observed treatment (DOT). With daily DOT, missed doses led to extended treatment until the planned total doses were administered. Our aim is to report adherence of clients undergoing daily DOT and the proportion who extended duration of treatment.

Methods: Daily dosing of DAAs was recorded on medical prescription charts. Data were analysed to determine the number of missed doses, extended duration of treatment, and median adherence with and without extension.

Results: Twenty-six of 120 (22%) clients initiated on DAA therapy from March 2016 elected to receive DAAs as DOT. The mean age of these clients was 40 years, 16 (62%) were male, 13 (50%) identified as Aboriginal or Torres Strait Islander, 22 (84%) were prescribed OST, 23 (89%) injected drugs in the last 6 months, 12 (46%) sex worked in the last 12 month, 94% had been in custody, all were unemployed, and 62% were homeless. Median adherence for four-weekly dosing periods ranged from 89–93%. Seventeen (65%) clients required extension of treatment (median 5 days, range 2–41), including 6 clients who extended by at least two weeks. At expected end of treatment the median proportion of doses missed was 7% (IQR 5–15%) which was reduced to 1% (range 0–5%) by extending treatment. Among those who are 12 weeks post-treatment with HCV RNA assessment (n=20) all are undetectable.

Conclusion: This study demonstrates daily dosing can achieve high medication adherence for socially marginalised clients within this model of care. Further, extension of treatment to adjust for missed doses appears feasible.

Disclosure of interest statement: The authors have no conflicts of interest to declare.

P55

Client acceptability and feasibility of expanded access to direct acting antiviral therapy for hepatitis at the Kirketon Road Centre

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Introduction: The Kirketon Road Centre (KRC) is a publicly funded primary health care service in Kings Cross, Sydney providing prevention, treatment and care of viral hepatitis in people who inject drugs. Since the introduction of direct acting antivirals (DAAs) in Australia, KRC has sought to support treatment by offering clients daily or weekly medication through our opioid substitution treatment (OST) program regardless of participation in OST or opioid dependence. The aim of this study was to evaluate the acceptability and feasibility of delivering DAAs daily, and the impact on the provision of care to other clients.

Methods: A cross-sectional survey was conducted six months into the program to ascertain feedback and satisfaction of clients accessing KRC, including those receiving DAAs through a daily treatment plan, those on treatment who managed their own DAA prescriptions, and those not on treatment. Data were analysed to determine acceptability of offering daily dosing plans.

Results: A total 117 clients completed the survey: 32 on HCV treatment (10 receiving DAAs daily through KRC), and 85 accessing other services at KRC. More than 90% of clients on DAAs were satisfied or very satisfied with their treatment plan including frequency of visits and discussion of risks, benefits, and side effects of treatment. All (100%) of those receiving DAAs through the OST program found it very helpful. Among OST clients, only four of 25 (16%) indicated the wait for dosing OST was now longer. Only three of 85 (4%) clients accessing clinical or needle syringe program services indicated that the increased number of people waiting for medications affected their access to these services.

Conclusion: This study demonstrates that providing daily or weekly dosing of DAAs through an OST program within a primary health care setting is both feasible and acceptable, and has minimal impact on other service provision.

Disclosure of interest statement: The authors have no conflicts of interest to declare.

P56

Opportunities for hepatitis organisations to compliment needle syringe programs for people who inject drugs by providing hepatitis C treatments

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Introduction: HepatitisWA has implemented a hepatitis C treatments clinic primarily focusing on people who are currently injecting drugs. Being a community based organization providing a Needle Syringe Program (NSP) enables the clinic to recruit and follow-up clients whilst ensuring they are supported and educated about safe using methods during their treatments and all once they have cleared the virus.

Methods: The clinic is staffed by 1 Clinic Coordinator, 1 Nurse Practitioner, 2 GPs and 1 Gastroenterologist who provide 3, 4-hour hepatitis C treatment clinics per fortnight. The clinic is bulk billed and our GPs and Gastroenterologist receive only the Medicare rebate. By physically aligning the clinic with our established NSP the prevailing culture of the organization makes it a familiar and safe environment for clients. This environment has encouraged fiends from injecting networks to also attend the clinic. Data is collected at intake, during treatments and post sustained viral response.

