Refresh of

Healthy Pathways Forward:

A Strategic Integrated Approach to Viral Hepatitis in B.C.

Overall Engagement Summary

BRITISH COLUMBIA
Ministry of Health

BC Centre for Disease Control

BRITISH COLUMBIA CENTRE *for* EXCELLENCE *in* HIV/AIDS
Together, we can stop HIV/AIDS

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Contents

Introduction

Between November 25, 2015 to January 20, 2016 the Ministry of Health (the Ministry), the BC Centre for Disease Control (BCCDC) and the BC Centre for Excellence in HIV/AIDS (BCCfE) partnered with six health authorities (First Nations, Fraser, Northern, Vancouver Coastal, Interior, and Vancouver Island Health Authority) to refresh the Ministry's strategic policy for viral hepatitis: *Healthy Pathways Forward: A Strategic and Integrated Approach to Viral Hepatitis in BC.* This was done by hosting seven engagement sessions, one for each health authority and a provincial session that included organizations and partners with a provincial mandate.

The discussion and feedback was incorporated from a number of health system partners from across the Province of British Columbia, including: community organizations (including HIV and HCV), individuals with lived experience of hepatitis C, public health (including communicable disease, prevention, immunization, and medical health officers), primary and specialist care providers, including infectious disease and hepatology specialists, nurse practitioner practice, harm reduction services, mental health and substance use, provincial corrections, pharmacy, regional laboratory, First Nations Health Authority regional partners, First Nations Health, Authority regional staff, the BC Association of Friendship Centres/Metis Nation representative, Aboriginal community based organizations including Red Road and Chee Mamuk, representatives from the CEDAR project and PHSA Aboriginal program, and First Nations Health Directors Association representatives.

This document summarizes the feedback received and discussion that occurred during these engagement sessions.

Discussion Summary

Each engagement session included presentations from the Ministry that outlined the purpose, process and goals of the session; presentations by the BCCDC and BCCfE; and a group discussion using the engagement session workbook. The discussion focussed on Vision and Mission statements, Goals and Actions for the refreshed version of the Ministry's strategic policy for viral hepatitis: *Healthy Pathways Forward: A Strategic and Integrated Approach to Viral Hepatitis in BC*.

The BCCDC presentations summarized provincial and region-specific data for hepatitis A, B and C (HAV, HBV, HCV), with more detailed information on HCV including a breakdown of populations affected, characteristics of those groups, outcomes, testing and treatment, and a

quantified cascade of care for each session/region. The BCCfE presented on the opportunities and barriers related to a Treatment as Prevention (TasP) model for HCV, as well as the opportunities for ensuring problematic substance use treatment and harm reduction are integrated with HCV testing and care.

Connection to Ministry of Health Policy Papers

Syndemic Approach

Conversation during the engagement sessions touched on the many health issues that people affected by viral hepatitis may also experience, including mental illness and problematic substance use. The use of an integrated, syndemic[1] approach was discussed in depth by the engagement sessions participants, who highlighted it as being crucial to a refreshed approach to hepatitis in BC, particularly with the expertise available within the province. The approach to integrate hepatitis services with problematic substance use and mental health treatment services and primary care aligns well with the existing Ministry of Health policy papers related to patient centred care, and primary and community care.[2]

Social Determinants of Health

Social determinants of health were identified as a significant issue related to hepatitis prevention, testing and treatment. Some engagement session participants in the North and Interior discussed the significant challenges faced by people without adequate housing, transportation, food, or clean drinking water, and the negative health outcomes associated with these challenges. The participants said that these issues are particularly present in rural and remote communities. Also, community development and education was identified as important for engagement in First Nations communities.

Treatment as Prevention

The treatment as prevention approach and success of this for the STOP HIV/AIDS initiative was discussed by the session participants in the Interior and on Vancouver Island. Treatment as prevention was identified as a successful strategy for HIV, but it was noted that currently available data might be insufficient to evaluate the use of the same model for HCV. It was

[1] A syndemic is an interaction of two or more diseases or health issues that result in compounded burden of disease. This can be a result of either a biological interaction or an interaction of disease with the ecological or social contexts affecting populations living with that disease.
[2] MoH Policy paper – Patient centred care: http://www.health.gov.bc.ca/library/publications/year/2015/delivering-patient-centred-health-BC.pdf
MoH Policy paper – primary care: http://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf

suggested that the strategy should focus on treating people who inject drugs for HCV, as those people are the cohort with new infections.

Harm Reduction Approach and Vulnerable Populations

Integration of hepatitis prevention, testing and care with opioid substitution therapy and other harm reduction measures were mentioned by participants on Vancouver Island as part of a differential approach to the health care needs of different populations. Participants noted that connecting the refreshed hepatitis policy with the *Healthy Minds, Healthy People* mental health and substance use strategy would be useful. They also identified another group of concern: youth aged 18 - 19 who have aged out of the foster care system, and who may be at higher risk of infection.

