






NOW

END THE EPIDEMICS

LEVERAGING BRIDGE COUNSELORS TO DEVELOP A HEPATITIS C CARE CASCADE IN NORTH CAROLINA

 TARGET POPULATION	Individuals living with hepatitis C
 LOCATION	North Carolina
 PROGRAM DESIGN	Bridge Counselor/ Case Management Program for HCV modeled after an HIV Bridge Counselor program.
 ESTIMATED COST	Approximately \$400,000 (\$80-100,000 per bridge counselor, with three county-based and one state-wide bridge counselors)
 FUNDING SOURCE	State and Federal Funds

SUMMARY

During the past eight years, North Carolina has experienced more than a 300% increase in reported cases of acute HCV infection, from 37 during 2011 to 178 during 2018. Utilizing census data, it is estimated that between 110,000 to 150,000 North Carolinians are infected with hepatitis C. Liver cancer related to viral hepatitis has nearly doubled in the past ten years. To respond to these increases, the viral hepatitis program expanded the services across the continuum including prevention, free testing in local health departments, and expanded treatment access through provider education and mentoring. Linkage to care and navigation was identified as one of the biggest gaps in the care continuum so NCDHHS developed a bridge counselor program to support people living with HCV as they navigate care to cure. The focus of this program has been on connecting people with non-judgmental care and approaching the needs of the whole person, so ensuring that people are linked to substance use treatment, mental health, primary care and other services in addition to or if they are not ready for HCV treatment.

BACKGROUND

During the past eight years, North Carolina has experienced more than a 300% increase in reported cases of acute HCV infection, from 37 during 2011 to 178 during 2018. Utilizing NHANES and census data, it is estimated that between 110,000 to 150,000 North Carolinians are infected with hepatitis C. Liver cancer related to viral hepatitis has nearly doubled in the past ten years. To respond to these increases, the viral hepatitis program expanded the services across the continuum including prevention, free testing in local health departments, and expanded treatment access through provider education and mentoring. Linkage to care and navigation was identified as one of the biggest gaps in the care continuum so NCDHHS developed a bridge counselor program to support people living with HCV as they navigate care to cure. The focus of this program has been on connecting people with non-judgmental care and approaching the needs of the whole person so ensuring that people are linked to substance use treatment, mental health, primary care and other services in addition to or if they are not ready for HCV treatment.

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CORE ACTIVITIES

The HCV bridge counselor program was modeled after the HIV bridge counselor program, with extended follow up time to navigate the unique needs of people living with HCV and limited infrastructure that exists to respond to hepatitis. Bridge counselors maintain contact with patients through cure, with one year follow up check ins to determine sustained virologic response (SVR) as a marker for cure and reinfection rate. Patients can be referred to bridge counselors through private provider, health department, or self-referral.

At receipt of a patient referral, bridge counselors attempt to contact patients three times by phone or letter. If a patient cannot attend in person due to travel restrictions, bridge counselors will meet the individual in a more convenient location, or at their home. The priority is to remain nimble based on an individual's unique care needs. Bridge counselors initiate appointments for a "bridging session" with individuals, where they determine feasibility for linkage to treatment, and initiate referrals for integrated health appointments. These appointments may include primary care, homeless health, stable housing, transportation, food services, syringe service programs, substance use and/or MAT programs.

On average, the bridge counselors meet with a patient five times during the HCV treatment regimen and track appointment attendance, DAA prescription, treatment completion, and SVR documentation. Bridge counselors monitor patients utilizing individual records, and care cascade variables are entered into the North Carolina Electronic Disease Surveillance System (NC EDSS) for ease of tracking.

DATA

Outcomes for bridge counseling are immediate referrals to HCV and other health care services. Outcomes are tracked across the continuum including 1. diagnosis

of active disease; 2. Attendance of first appointment; 3. Attendance of second appointment; 4. Start of DAA regimen; 5. Four-week contact; 6. Completed drug regimen; 7. Documented SVR; 8. Documented SVR1; and 9. Maintenance of SVR 12 for one-year post cure.

In two regions that participated in the bridge counselor program, a total of 344 people were referred to the regional bridge counselors following a positive HCV antibody test. For patients in Region 2, the major sources of referrals were HCV treatment providers and local health departments. Of the 254 participants that continued through the program (100 were excluded from the analysis because of reasons such as not having chronic HCV, etc.), 32 (12.6%) successfully completed the program, 79 (31.1%) were lost to follow-up, and 143 (56.3%) were still in the program as of June 2019. Of individuals attending the first appointment, 78.6% attended the second appointment, and 61.0% began a DAA regimen. 51.9% of enrolled individuals completed a 12-week course of DAAs, and 39.0% achieved SVR. 26.6% have a documented SVR12. Among patients who achieved SVR12, there were no cases of reinfection during the one-year follow-up period.

It is important to note that this is a fluid cascade, and as such individuals currently in the cascade may not reflect cure at the time of data collection. Also of note, as RNA quantitative tests are expensive and patients are largely uninsured, many patients do not return for SVR and SVR 12 testing. Cure rates are believed to be underestimated.

FUNDING & COST

State and Federal Funds are used to cover the cost of bridge counselors which is approximately \$80,000-100,000 per staff person with an overall cost to the program at approximately \$400,000. There are currently four bridge counselor positions in the state, three that are county-based (Buncombe, Jackson, and New Hanover) and one that works across North Carolina.

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STRENGTHS

- The bridge counselor program focuses on whole person care and views health from a wellness framework so links people to the services they need, even if they are not immediately ready for HCV treatment and including services outside of what is considered standard healthcare (e.g. housing);
- Provides a case management approach to help navigate and support people to address the multiple barriers to care they face such as lack of transportation, judgmental medical providers, lack of insurance, substance use disorder, etc.;
- The bridge counselors establish trust with patients as they guide them into care as well as providers that they work with and they maintain these relationships post cure; and
- Leverages the infrastructure being built by other programs such as surveillance, prevention, harm reduction, HCV testing in local health departments, and CHAMP.

LIMITATIONS

- Funding for this work is limited and bridge counselors are not available in all regions of the state; and
- Barriers to care still exist such as lack of transportation cost of pretreatment labs, stigma, and attitudes towards people who use drugs that cannot entirely be addressed through this program.

STAKEHOLDERS

Local Health Departments; Local primary care providers; Syringe Access Programs; North Carolina Harm Reduction Coalition; CHAMP; Gastroenterology departments; University of North Carolina; Duke University; NC Viral Hepatitis Program; and Community Care of Western NC

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