Results: The *'Deen Clinic'* commenced in September 2016. Most clients are self-referrals, with some referrals from Alcohol and Other Drugs (AOD) and Mental Health services, and tertiary liver clinics.

To date 11 people, have complete treatment, 25 are currently on treatments and approximately 80 being followed-up. No reinfections to date.

Conclusion: As a new service operating less than 12 months the 'Deen Clinic' has experienced a number of wins and challenges. As expected many of our clients lead chaotic and transient lives so there are high numbers of clients not attending appointments. Some clients require considerable support to successfully complete the treatment journey. Being a community based organization we have the flexibility to be able to do this without penalty to clients. Most clients attending our clinic do not access mainstream services and so the feedback we receive has been extremely positive, with clients reporting that they feel comfortable and well supported when attending our clinic.

Disclosure of interest statement: HepatitisWA recognises the need for transparency of disclosure of potential conflicts of interest, at this time there are no conflicts of interest to be disclosed.

P57

Taking hepatitis C issues to the homes of Arabic communities in NSW

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According to the World Health Organisation, hepatitis C is a major global health problem with more than 150 million people living with chronic hepatitis C globally. Three to four million people are newly infected each year. In Arabic-speaking countries alone, 20 million people are living with the virus.

In 2016, the MHAHS initiated a 12 month community development project with the Arabic community in NSW to enhance its capacity to deal with and address hepatitis C issues in culturally relevant ways.

This paper outlines the multi-strategic approach adopted by the project to engage and empower the community, In particular the paper will examine the use of ethnic media in promoting health issues and engendering social change particularly in Culturally And Linguistically Diverse (CALD) communities. The paper will describe the process taken to implement an innovative media approach with a local Muslim and Christian radio stations in Sydney.

The paper also considers the overall community development frame work adopted in order to mobilise community members to develop and implement community based activities on such a sensitive and stigmatised issue as hepatitis C.

P58

Education of general practitioners (GPs) regarding hepatitis C (HCV): the use of plan, do, study, act (PDSA) cycles

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Introduction: General Practitioners (GPs) have an expanding and vital role to play in increasing diagnosis and treatment of hepatitis C (HCV). HCV education to optimally equip GPs for this role has been proposed but details about the most effective form of education is lacking. Plan, Do, Study, Act (PDSA) cycles are used as a practice improvement tool and recognised as an effective form of continuing medical education. PDSA cycles involve participants investigating an area of care identified for improvement, developing and implementing small changes intended to improve care, and then measuring the effect of these changes before planning and implementing further change. The GPs involved in the PDSA cycles can implement interventions that take into account the context of their practice and can use simple, complex, or multifaceted interventions to address issues that they identify.

Methods: As part of a broader PhD study, this study involves multiple case studies of GPs in four South Australian private general practices participating in PDSA cycles regarding provision of best practice care for HCV-related issues. Short pre-PDSA and post-PDSA surveys will

be administered. PDSA meetings and post-PDSA interviews with participants will be recorded and transcribed. Thematic analysis of the qualitative survey questions, interviews and meetings will be undertaken. Perceptions of GPs regarding the barriers and enablers to providing HCV-related care and how PDSA cycles improve this care will be reported in a descriptive narrative. Of specific interest is whether GPs' participation in the PDSA cycles affects their intention and confidence to provide care, and the usefulness of the PDSA cycles to improve care.

Results: Preliminary results will be presented.

Conclusion: If PDSA cycles are shown to be an effective educational and practice improvement tool then resources could be directed into this form of HCV education and HCV-related care by GPs will be maximised.

Disclosure of interest statement: None to disclose.

P59

Reaching hepatitis C virus elimination targets requires health system interventions to enhance the care cascade

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Background: Modelling suggests that achieving WHO elimination targets for hepatitis C virus (HCV) is possible by scaling up use of direct-acting antiviral (DAA) therapy. However, poor linkage to health services and retention in care presents a major barrier, in particular among people who inject drugs (PWID). We identify additional health system interventions required to achieve HCV elimination targets in Australia, a setting where all people living with HCV have access to DAA therapy.