Health Care Providers

Interactions with health care providers were discussed by the Interior participants. It was noted that primary and clinical care physicians are limited in their ability to provide hepatitis care due to the need to refer their patients to specialists. Engagement with health care professionals regarding up-to-date information was lacking, and more assistance is needed with clarifying the qualifications and options for treatment with direct acting antivirals (DAAs).

Engagement of key populations in effective care for HCV requires intensive participation from nurses and other front-line health staff due to the heavy emphasis on treatment through specialists. With more people now accessing treatment, this is likely to increase. Interior participants highlighted insufficient resources available to these health care workers, which is critical to the increased engagement.

Health professionals' stigmatization of drug or alcohol users was discussed by the Interior participants. The provision of treatment to individuals who may still be injecting drugs or using alcohol was identified as an area where health professionals could use additional information to support a culture shift that recognizes the importance of providing treatment for these individuals.

General Feedback

Following the presentations, participants discussed aspects of a refreshed strategy for viral hepatitis, such as a syndemics approach, use of a health equity lens, the incorporation of cultural safety, and ensuring that information and support is provided at all levels of the health system.

Syndemic Approach

Participants highlighted the need for a syndemic approach, where hepatitis C is addressed hand-in-hand with issues such as mental illness, substance use, and social issues and services that wrap around the individual. They identified that interactions with the health system for one health issue, such as HCV, may provide a platform to reach and engage individuals with multiple concerns. Participants from Vancouver Coastal region noted that while opioid addiction is one syndemic that needs to be addressed in relation with HCV, addictions to alcohol and methamphetamines are significantly more problematic to address. They discussed the lack of problematic alcohol treatment services, disconnect between alcohol recovery facilities and the rest of the health system, private facilities, and lack of post-detox support. In addition, participants noted the lack of evidence-based interventions for problematic amphetamine use, which can limit health systems ability to engage with some individuals.

Social Determinants of Health

Participants emphasized that response to hepatitis must address some of the social determinants of health. Participants from the North identified the lack of housing as a major contributor to negative health outcomes, but also mentioned issues of food security and access to clean drinking water. Participants stated that community organizations help to address barriers because of their flexibility in meeting peoples' needs, and can provide a valuable link to services and care for people not reached in other ways. Participants from Vancouver Coastal region spoke of missed opportunities to engage individuals in care due to a lack of understanding that treatment is only one of many pieces of care for people with HCV, and that other factors such as treatment readiness, food security and housing overall are not prioritized for people.

Health Equity Approach

Participants discussed the value of a health equity approach, the incorporation of cultural safety, and ensuring that all levels of the health system receive relevant and timely information and support. Many participants strongly expressed the refreshed strategy should not pathologize populations. A participant from the North articulated that the burden of compounding inequities, rather than culture or ethnicity, is what predisposes some people to HCV infection.

Community-Driven Approach

Participants of the Aboriginal Engagement Session felt the wording for the Ministry of Health strategy must acknowledge the need for any work to be community driven and nation-based. Some participants felt that a truly Indigenous response to viral hepatitis (or any health issue)

requires the development of policy and programs by Indigenous people. Participants discussed the important role of community based organizations as a way to respond to the social determinants of Aboriginal health and provide education in communities. Community based organizations and meaningful engagement with First Nations communities can ensure that community priorities are voiced, and that any response is done in a culturally appropriate way.

Trauma Informed Practice

Some members of the Aboriginal group identified trauma informed practice as a key component of any response for Aboriginal people. Discussion surrounded the need to acknowledge the intergenerational trauma from colonization and residential schools, and the spiritual and emotional pain incurred so as to help providers understand what has led people to the pathways they are on. Others were cautious about this approach, stating that an Indigenous led trauma informed practice needed to be used, which may be different than general principles of trauma informed practice.

Information and Education

Participants discussed how more information and education is needed for the general public and for health care providers. Participants from Fraser and Vancouver Coastal regions identified that individuals need information on their risk of HCV infection and where to get tested, and health care providers need education on risk, testing, care and treatment options, as well as the PharmaCare process for drug coverage and parameters of eligibility. Participants provided examples where second hand information about treatment option, eligibility and coverage disrupted care for people; and, how in the Fraser region the testing of the “baby boomer” population is insufficient due to lack of identified risk in this population.

Participants from the Aboriginal group highlighted some of the challenges in BC’s north, including the need for more education, resources, and translation of information to communities. Participants also discussed how better strategies are needed in rural settings to ensure confidentiality of personal health information.

Vulnerable Populations

For HBV, participants from Vancouver Coastal and Fraser sessions discussed preventing perinatal transmission as a priority, as well as the need to identify barriers to diagnosis and care for refugees and new Canadians from countries where HBV is endemic. They highlighted gaps for new Canadians living with chronic hepatitis B, including inability to receive medication coverage for long-term infection once relocated to Canada, as well as a general understanding from new immigrants that their immigration screening included test for HBV when in fact it did

not. Participants were not receptive to the idea of required screening of immigrants upon arrival in Canada because of possible resulting stigma or perceived repercussions. In addition, participants expressed concern over the challenges that new immigrants face in trying to obtain equitable access to services, and reiterated the need for a health equity lens throughout the refreshed hepatitis strategy.

