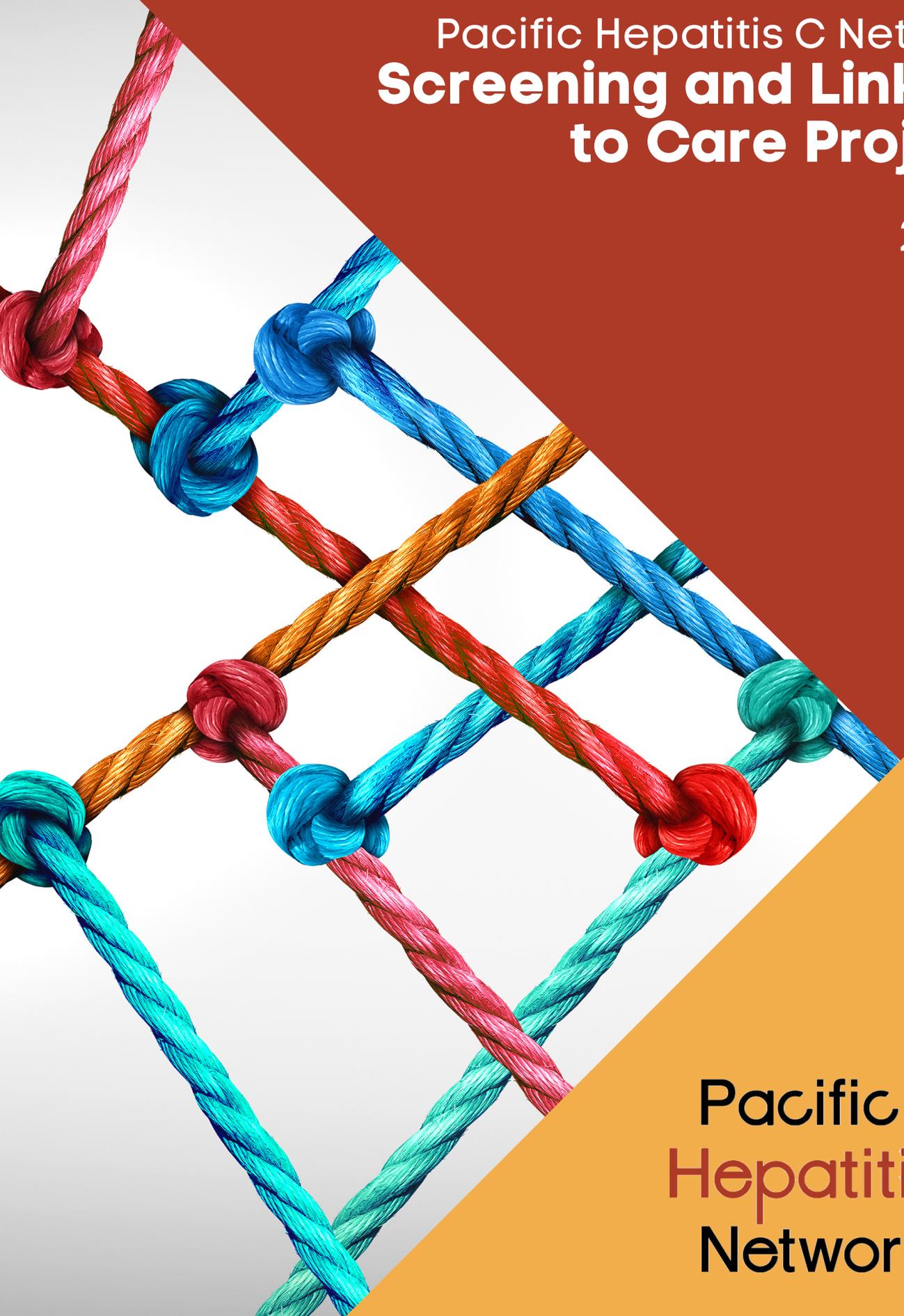


Pacific Hepatitis C Network  
**Screening and Linking  
to Care Project**

2020



Pacific  
Hepatitis   
Network

# ACKNOWLEDGEMENTS

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ANKORS (East and West)

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# BACKGROUND

## SCREENING + LINKING TO CARE PROJECT

**WHILE SCREENING FOR HEPATITIS C AMONG PEOPLE WHO USE DRUGS (PWUD) IS RELATIVELY ROBUST IN BC, TREATMENT UPTAKE IS LOW.**

Many PWUD do not receive their screening results. Even if they do

collect the results, a 2019 study of treatment cascade in BC showed that only 44% of people with a history of injecting drug use who tested RNA-positive in 2018 actually initiated treatment, compared to 63% of British Columbians overall [1]. The same research showed that PWUD had very similar cure ratios to the overall population when they completed treatment.