Methods: We used a dynamic HCV transmission and liver-disease progression mathematical model, capturing testing, treatment and other features of the care cascade. Interventions tested were: availability of point-of-care RNA testing; increased testing of PWID; using biomarkers in place of liver stiffness measurement; and scaling up primary care treatment delivery.

Results: Without additional health system interventions the projected increase in treatment uptake substantially reduced the number of people living with HCV by 2030. However, most remaining infections were undiagnosed and chiefly among PWID. Scaling up primary care treatment delivery and using biomarkers in place of liver stiffness measurement produced only modest impacts on transmission but were estimated to save AU$32 million by 2030, with no decrease in health outcomes. Adding point-of-care RNA testing increased the healthcare cost savings to AU$62 million but critically, additional screening of PWID was required to achieve HCV elimination targets.

Conclusion: Even with unlimited and unrestricted access to HCV DAA treatment, interventions to improve the HCV cascade of care and target PWID will be required to achieve elimination targets.

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P60

Supporting hepatitis C treatment uptake by primary care providers: a successful model

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Background: The change to PBS listings for hepatitis C (HCV) treatments on Mar 1st 2016 provided the opportunity for hospital treatment services to re-evaluate existing models of care. We redesigned services to support Primary Care Providers (PCPs) to update HCV treatment prescribing.

Method: Redesign involved education, clinical support, managing specialist consultations and service coordination. Education sessions were based on the Australian Consensus Recommendations. Clinical support included community nursing clinics, with FibroScan® and hotline establishment. Specialist Hepatologist/Gastroenterologist consultation was established using a localised, fax-back form. Service coordination included staff deployment, inter-department collaboration, PCP networking and fax tracking. Any PCP who wished to participate, between Mar 2016 and Feb 2017, was eligible. Primary outcome was the number of HCV treatments prescribed by PCPs. Secondary outcomes included number and category of PCPs, number of patients per PCP, genotypes (GT), fibrosis assessment methods, regimens prescribed, specialist recommendations to change regimen and treatment outcome.

Results: A total of197 patients commenced treatment prescribed by 43 PCPs, supported by 3 Specialists. The PCPs were from 23 settings, including General Practice (n=17), Opioid Substitution Therapy clinics (n=4), Aboriginal Medical Services (n=1) and Sexual Health Clinics (n=1). Numbers commenced per PCP ranged from 1 (n=27), 2–6 (n=12) and 16–66 (n=4). GT distribution was GT1 (59% n=116), GT3 (36% n=70), GT2 (5% n=9) and mixed GT 1% (n=2). PCPs assessed fibrosis using Fibroscan (64% n=126) and/or APRI score (42% n=82), with 98% (n=194) non-cirrhotic. Most commonly prescribed regimens were sofosbuvir/ledipasvir (56% n=111) and sofosbuvir/daclatasvir (39% n=76). Only 10% (n=20) of proposed regimens resulted in specialist recommendation to change treatment duration (9%) or regimen, to avoid drug to drug interactions (1%). Sustained Viral Response (SVR) data are awaited.

Conclusion: Service redesign of a hospital based service supported PCPs working in a range of settings becoming experienced in prescribing HCV treatments successfully. Low rates of specialist recommendation to change proposed regimes indicated good adherence to Australian Consensus Guidelines.

P61

The accidental hepatitis C virus nurse: supporting HCV community treatment for people living with HIV and a mental illness

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Introduction: The up-scaling of Hepatitis C Virus (HCV) treatment to high risk populations living with HIV and mental illness is pivotal in working toward elimination of chronic hepatitis C and the reduction of the projected burden of the disease in Australia. The HIV Outreach Team (HOT) is a community based case management team that works with people living with HIV and other health issues such as mental illness, AOD and HCV co-infection. The role of a mental health CNC working in the HIV outreach team has resulted in a client load of 18 people where 8 are co-infected with the Hepatitis C virus. People living with schizophrenia have a life expectancy of 20+ years less than the general population and this highlights the importance of HCV treatment for people living with a mental illness.