For HCV, participants from Vancouver Island discussed need for added intensity of interventions for people who inject drugs, and individuals who are co-infected with HIV. They also noted that Aboriginal people are over-represented as living with HCV as compared to the rates for all British Columbians and identified gaps with respect to data for those involved in the corrections system where there are high rates of HCV. Participant from the Interior identified "baby boomers" and people who inject drugs as two distinct groups requiring different approaches for their involvement in testing and care. Another group of concern was identified as youth (18-19 years old) aged out of the foster care system. Participants from Vancouver Coastal region identified the need for different engagement for younger people, and highlighted young women new to injecting drugs as particularly vulnerable to HCV; they also noted need for added focus for people living in the downtown eastside of Vancouver and people in the corrections system. They also identified the need for more creative, comprehensive, and culturally sensitive services in the health system for multiple populations, including Aboriginal people and men who have sex with men.

Participants of the Provincial Engagement Session discussed the challenges and gaps for HCV treatment in the corrections system, including the lack of harm reduction supplies in these settings. The latter was described both as inequity of service and a risk for ongoing viral transmission in this setting. As a result of short average length of stay at the provincial correctional facilities, uninterrupted HCV treatment is not always possible.

The provincial group also discussed the need for gendered spaces and services when caring for women, particularly for those in their reproductive years, and how engagement for reproductive health is an opportunity for viral hepatitis care. The group heard about evidence-based co-located services providing women-centred care such as Oak Tree Clinic in Vancouver. This model was described as valuable for engaging and retaining women in care.

Some participants of the Aboriginal Engagement Session criticised the use of the word "vulnerable" as they felt it was a paternalistic label that lays blame with people ("key populations" was identified as a better term), rather than celebrating their strength and resiliency.

Harm Reduction

Provincial Engagement Session participants discussed the importance of providing adequate harm reduction and mental health supports along the continuum of care to prevent infection, ensure treatment adherence and sustained cure. Outreach is a key component of more intensives services for this population. The group identified a need for research on how to best prevent reinfection that could inform development of wrap-around services to support a long-term viral hepatitis response. Participants also emphasized the need for opioid substitution therapy as way to support long-term sustained HCV cure.

Multiple other issues were noted by the participants. Access to specialists and the health care system in general, the Treatment as Prevention approach, accessibility of data and research regarding specific populations were some of them.

Health Care Access

Participants from Fraser and Interior regions identified the need for better access to specialists and physicians who can provide treatment for viral hepatitis, as well as improved access to supports such as social workers. They felt that these supports were critical to ensure adherence over the course of treatment. Participants from the North felt that in their region the personal relationship between the client and the service provider was important, and that service delivery has to be creative in order to work around barriers to care. Participants of the Provincial session identified the need for additional resources to support HCV treatment and care: although cure rates are high, the cost of treating with DAAs is currently prohibitive for many jurisdictions.

Treatment as Prevention

Health system partners widely regard Treatment as Prevention as a potentially highly effective strategy applicable to HCV. Participants from Interior suggested that lessons learned from STOP HIV/AIDS program could be used to develop models of HCV treatment and care; Vancouver Island participants, too, identified TasP as a successful strategy but noted that currently available data might be insufficient to evaluate the use of the same model for HCV.

Access to Health Data, Monitoring and Evaluation

Participants from Provincial session identified monitoring and evaluation as priorities. One participant mentioned that responsive and targeted approaches, such as phylogenetic analysis of transmission clusters (as is done for HIV), could be used with a more focused use of available datasets. For the Fraser region, data linkages with corrections was highlighted as a priority to identify gaps and barriers to service, evaluation, improvement of harm reduction programs, and support for the continuity of care as people transition within and outside of the corrections system. Participants from Vancouver Coastal session acknowledged the significance of data and

evidence from BC to inform this policy development, with some members identifying Vancouver Coastal as well positioned to move on new programming.

Vision Statement

Health system partners were presented with two potential vision statements:

Vision statement options:

Vision Statement 1: Healthy pathways forward to a (viral) hepatitis-free BC (current)
Vision Statement 2: British Columbians are free from harms related to viral hepatitis

Participants discussed the statements and offered suggestions regarding the proposed vision statements.

Overall discussion:

1) Some people found that it was hard to encompass all three types of viral hepatitis in one statement and that HAV and HBV were not reflected in the statements proposed.
2) Some participants felt that the vision statement needed to reflect a harm reduction approach that addressed the underlying needs of those living with, or at risk of contracting, viral hepatitis. Overall, neither of the suggested vision statements encompassed a more unified, fulsome vision that would incorporate a harm reduction pathway as well as a treatment pathway.
3) Some participant suggested that the vision statement take a wellness approach that is inclusive and holistic, includes cultural and Aboriginal perspectives, is multidisciplinary, and meet people where they are in their lives and connection with viral hepatitis.
4) Some participants suggested that the vision statement should reflect a long-term approach that is focused on sustained elimination of hepatitis C, but reflect an inclusive, social determinants-based, health equity approach where services are available closer to where people live.