The Pacific Hepatitis C Network (PHCN) Screening and Linking to Care project aimed to engage PWUD who had never had hepatitis C virus (HCV) screening, or who have been screened but were not engaged in ongoing care and treatment, to screen, confirm and then engage with local hep C treatment providers. Partners with PHCN include BC Centre for Disease Control (BCCDC), Interior Health and community partners ANKORS and ASK Wellness. Screening, education, and linking to care took place in the Interior Health region. Three half-day events provided free screening and linking to care in 3 different Interior Health communities in February and March 2020. The project engaged with local health care providers, HCV treatment providers and support services before, during and after events. The project led PHCN to identify barriers to screening, testing, and treatment initiation, and to show that they can be overcome through local agreements without putting undue stress on the healthcare providers.

# PROJECT GOAL

Pilot HCV screening and linkage to care services in 5 harm reduction/ supported housing settings in 4 communities in BC's Interior

## PROJECT OBJECTIVES

- 1 Increase HCV screening and linkage to care among PWUD who access harm reduction sites and supported housing.
- 2 Increase HCV treatment uptake and completion among PWUD who screen positive and/or are confirmed positive or are linked with care based on previous diagnosis.
- 3 Increase understanding of the relevance and importance of HCV testing/screening, care and treatment among project participants (PWUD, health care providers).
- 4 Increase understanding of and document what worked and didn't work in this pilot project; form recommendations for future similar initiatives.

## SUMMARY

PHCN's Screening and Linking to care project successfully piloted a partnership with local harm-reduction organisations to test 49 people at high risk of HCV and link the 14% who were positive with medical care as soon as their test results came in. The local organisations showed great interest in continuing testing. The project also raised the profile of HCV as a concern of the people at the screenings, the local organisations, and the treatment providers.

PHCN gained familiarity with the functioning of the Interior Health Region, the stakeholders in the harm reduction and HCV fields in BC's Interior and North, and the challenges to providing timely HCV care in BC. PHCN noted the barriers to HCV care, and needs and concerns of the stakeholders.

## INTRODUCTION

British Columbia has had a policy to treat all BC residents for hepatitis C since 2018 [1]. Approximately 1.4% of BC residents are HCV-antibody positive. Although testing and care is universally available in theory, on the ground, not only are there nearly 10,000 antibody-positive BC residents who have never been tested, there are many people who test positive for chronic hepatitis C who do not initiate treatment. Particularly hard to reach and at high risk are people who use drugs (PWUD), and people in precarious housing or without housing. Only 44% of PWUD who test positive for chronic hepatitis C in 2018 initiated treatment [2].

PHCN sought to identify barriers to testing and treatment uptake among PWUD and other HCV priority populations in the Interior Health region. Local partners who regularly provide services to via outreach, low-barrier clinics or drop-in centres collaborated by providing information, space for the testing events to take place, volunteers and staff to participate, and outreach to bring people in for health education and testing. Despite the many demands on local partners' services and facilities, these organisations were able to provide all the support necessary for the success of these events. The search for confirmed treatment providers enabled PHCN to become more familiar with the organisations providing healthcare in the Interior Health Region.

Finding healthcare providers who would guarantee quick assessment and treatment initiation for anyone who tested positive proved to be the most difficult part of this project. Many people with HCV in BC do not have a healthcare provider in their area who can provide treatment even for uncomplicated cases.

# Pacific Hepatitis C Network Screening and Linking to Care Project Report

This pilot project showed that it is possible to engage with members of the PWUD population and other hard to reach populations. Many people in these populations show great interest in hepatitis C when it is presented to them, and took an opportunity to test. However, in both service-providing organisations (drop-in centres, outreach, low-barrier clinics) and these populations, hepatitis C rarely rises to the top of priorities, unless the topic is specifically introduced. Once the organizations had been engaged in hepatitis C screening, testing, and linking to care, all expressed an interest in continued screening. PHCN left a supply of test kits in each place, to enable them to continue to screen while interest was high.

## SETTING UP THE PROJECT

For this project, three sites were chosen based on the capacity of community partners and the availability of hepatitis C treatment providers. Each site served a different type of population, with Site 1 serving a more stable population of people with a variety of issues leaving them in need of harm-reduction services, Site 2 mainly older, precariously housed people, and Site 3 the drop-in centre of last resort for harm reduction and other needs of many of the people who attended.

	Screened	Antibody positive (%)	Previously diagnosed	Total linked to care
Site 1	6	3 (50)	0	3 (50)
Site 2	19	1 (5)	0	1 (5)
Site 3	24	2 (8)	1	3 (13)
Total	49	6 (12)	1	7 (14)

## OBJECTIVE 1

INCREASE HCV SCREENING AND LINKAGE TO CARE AMONG PWUD WHO ACCESS HARM REDUCTION SITES AND SUPPORTED HOUSING.

**This objective was achieved, and wider HCV screening and linkage to care is feasible**

During this project, 49 people were tested for antibodies, of whom 7 were confirmed as HCV anti-body positive. All were linked to care. While all of these people had access to HCV screening services through harm reduction sites, GetCheckedOnline, outreach nurses, or other healthcare services, most of them had never been screened before. A few had been screened before, and took the opportunity to get another check, following potentially risky behaviour.