Methods: The HOT team partners with numerous HCV treating agencies (St Vincent's Hospital, Prince of Wales Hospital Infectious Diseases Department, The Albion Street Centre) and works under a case management/self-management model of care. Seven patients have been treated with various degrees of planning and support. This paper will explore the challenges and success of the six clients that have been treated for HCV. A snapshot of demographic information will be discussed, co-morbidities and the challenges of prescribing, adherence strategies, access to medication and advocacy.

Results: seven of nine clients have been provided with access to HCV treatment. Clients prescribed HCV treatment with support from the HIV Outreach Team have been successful in clearing the HCV despite inconsistent adherence, ongoing drug use and mental illness.

Conclusion: Incorporating HCV treatment with people living with HIV and a mental illness offers the opportunity of a cure and the challenge of implementing intensive and expensive health care. Nurses in community health settings are in a position to support HCV treatment.

P62

High SVR rates with eight and twelve weeks of pangenotypic glecaprevir/pibrentasvir: integrated efficacy and safety analysis of genotype 1–6 patients without cirrhosis

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Background: The pangenotypic direct-acting antivirals (DAAs) glecaprevir (NS3/4A inhibitor developed by AbbVie and Enanta) and pibrentasvir (NS5A inhibitor), comprise the interferon (IFN)- and ribavirin (RBV)-free regimen G/P. In seven phase 2/3 clinical trials, G/P achieved SVR12 rates of 92–100% across all six major HCV genotypes (GTs). Here we present an integrated analysis from these studies on the efficacy of 8 and 12 weeks of G/P treatment in non-cirrhotic patients with GT1-6 infection.

Methods: Data were pooled from 7 phase 2 and 3 studies. Patients with chronic HCV GT 1, 2, 3, 4, 5 or 6 infection without cirrhosis received G/P for either 8 or 12 weeks. Patients were either treatment-naïve or treatment-experienced with IFN-based or sofosbuvir (SOF)-based regimens. Patients experienced with a DAA other than SOF were excluded. Efficacy was evaluated as the rate of sustained virologic response (HCV RNA <lower limit of quantification) 12 weeks after the end of treatment (SVR12). Safety was assessed in all patients.

Results: In total, 1981 patients without cirrhosis were enrolled and 1975 received study drug. 74% of patients were treatment naïve and 81% had F0-F1 fibrosis. In the intent-to-treat population (ITT), 1911/1953 (98%) patients achieved SVR12, with similar rates of 97% and 98% in patients treated for 8 and 12 weeks, respectively. Across all genotypes, there were 4 breakthroughs (0.2%), 14 relapses (0.7%) and 11 discontinuations (0.6%). G/P was well-tolerated; discontinuations due to adverse events, DAA-related serious adverse events and grade 3 or higher laboratory abnormalities were rare.

Conclusions: The G/P regimen yielded high SVR12 rates across all genotypes, regardless of prior treatment experience or treatment duration. The results from this integrated analysis suggest that the G/P regimen could provide an effective 8-week IFN- and RBV-free treatment option for patients with HCV GT1-6 infection without cirrhosis.

Disclosure of interest statement: AbbVie sponsored the studies analysed, contributed to their design, collection, analysis, and interpretation of the data, and participated in the writing, review, and approval of the abstract. All authors had access to relevant data. This abstract contains information on the investigational products glecaprevir and pibrentasvir.

S Wang, R Liu, T Pilot-Matias, and F Mensa: Employees of AbbVie and may hold stock or stock options.

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P63

Knowledge and practices of chronic hepatitis B virus testing by general practitioners in Victoria, 2014–2015

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Introduction: General practitioners (GPs) play a vital role in diagnosis and treatment of people with chronic hepatitis B virus (HBV) and are crucial to Australia achieving elimination targets. This study assessed GPs' knowledge and practices regarding chronic HBV diagnosis and identified opportunities to improve HBV testing rates.

Methods: A cross sectional study was conducted with GPs working in Victoria in 2014. Participants completed a survey that collected information on demographics and patient profile and assessed knowledge about chronic HBV, resources and support awareness, and diagnosis and management. Statistically significant adjusted odds ratios (AOR; $p<0.05$) of (1) high knowledge, and (2) ordering more than two HBV tests per week were reported.