Vision Statement 1:

1) The first statement was considered optimistic and representative of a positive vision that provided flexibility in how it was reached (that could be further described in the mission statement).

2) This statement does not acknowledge that some clients may never be symptomatic or engage in treatment. This statement could be more strength-based and focus on positive outcomes.
3) Participants also thought that it was not inclusive of those people living with hepatitis who could not be cured (in the case of HBV) or who could not be treated at this time (HCV).
4) Some participants stated that the vision should take a harm-reduction and informational approach, not an all-or-nothing approach that may add to the stigma surrounding viral hepatitis.
5) Some participants liked the suggestion of an approach of "journeys towards healthy pathways", which is more illustrative of the multiple pathways people take to care for viral hepatitis, as well as the multiple interactions and experiences that determine their pathway.

Vision Statement 2:

1) Some participants supported the second suggested statement with the caveat that "harms" needed to be defined more clearly (e.g., does this include aspects like harms due to stigma?).
2) The second vision statement could be adjusted to be more positive, and remove or change the word "harms".
3) The second vision statement was considered more realistic, grass roots, and client centred. As with the first statement, people who are not eligible for treatment, or who do not want treatment, are not represented in this vision. This statement should maintain a focus on prevention. Some participants suggested that the second vision statement should state that British Columbians should be free from harms and to stay free from harms related to viral hepatitis (e.g. mention prevention).

Mission Statement

Health system partners presented with two potential mission statements:

Mission statement options:

Mission Statement 1: British Columbians will experience improved health and wellness by being empowered to reduce vulnerability to viral hepatitis and by being engaged in seamless systems of care, responsive to the individual, family, environmental and community needs. Progress will be made on the control and elimination of acute and chronic hepatitis for all British Columbians through the implementation of population health strategies and integrated health promotion, disease prevention, harm reduction, diagnosis, treatment, care, case management and support

services.
Mission Statement 2: BC will reduce harms associated with viral hepatitis through improved health equity, informed consent, enhanced primary and secondary prevention, innovative testing, treatment and supports.

Engaged groups discussed the statements and offered suggestions regarding the proposed vision statements.

Overall discussion:

1) Participants suggested that the mission statement include reference to cultural safety, trauma informed practice, holistic and wellness approach, informed consent (as per lessons learned from HIV), a case management approach (inclusive of peer navigation), and be inclusive of people with lived experience. Mental health and substance use were noted as key to the solution and should be acknowledged within the Mission. Other language to include could be: seamless, comprehensive, integrated, client-driven approach.
2) Participants identified that the mission statement provided a good opportunity to highlight health equity and enhanced harm reduction, as well as mental health, and social and economic determinants of health.
3) It was suggested that the province should focus on creating diverse pathways to care, to reflect the many ways to approach viral hepatitis (e.g., pathways that are focused on cultural safety, women, and youth).
4) It was suggested that the development of different pathways would create space for people with lived experience to contribute in a meaningful way. This input would "close the loop" between patients and service providers. Some participants spoke of privileging the voice of people with lived experience. Wording could include statements such as "partnering with people who have hepatitis", and "value of the lived experience".
5) Some participants suggested that cultural safety and trauma informed practices should be imbedded into services, and not just for Aboriginal people. Some participants noted that "culturally safer" or "cultural safety" be used instead of "culturally safe".
6) Some comments also included that the mission needed to acknowledge the individual as the one who will be making the choice to further the goal. Our responsibility is to create the context for people to make healthy choices.
7) Feedback indicated that the "seek and treat" notion of the STOP HIV/AIDs program was helpful in framing the response to proactively reaching people. The notion of "seek and treat" has been positive with HIV; however, HCV is distinct from HIV.

8) The mission needs to be achieved through community, and the recognition that for some people hepatitis is not the most imminent pressing issue. Meeting people where they are at is also important to emphasize, as well as the use of a chronic disease model of care.
9) Participants indicated a wellness, strengths-based mission statement was important. Elements to highlight would be holistic and wellness approach, cultural safety and gender appropriate. The group highlighted the importance of relational care, where a relationship between provider and individual is key to holistic care.

Mission Statement 1:

1) The first mission statement was identified as being too wordy, confusing and not focusing on a strategy or objectives.

Mission Statement 2:

1) The second mission statement was liked by multiple groups. It was interpreted as being simple and inclusive, yet still broad.
2) Feedback indicated that the second mission statement should include recognition of harm reduction, mental health, and cultural safety, as well as response to individual, family and community. As well, it should apply to all British Columbians, not one specific group.
3) The four principles of Trauma Informed Practice should be included, as well as the key phrases: innovation in terms of supports; equity; reference to reducing stigma; harm reduction.
4) Some participants wondered why informed consent needed to be identified, as patients are seen as partners. Although acknowledged as an important part of care, it was unclear how informed consent could reduce harms related to viral hepatitis. As well, it is unclear what is meant by innovative testing vs. testing (various venues for testing can become available soon, such as laboratory testing, home testing, and peer testing).
5) The difference between "screening" and "testing" should be considered, and which term is more appropriate.