Results: The survey was completed by 232/1000 GPs; 49% (n=113) were female. Chronic HBV knowledge was low (n=55, 23% answered all questions correctly), due to few participants (28%, n=66) recognising that culturally and linguistically diverse (CALD) communities comprise the main risk population for chronic HBV in Australia. In adjusted analysis, high level of knowledge remained negatively associated with increasing age (AOR 0.94, 95% CI: 0.91–0.97) and positively associated with having graduated from medical school in Australia (AOR 4.6, 95% CI:1.67–12.7). Ordering more than two HBV tests per week remained negatively associated with being male (AOR 0.47, 95% CI: 0.26–0.85), increasing age (AOR 0.96 for each additional year, 95% CI: 0.94–0.99) and graduation from medical school outside of Australia (AOR 0.43, 95% CI: 0.22–0.85).

Conclusion: This study identified gaps in GPs knowledge about chronic HBV. Several barriers to improving testing rates among risk populations were identified, including focus on sexual transmission in key documents targeting GPs and low use of interpreting services. Revision of guidelines for prevention in general practice is recommended, as well as educational activities to improve knowledge of risk populations for chronic HBV in Australia.

Disclosure of interest statement: Julie Wang was a member of the Adult Hepatitis B Advisory Board for GlaxoSmithKline Australia and Bristol-Myers Squibb. Margaret Hellard receives funding from Gilead Sciences for an investigator initiated research project.

P64

Concomitant proton pump inhibitor use does not reduce the efficacy of elbasvir/grazoprevir

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Presenter: David Ward (Merck, Sharpe & Dohme)

Background: It is estimated that up to one-third of hepatitis-C virus (HCV)-infected patients use proton pump inhibitors (PPIs) and other acid reducing agents. Concomitant PPI use with some NS5A inhibitors impacts the pharmacokinetics (PK) of direct-acting antiviral agents (DAAs), potentially reducing efficacy. Phase I study results demonstrated no effect of PPI use on the PK of the fixed-dose combination of elbasvir/grazoprevir (EBR/GZR) in healthy volunteers. This post hoc analysis of studies in the Phase 3 clinical program of EBR/GZR assessed the 12-week sustained viral response (SVR12) in subjects with self-reported PPI use and the PK of EBR/GZR in these patients.

Methods: Data were derived from six Phase 3 EBR/GZR trials with treatment-naïve or treatment experienced GT1/4-infected subjects, with or without cirrhosis. Analyses were done in the modified Full Analysis Set population (excludes administrative discontinuations). Self-reported baseline PPI use was defined as ≥7 consecutive days of use between Day −7 and Day 7. Bivariate analyses assessed PPI use and other factors associated with SVR, with gender, age (continuous and dichotomous), cirrhosis status, prior treatment status, baseline HCV RNA (continuous and dichotomous), HCV genotype, and baseline resistance associated variants as variables in the models.

Results: Overall, 12% (162/1322) of EBR/GZR-treated subjects reported baseline use of PPIs. Of those, 155/162 (96%) achieved SVR12. In patients without PPI use, 1129/1160 (97%) achieved SVR12. PPI use was not a predictive factor in achieving SVR12 based on a univariate analysis (p=0.188). In the bivariate models, none of the interaction terms was statistically significant, indicating that any potential effects of PPI were consistent across the factors considered. In addition, PPI usage was not a statistically significant effect, regardless of adjustment for the factors considered.

Conclusions: These results demonstrate that PPIs use with EBR/GZR has no clinically significant effect on SVR12 rates in GT1/4-infected patients with and without cirrhosis.

Disclosure of interest statement: David Ward (Presenter) is a Senior Medical Science Liaison at Merck, Sharpe and Dohme (MSD).

P65

Nurse-led hepatitis C treatment models in drug and alcohol services can support, treatment uptake, healthcare engagement and community prescribing

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Background: People living with hepatitis C (HCV) experience stigma and discrimination when seeking healthcare. This results in poor health outcomes through late presentations and ongoing transmission. Accessibility of direct acting antiviral (DAA) therapy enables a simplified treatment paradigm, reducing the barriers to treatment within community-based services. The Integrated Hepatitis C Service (IHCS) at Melbourne Health partnered with two Alcohol and other Drug (AOD) services in metropolitan Melbourne, to develop an accessible nurse-led model to increase treatment uptake.