Goals for Consideration

Existing *Healthy Pathways Forward* goals:

1. Prevent new hepatitis infections and reduce the risk of those infected from progressing to serious liver disease

2. Enhance program reach and engagement of vulnerable populations in health promotion, prevention, care, treatment and support service continuum
3. Strengthen the system's capacity to respond
4. Create seamless service delivery

Discussion Summary:

Separate Goals

Most of the participants from across the province thought that the three viral hepatitis encompassed by the refreshed strategy should have separate goals, with a strong focus on HCV. Some participants identified the ability to use interest in HCV to improve care for other types of hepatitis.

Cascade of Care

Participants stated that a well-developed cascade of care for each kind of hepatitis would provide the opportunity to design a data-driven approach, and that that research and evaluation is an important component that should be explicit and embedded within the goals. Data regarding focused populations and outcomes could inform therapy approaches for the treatment of HCV. This would also allow assessment of the impact of HCV and treatment approaches on various groups, such as First Nations people, to quantify and highlight health inequities. It was also suggested that separate cascades could be developed for different populations, with respect to the stage of disease prevention/progression and what are the end results. It was also suggested that the cascade contain aspects of both prevention and care. Participants from the interior mentioned that limitations to a cascade for hepatitis C are rate-limiting factors in terms of how the system is organized (time for care), human resources, delivery mechanisms, cost of treatment, adherence to treatment, and that the provision of treatment is limited as not everyone is treated for their HCV upon diagnosis. However, a cascade approach could be a useful tool to examine these factors and come up with different ways to approach the issue.

Participants discussed the broad range of groups affected by viral hepatitis and the differing needs of each group.

Vulnerable Populations

Participants mentioned correctional facilities as one of the priority settings, where accountability for outcomes in both provincial and federal institutions needed to be clear. The group discussed the lack of harm reduction services in facilities, indicating strong support for harm reduction services and supplies in correctional facilities. Some participants mentioned

gaps and disruptions in services between correctional facilities and the community, and the need to improve engagement, treatment adherence, and prevent reinfections in this population.

Some participants identified that new Canadians require additional intensity of services to ensure barriers to care are overcome, and that the approach must be proactive. Participants mentioned expanded screening (HBV and HCV) and immunization (HBV) and health promotion as viable strategies. Participants from the Interior region noted that acute cases of HBV are not often seen in the region; however, there may be merit in a renewed focus on testing of people who have emigrated from endemic countries as they are not regularly screened. It was mentioned that the Interior needs to address the stigma associated with the use of community organizations, particularly among Indo-Canadians.

Participants had concerns regarding the ethical treatment of individuals with HCV and the potential for denial of access to future care or treatment for those who are reinfected with HCV. Participants from Interior region provided examples of people who had been denied access to treatment by physicians due to current alcohol or drug use. Equitable access to care is important, and lessons learned from HIV is that denying care or treatment is not equitable for people who use drugs. Participants noted that physicians are well aware of the link between alcohol use and liver health, but reiterated the lack of services for individuals who use alcohol problematically. Work on reducing stigma and bias within primary care is an important area to focus to ensure that people with HCV who are challenged by problematic alcohol use are not overlooked for treatment and care. Physicians need education and support regarding what systems are in place to support them and their patients after diagnosis of viral hepatitis when alcohol and/or drug use is involved. The system needs to take a multidisciplinary approach and consider the long term care of individuals with addictions.

In addition, some participants identified the “baby boomer” generation as being at risk of disease progression without a diagnosis of chronic viral hepatitis. It was also mentioned by participants that the refreshed strategy needs to acknowledge how viral hepatitis is experienced by different genders. Some participants from the North identified the challenge of communicating to people without liver fibrosis that PharmaCare drug coverage is not available. Participants mentioned that this can result in people disengaging from care.

Harm Reduction

Harm reduction was identified as a key component in the prevention of HCV infection, as well as critical to reduce reinfection rates. Participants noted that harm reduction strategies should be broad, access should be consistent, and funding should be expanded beyond needles and syringes to include other drug use equipment (such as crack and meth pipes). Correctional facilities should be an area where gaps are assessed, with added intensity regarding reach and

provision of harm reduction supplies in this setting. Participants from Vancouver Island mentioned that the expansion of harm reduction is important to include as a goal, and it should reflect opioid substitution treatment, supervised consumption sites, and harm reduction supply and distribution. Opioid substitution therapy provides an opportunity for a person with viral hepatitis to be engaged in care; however, the challenge is to promote harm reduction and opioid substitution therapy at a provincial level, particularly with private clinics. Participants from the Aboriginal session identified stigma associated with the use of harm reduction supplies and services stemming from where they are distributed. Some members of the group felt that the primary care home model may help with stigma, but time is needed to create system changes that would see service delivery improved in this way. There was agreement in the group that measuring harm reduction supply distribution is important to ensure that people who need services are receiving them, but that harm reduction services and strategies need to be trauma informed and culturally safe at both the system and individual level. The crucial role of the social determinants of health was yet again mentioned by the participants:

Social Determinants of Health

Participants expressed a desire for the refreshed policy to take a step back and focus on equity and the determinants of health, and move away from a disease-specific focus. The Aboriginal group participants identified the need for a focus on the social determinants of health, including housing, and that a harm reduction approach would need to incorporate the various social determinants. Participants mentioned that there are multiple government partners required for this response, including Ministry of Children and Families given the number of Aboriginal children in care; the Ministry of Education; and the Ministry of Public Safety and Solicitor General (BC Corrections). Two major determinants of Indigenous health were discussed: racism (structural and interpersonal) and colonization (assimilation, having strategies created for First Nations people rather than providing the means to create strategies for their own health). A theme throughout the Northern engagement session was the discussion about how adequate housing is a key support for those living with HCV and other health conditions, and that it should be reflected in the goals. Participants expressed that adequate housing is needed to enable engagement and treatment, which helps people get to a cure for HCV. Participants described that there were significant barriers to adequate housing in the North. Some participants identified the need for government to provide leadership on health and housing, and gave the examples of a “Housing First” approach, and an “Action on Housing” program that supports people to achieve their housing goals.

Health Promotion and Education

Testing and treatment for viral hepatitis should be normalized[3], and there should be opportunities created to provide education and open conversations in communities so that people could have discussions about viral hepatitis and what it means to their health. There needs to be more current information available to those individuals previously diagnosed. The goals should include health promotion and education that will reach across lifespan, achievable at the community level, spreading the message and creating opportunity. Participants felt it was important to include an overarching goal that focused on cultural safety/awareness/competence, and that addresses stigma. Approaches for First Nations should include use of spiritual healers, role models, and success stories.

Culturally Safe Services

Participants highlighted culturally safe services, such as the Fire Pit, as key to engaging with First Nations and other Aboriginal people in Prince George. Other participants described Central Interior Native Health as the key primary care hub for First Nations living with viral hepatitis. Some members of the group described culturally safe, low barrier services that reach into community as the way forward in reaching First Nations people as part of a holistic wellness model. One participant identified that the framework needed to include an imperative for cultural safety training for providers.

The Aboriginal Session Participants discussed the elements required to appropriately serve First Nations and other Aboriginal people, which include first and foremost acknowledging the Truth and Reconciliation Commission recommendations, as well as the United Nations Declaration of the Rights of Indigenous Peoples. Participants felt the viral hepatitis policy development process must take the messages from these documents seriously to lead to meaningful change and appropriate engagement.

Addressing Stigma

Some participants felt reducing stigma was important to normalize testing for viral hepatitis, and that the STOP HIV/AIDS program could be a model for hepatitis C. Participants suggested that stigma regarding viral hepatitis needs to be addressed in the general population, and within the health care system. One suggestion was to offer regular or possibly mandatory testing for HCV in order to normalize it. There was significant discussion by participants about language usage and how language can further stigmatize people. Some participants mentioned that the health system and providers need to understand the resiliency of First Nations and other Aboriginal people, and recognize that these people are disproportionately harmed by viral hepatitis, and not a “high risk” group.

[3] To normalize testing and treatment is to make it a routine activity in health care settings, thereby reducing the stigma of being “singled out”.

Primary Care

Participants supported an approach to HBV and HCV that is driven by primary care, particularly given the ease of new HCV treatments, something that could enhance reach of treatment to rural and remote BC. Clear information and support needs to be available to primary care providers regarding HCV. Care plans are a good place to start, but a lot of work is needed to support this process. It was also identified that health authorities should have a consistent approach to hepatitis and liver disease management.

Seamless Access to Services

It was proposed that the health system take a more proactive approach to HCV prevention and treatment, rather than be reactive, so as to provide more seamless access to services. Because treatment and care for people with diseases like viral hepatitis and HIV involve multiple care providers, participants said that there is a need for organizations to work closely together. Some participants identified that the goals should foster collaboration and integration and not focus on separate roles.

Holistic Approach

Some participants discussed how a holistic approach to viral hepatitis is necessary and that the health system should look at the whole of the person affected, not just through the lens of one disease. This was seen as a gap with HIV Treatment as Prevention. Participants discussed how a perspective that looks at the individual as part of a community and a broader environment is necessary to understanding supports that are needed. Brief action planning[4] was suggested by participants as a patient-centred approach that allows people to set their own goals on how to move forward with the support of the health system. Participants identified that nurse practitioners play an important role in developing and implementing access plans, particularly for people located in rural and remote areas.