Method: The IHCS clinical nurse consultant (CNC) established treatment clinics with Uniting Care ReGen in Coburg and First Step Program in St Kilda. Referrals were received from the AOD workforce, local General Practitioners (GP), self-referrals and from specialist pharmacotherapy providers. Triaging was determined with assessment of fibrosis or clinical complexity, by case conferencing with an Infectious Diseases Specialist. Clients were allocated to the nurse led clinic or rapid-tracked for specialist review if required. The CNC facilitated testing, assessment and treatment monitoring through to demonstration of sustained virological response (SVR). The CNC also provided clinical decision support to GP's and AOD clinicians within their practice supporting the incorporation of HCV treatment into existing programs.

Results: In the first year of availability of DAA treatments 173 clients sought information about HCV treatment through the nurse led clinics, 52 commenced treatment and 37 completed with a documented SVR in 29 currently. Of those who commenced assessment 26 had advanced disease which was not previously identified and managed and 1 diagnoses of hepatocellular carcinoma was made. Two previously referring physicians commenced prescribing.

Conclusions: Providing nurse-led HCV models in AOD services provides opportunities to engage those at risk to seek liver health assessment and treatment of HCV. It provides a mechanism for earlier treatment access, urgent secondary referral and facilitates community prescribing therefore delivering mainstream, access to care.

Disclosures: No disclosures.

P66

A year of living safely: 12 months of DAA treatment in Canberra's prison system

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Background: On March 1, 2016 the Australian government authorised the prescription of direct-acting antiviral (DAAs) medications for the treatment of chronic hepatitis C. The custodial setting presents both unique opportunities and challenges for the treatment of hepatitis C. The Alexander Maconochie Centre (AMC), the ACT's only adult prison, is the first human rights compliant prison in Australia. We report on our first 12-month experience of treating chronic hepatitis C at the AMC with the new DAA medications.

Methods: The hepatitis C treatment program was a nurse-led program. Patients were identified through admission bloods plus self or peer referral. Nurses engaged patients then worked with GPs and, if needed, gastroenterologists to determined appropriate treatment type. Once commenced on treatment the patients worked with nurses for ongoing support and pathology.

Results: Between March 1st, 2016 and 2017, 58 patients commenced treatment. Of these patients, 25 were negative at 12 weeks post-end of treatment (EOT). EOT pathology for twenty-four patients was still

pending. Eight patients have been lost to follow up post-release from custody. There were 2 positive results at 12 weeks post-EOT which, due to the nature of the custodial setting, are likely to be re-infections but treatment failure is possible. One ceased treatment at week 4 due to side effects.

Conclusions:

1. The custodial setting can afford many patients the stability to access hepatitis C treatment.
2. There is often less stigma around being hepatitis C positive in custody, with patients feeling more comfortable addressing their hepatitis C infection.
3. We have a young patient population and therefore few patients with advanced liver disease or cirrhosis.
4. Our multi-disciplinary approach and daily access to healthcare services during treatment have contributed to positive patient outcomes.
5. Similar to reports from the community, we have struggled with differentiating re-infection from treatment failure

Disclosure of interest statement: None to disclose.

P67

Strategies supporting and increasing hepatitis C testing and treatment for people in NSW prisons

S Wilkinson, M McMahon

Hepatitis NSW, Australia

Introduction: NSW prisons' Common Automatic Dial List allows free calls to our *Hepatitis Infoline*. We provide information about viral hepatitis, transmission, prevention and access to testing and treatment within the custodial system.

People in NSW prisons are assessed and treated under Justice Health and Forensic Mental Health Network's (Justice Health's) Nurse-Led Model of Care.