Despite the focus of the discussion on HCV, participants also mentioned HBV and HAV:

HAV and HBV Vaccination

The discussion highlighted that the focus for hepatitis A and B should be on complete prevention, with a strong focus on stigma reduction. For HAV and HBV, there was a question of how well the vaccine is reaching people who need it. HAV immunization provides a good opportunity for engagement on other health issues such as HCV. Participants identified the need for a universal HAV vaccine program. The examination of the cost effectiveness of a universal HAV vaccine should be conducted, particularly in comparison to the impact of

[4] Brief action planning is a highly structured, stepped-care, self-management support technique grounded in the principles and practice of motivational interviewing and behavior change theory and research

responding to outbreaks. Mass vaccination of key populations can be effective, such as that done in the Vancouver in 1999. Participants of the Aboriginal session discussed HAV vaccine coverage in First Nations communities, indicating that from their perspective this vaccine covers many community members as it is routinely included in childhood immunization visits.

The challenging nature of caring for someone currently living with chronic hepatitis B was noted, given the lack of highly effective medications.

Community Pharmacies

Participants described that many community pharmacies provide additional adherence services (free or at additional cost), such as blister/pouch packaging, daily or weekly dispensing, medication reviews, and home delivery. Participants identified pharmacists as a valuable point of contact with the individual, especially for people with no fixed address or phone. One participant identified that community pharmacists in the North are unable to bill the health system for any services related to HIV medications, which may result in the pharmacy not engaging with the individual on their care needs.

HIV and HCV

Some participants identified the opportunities to engage people living with both HIV and HCV. The group felt that there are many lessons to be learned from the STOP HIV/AIDS program as well as the many decades of work on HIV. It was suggested that health partners need to work in conjunction with one another in order to identify and remove bureaucratic barriers and increase access to care.

Use of New Technologies

One participant from the Northern region suggested adoption of new technologies to optimize treatment decision and to track hepatitis infection. The participant noted that the development of new technologies to identify individuals with lower than usual treatment response rates (people with cirrhosis, people previously treated but not cured, and people with HCV genotype 1a) will ensure the best drug treatments are used to improve outcomes and prevent drug resistance.

Accountability and data access

Participants from the Aboriginal Engagement Session felt that improved accountability was needed through provincial goals and actions. One member identified the need for data related to First Nation and Aboriginal people (via the First Nations Client File) to be more available to people who are planning and providing services. Discussants from the Provincial session

indicated that it would be beneficial to include goals that facilitated working across organizations and systems, and goals that are inclusive of community based organizations.

Actions for consideration

BC's Guiding Framework currently has two targets that include viral hepatitis:

Target	Baseline (2012)	2023 Target
The incidence of HCV among repeat testers per year (per 1,000).	6	3
Immunization coverage rates up-to-date by second birthday in accordance with the routine childhood immunization schedule*	70%	90%

**while this target is for the entire schedule of immunizations, this schedule includes hepatitis B vaccine*

Discussion Summary:

1. **Actions to prevent new infections/treat existing disease.**

Action: Enhance reach and range of publicly funded harm reduction supplies across BC.
Discussion by the groups reflected a need to look at the lessons learned from the STOP HIV/AIDS harm reduction target, and use this information to frame the actions to improve not just quantity of harm reduction supplies but reach of services. Some participants identified that equitable access to harm reduction services—such as safe injection—may be a challenge in BC due to geographic restrictions; however the group identified this as an important service to support and expand. Participants called for increase in access to the inhalation supplies (they are not supported through provincial program and health authorities pay for glass stems). Participants noted that they are seeing increase in crystal meth use and pipes are expensive so this needs to be addressed; participants from Interior highlighted the opportunity of developing harm reduction program within a new correctional facility (in Oliver).

In addition, participants highlighted the need for safe injection/safe consumption sites in the province. Some participants expressed a need to expand harm reduction services to include education regarding viral hepatitis (in general), as well as safer drug use, and not have it focus on the distribution of supplies. This could reduce discrimination related to both viral hepatitis and drug use.

Action: Increase coverage of the HAV/HBV vaccine for eligible people.

Increasing the coverage of HAV/HBV vaccine was discussed, as was the potential for a universal HBV vaccine program inclusive of adults born prior to 1981 and requesting the Communicable Disease Policy Advisory Committee to review the cost effectiveness of a universal HAV and/or HBV vaccine program. Participants have suggested that HAV vaccination rates among First Nations children could be measured to determine effectiveness of program.

Action: Increase the proportion of people who are eligible for publicly funded HBV and HCV treatment that are receiving treatment.

In discussions regarding eligibility for HCV treatment, the group felt that the F2 criteria was limiting, and that the definition of eligibility should be reviewed to be more inclusive Participants also felt that that general practitioners may not have sufficient information about the PharmaCare requirements for eligibility, or how to access ways to assess liver health. As well, rural and remote areas require added intensity for support due to transportation limitations and limited access to health care services. Telehealth could be utilized for this purpose.

Action: Expand harm reduction program (syringes) through collaboration with BC Corrections.

In general, it was felt that harm reduction should be expanded within the corrections system, but it should include harm reduction supplies beyond those currently available (needles and syringes). Gaps need to be assessed, particularly with respect to transitions in, out, and between facilities, as well as across regional health authority boundaries. It was noted that engaging with corrections may require a separate approach and specific actions within the strategy.

Action: Increase access to harm reduction supplies

Participants noted that opportunity for opioid substitution therapy is important; however substance dependence is broader than opiates. For example, Interior has seen a rise in methamphetamine use, and meth pipes as a core supply from the Harm Reduction Program could be important. Additional actions could focus on the prevention of substance dependence to prevent HCV acquisition.

In addition, participants proposed to change this action's wording to reflect enhanced reach of harm reduction programs and supplies, using word "interventions".

Suggested additional action:

Focus on engagement with youth regarding the prevention of addictions and substance use.

Participants identified the need for increased resources to improve community capacity to prevent problematic substance use, particularly in youth. The way health partners work with youth-related organizations on early prevention is an area that requires additional focus.

Engagement with youth at a younger age (before 14 years) needs to be coordinated with school districts; a move away from the fear-based approach and to harm reduction approach is needed. In addition, the youth in care with the Ministry of Children and Family Development are vulnerable as they transition out of care.

2. **Actions to increase the number of people living with viral hepatitis who are aware of their infection.**

Action: Implement a one-time screening for HCV for people born between 1945 and 1965.
Participants felt that the "baby boomer" population in BC should be tested, as recommended in the United States. A plan for treatment and care (particularly with respect to how physicians are informed) will need to be in place prior to any implementation of enhanced testing for "baby boomers" as it may result in a bottleneck within the system. It was recommended that acute care testing protocol for HIV be linked to HCV screening, and that there should be a mechanism to prevent over-testing of those who are low risk, or already have viral hepatitis.

Action: Develop BC specific guidance for one-time screening of HCV.
Feedback indicated that the guidance for screening HCV is not as clear as it is for HIV. It could be helpful to undertake the same guideline development process as that for HIV (e.g., form a provincial working group). A one-time screening does not speak to those with an ongoing risk; more information is needed regarding risks and frequency of reinfection. As well, the impact of increased testing on transmission and reinfection rates should be evaluated. One member identified that testing in the absence of being able to offer treatment may be unethical, while other members of the group highlighted the benefits of diagnosis even in the absence of treatment (including alcohol risk reduction and other lifestyle changes).

Action: Increase proportion of people who are vulnerable to HBV and HCV who have been tested.
No specific comments

3. **Increase the proportion of people diagnosed and subsequently assessed for liver health**

Action: Increase the proportion of people assessed for liver health when living with chronic viral hepatitis.

Participants identified liver health assessment as one of the barriers to care: people mentioned the need for a Fibroscan in order to qualify for access to new medication; however, discussion

clarified that PharmaCare guidelines require serum markers or an APRI score for application for coverage. Therefore, there may be a need for education for primary care physicians related to PharmaCare coverage policies and patients' care pathways after diagnosis.

Participants emphasized the need for an established process for people after diagnosis. Also mentioned was the need for support for primary care physicians to monitor liver health for people not eligible for treatment, as well as after treatment. Participants added that the availability of point-of-care diagnostics and non-invasive liver assessments should be increased across the province.

Action: Increase the proportion of people who receive regular HBV laboratory testing as recommended, if not eligible for treatment.
Participants mentioned that the need to identify the size of HBV at-risk population is important.

4. **Reduce the number of people who progress to serious liver disease and require treatment**

Action: Increase proportion of people diagnosed with chronic HBV and HCV who are screened for alcohol and other drug use (for example, through a screening and brief intervention and referral tool).
Participants supported a syndemic approach in response to this action. The alcohol screening brief intervention tool should include a flag for those affected by HCV/HBV. Participants supported an action related improving awareness of alcohol's impact on liver health in people with viral hepatitis, including gender differences. Additional action was proposed by the participants: decrease alcohol dependence.

5. **Increase the number of people cured of HCV who are free of the virus one year on.**

Action: Increase the proportion of people who are cured of HCV and retained in opioid substitution therapy (OST).
Participants emphasized that consistent, long-term support was required for a subset of people successfully treated for HCV to achieve sustained cure. The group identified the role of community based organizations, as well as the expertise from hepatology nurses. Discussants highlighted the need for more equitable access to sobering and detox centers, and the inclusion of non-opioid addiction care. Participants discussed how the linkage to OAT provides an invaluable opportunity to assess people for viral hepatitis while they are engaged in the health care system. Participants also noted the value of OAT in improving adherence to things like HIV and HCV treatment.

Action: Increase the proportion of people engaged anywhere in the system for opioid dependence that are tested for HCV.

Participants mentioned Vancouver Coastal publishes a Hepatitis C Passport, which is a useful tool for people who access multiple organizations. The passport has been useful to engage people in their care, and it has helped to reduce stigma as compared to using an electronic record system.

Action: Increase adherence to OST.

Participants thought that OST system requires changes to improve access and cost for the user, and that introduction of clinical guidelines for the system would be beneficial. Involvement by mental health and substance use service providers to support those cured of HCV and on OST would be highly beneficial as well.