Methods: Strategies supporting and increasing testing and treatment include:

- Practical information eg: ask to see the nurse
- Encouragement to 'refer your mates'
- Hepatitis Information Packs with resources:

Educational playing cards

Tx! Magazine

information on cleaning injecting equipment

3 extra *Hepatitis Infoline* cards and 3 Treatment Infographics to give away

- Feedback Forms
- 'Return to community' packs for people due for release including local GP DAA prescribers, Fibroscans, Liver Clinics, pharmacies and *Hepatitis Infoline* cards

Results: 858 prison originated calls July 2016–March 2017

164 Hepatitis Information Packs posted

81 Feedback Forms (44% from Aboriginal people) demonstrate people act on the information provided:

- put a form in to see the nurse to get blood tests: 40
- put a form in to see the nurse about hep C treatments: 24
- started treatment for hep C:19
- completed hep C treatment:19

After verbal consent, our staff advocate via encrypted email to Justice Health about individual's treatment issues:

- Eligibility
- Accessing testing
- When and how they will get their test results
- Treatment
- Waiting list and timeframe (3-6 months minimum)
- Lack of access to testing, Fibroscans and long wait times for test results
- Missed doses.

119 individuals consented to advocacy resulting in testing, accessing treatment, or maintaining treatment, including people entering or exiting prison.

Conclusion: Testing and treatment support for people in prisons is effective due to strategies by Hepatitis NSW, evidenced by:

- Ongoing high rate of calls from prisons;
- Hepatitis Information Pack requests;
- The rise in numbers treated by Justice Health matches our increase in calls.

Disclosure of interest statement: None to disclose.

P68

Hep Connect: delivering one-to-one telephone support to people undergoing HCV treatment by people who have treatment experience

S Wilkinson, M McMahon

Hepatitis NSW, Australia

Background: *Hep Connect* delivers a free telephone-based, peer-led service by people with treatment experience (some with liver transplant experience) for people in NSW undertaking hep C DAA treatment.

The program provides people living with hep C, their family and friends with information on the new DAAs and continuous support throughout the treatment duration.

Methods: Clients are referred mainly through the Hepatitis Infoline as well as the Hepatitis NSW website, online support and email services, and referrals from internal Hepatitis NSW staff and external agencies such as GP's, liver clinics.

The *Hep Connect* workers are trained annually and the Project Officer matches clients with appropriate peer support workers. Workers provide clients with lived experience psychoeducational information while respecting clients' autonomy and self-determination around the frequency of support delivery. Peer calls are made to clients off-site using a blocked/private number to protect the worker's confidentiality.

Results: The *Hep Connect* program delivered 175 calls to individuals accessing DAA treatment between March 2016 and April 2017. Some clients requested ongoing support where others required fewer support calls.

The evaluation demonstrated:

- Clients reported 100% satisfaction with their *Hep Connect* peers and that calls were relevant to their circumstances
- 100% of clients reported *Hep Connect* calls were instrumental to their decision to access HCV treatment
- 100% of clients reported the *Hep Connect* call was instrumental to treatment adherence

Out of the 175 calls delivered, clients reported that *Hep Connect* support calls were a key factor in curing their hep C.

Conclusion: The *Hep Connect* program demonstrates how central peer support services are to eliminating hep C in the DAA era.

Peer-based phone support is efficacious in supporting individuals and instrumental in informed decision making around accessing, adhering to, and successfully completing hep C treatment.

Disclosure of interest statement: None to disclose.

P69

Hepatitis B patient management system, Far North Queensland Aboriginal and Torres Strait Islander hepatitis B project

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Cairns Sexual Health Service, Australia

Introduction: The Far North Qld Hepatitis B Project was funded to enable a clear picture of the burden of Chronic Hepatitis B in Aboriginal and Torres Strait Islander people in the project area of Cairns and Hinterland and Torres and Cape Hospital and Health Services

One aim of the project was to create a Hepatitis B database to identify how many patients have Hepatitis B, where they live, whether they were in care and if they are on treatment, along with other clinical details.

Methods: To use data from NOCs (Notifiable Conditions System) and Auslab (Qld Health pathology database) to develop an Access based Hepatitis B patient management and recall system. This data will be cross checked and updated from other data sources within Queensland Health to further develop data fields, data accuracy and patient management.

Results: This presentation will show the development of the database, its functionality and usefulness in providing care to patients with Hepatitis B. It will cover who is currently using the database and feedback from those clinicians.

It will also highlight the challenges we have faced creating the database such as the project time being halved and difficulty accessing some of the base data.

Conclusion: Many lessons have been learnt in development of this database and it is hoped they will be able to be used to assist any further development of the database and also to assist any future projects.

The outcome of a working usable database to manage Hepatitis B patients is a great achievement for the project and a positive step towards lessening the impact of a chronic disease in Aboriginal and Torres Strait Island People in Far North Queensland. It is hoped that beyond this is will also have an impact on others who are impacted by Chronic Hepatitis B.

Disclosure of interest statement: None.

P70

Elimination of hepatitis C in a prison setting

C Lobo, C McGrath, J Wood

Justice Health and Forensic Mental Health Network, NSW Health, Australia

Introduction: The prevalence of hepatitis C virus (HCV) infection in the NSW custodial setting is 20–30 times higher than the broader community and HCV control has been a challenge for JH&FMHN. Following PBS listing of new Direct Acting Antivirals (DAAs), the Compulsory Drug Treatment Program (CDTP) provided a stable cohort to treat and examine HCV control. The CDTP's primary purpose is to provide an intensive D&A rehabilitation program over a period of approximately 18 months – 3 years. HCV treatment was not available during the 'interferon era' due to the potential impact of side effects on the rehabilitation process.

Methods: All patients in the CDTP with risk factors were screened for HCV and those requiring treatment were concurrently commenced. Concurrent commencement was viewed to be an important measure in reducing re-infection or treatment failure alongside the provision of harm minimisation education. A partnership between JH&FMHN, Corrective Services NSW (CSNSW) and Hepatitis NSW facilitated this process.

Results: In July 2016 all patients in the CDTP were reviewed for HCV risk factors (n=58) and patients with risk factors were screened (n=54). Of this group, 18 patients had chronic HCV and were concurrently commenced on treatment. In September 2016, all patients (100%) achieved an End of Treatment (EOT) Response, 15 patients (83%) achieved Sustained Virologic Response (SVR), and 3 (17%) were released prior to SVR assessment. New admissions were reviewed as required.

Conclusion: Broad screening, concurrent treatment initiation and ongoing review of new admissions in a centre with minimal patient movement and stable length of stay, is considered an innovative and novel approach for HCV control. Strong partnerships within JH&FMHN and externally with CSNSW and Hepatitis NSW along with DAA therapy present an opportunity to adopt a similar model in comparable size centers. This demonstrates potential for replication and scalability within JH&FMHN and other custodial health jurisdictions nationally.

Disclosure of interest statement: The conference collaborators recognise the considerable contribution that industry partners make to professional and research activities. We also recognise the need for transparency of disclosure of potential conflicts of interest by acknowledging these relationships in publications and presentations.

P71

High hepatitis C cure rate in a general practice cohort

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Introduction: Directly acting antiviral therapy (DAA) for the treatment of chronic hepatitis C (CHC) became widely available in Australia on 1 March 2016. General practitioners (GP) were able to prescribe in consultation with a specialist. The purpose of this paper is to describe treatment outcomes in a cohort of patients treated in the first 2 months of DAA prescribing in a single GP clinic with a large patient load.

Methods: A search of the clinic database (Best Practice) was performed to extract demographic and clinical data for all patients prescribed DAAs in March and April 2016. Patient outcomes were reviewed in May 2017.

Results: 47 patients had been prescribed DAA therapy by 7 GPs in the clinic. 5 patients had received DAA via an early access program. 6 patients were genotype 3 (G3), 41 were genotype 1 (G1). 11 patients were co-infected with HIV. All treated patients had an assessment of liver fibrosis performed with a FibroScan. Most patients had early disease with 3 classified as having cirrhosis. 33 patients were treated with ledipasvir/sofosbuvir (all G1) and 9 with sofosbuvir/daclatasvir (3 G1, 6 G3) 5 patients were treated with the '3D' regimen (all G1). Latest patient disposition is: 42 sustained virological response (SVR), 2 end of treatment response, 2 not started treatment, 1 failed treatment, 1 lost to follow-up. No serious adverse events were recorded.

Conclusion: A high hepatitis C cure rate has been achieved in a general practice setting using DAA therapy.

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