The link to care was more difficult to arrange than the screening. One of the sites had been actively testing for and treating HCV in the past, but had not tested for about three years. At another site, outreach nurses expressed their doubt about whether testing did any good because their patients could not get initiation of care within a reasonable time. They had not provided tests recently.

## OBJECTIVE 2

INCREASE HCV TREATMENT UPTAKE AND COMPLETION AMONG PWUD WHO SCREEN POSITIVE AND/OR ARE CONFIRMED POSITIVE OR ARE LINKED WITH CARE BASED ON PREVIOUS DIAGNOSIS.

This objective was achieved for treatment uptake; treatment completion and long-term feasibility are uncertain.

Seven people (14%) tested antibody positive. All proceeded to the next diagnostic steps, and expressed the intention to get treated. No one declined further testing or treatment initiation.

While linkage to care proved to be difficult to arrange, the Project Coordinator was able to set up linkage to care without delay in all sites. In some sites, linkage to care was only possible because of personal relationships with the providers, or there was only a single provider, usually one who was dedicated to work with harm reduction. There is a risk that these providers may move, retire, or stop providing HCV care, leaving patients with no nearby options for treatment.

BC PharmaCare requires an RNA test no older than 12 months for treatment to be initiated, so people with previous diagnoses would have to get the RNA test again prior to initiating treatment. In general the steps from screening to treatment were perceived as difficult to complete\* [3]. As long as there are 3 or 4 steps, spaced over a period of weeks, significant follow-up support will be needed.

\* In March 2020 there were three or four steps from screening to treatment, followed by SVR testing as an additional step, as identified by the BCCDC [3]

### OBJECTIVE 3

INCREASE UNDERSTANDING OF THE RELEVANCE AND IMPORTANCE OF HCV TESTING/SCREENING, CARE AND TREATMENT AMONG PROJECT PARTICIPANTS (PWUD, HEALTH CARE PROVIDERS).

This objective was achieved.

At each of the sites, the partner organizations expressed an interest in continuing to offer regular HCV screening and linkage to care, either as periodic screening events, or as part of regular services. Those who attended the events expressed interest in learning about hepatitis C. Health-care providers had been aware of the relevance and importance of HCV, but it had not been a high priority. All expressed interest in continuing to test.

### OBJECTIVE 4

INCREASE UNDERSTANDING OF AND DOCUMENT WHAT WORKED AND DIDN'T WORK IN THIS PILOT PROJECT; FORM RECOMMENDATIONS FOR FUTURE SIMILAR INITIATIVES.

Participant experience evaluations were conducted at each event, and information was noted about the capacity of the partner organisations, and sites further events would be welcome and useful.

See next section for recommendations.

## CONCLUSIONS

An evaluator was present at each event to collect participant experiences and the views of staff, to the extent possible without impeding the testing. The following observations and recommendations are based on formal interviews with 14 participants, informal interviews with 11 participants, and input from 8 staff members or volunteers from the partner organisations, and the experience of PHCN staff. All participants gave signed informed consent for use of their observations in reports and other internal and external materials.

### THE MAIN BARRIERS TO TREATMENT WERE:

1. Low number of treatment providers.
2. Reluctance of some treatment providers to take on marginalised patients.
3. Low priority of hepatitis C among some people who have more urgent issues in their life, such as problematic substance use, homelessness or precarious housing.
4. Inability of some patients to navigate the many steps of testing and consultations.
5. Lack of established linkage to care, leaving some diagnosed patients without treatment.
6. Discouragement of potential testing providers, who have seen diagnosed patients go untreated.

### THE MAIN NEEDS RAISED BY THE PARTICIPANTS WERE:

1. Streamlined linkage to care, ideally within a day once diagnosis is confirmed.
2. Respectful interactions with healthcare staff at all levels of encounter.
3. Ease of access to testing.
4. More knowledge about hepatitis C.

### LOCAL ORGANISATIONS MAY NEED ADVICE, SUPPORT, OR ADVOCACY TO HELP THEM:

1. Where possible, health communication on hep C and treatment should be given by a person with lived experience. At minimum, it must be tailored to the audience's interests and needs.
2. Give private post-antibody testing counselling emphasising prevention.
3. Having a certified nurse to do follow-up in each site is ideal.
4. Explore integration of HCV testing with regular service offerings. In the longer term, organisations could seek to combine with other services (rapid test for hepatitis B, HIV, TB, information on PrEP) as seen as feasible and useful by the local service providers.

### FOR EXTERNAL INFORMATION OR ADVOCACY:

1. Participants need to be met where they are, physically and in the course of life. When they are, treatment uptake is high.
2. Treatment initiation needs simplification.
3. The number and geographical dispersion of HCV healthcare providers needs to be increased. For uncomplicated cases, consider telemedicine or other options.

## REFERENCES

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## ABBREVIATIONS

<b>ANKORS</b>	AIDS Network Kootenay Outreach and Support Society
<b>BC</b>	British Columbia
<b>BCCDC</b>	British Columbia Centre for Disease Control
<b>HCV</b>	Hepatitis C virus
<b>Hep C</b>	Hepatitis C (virus or infection)
<b>IH</b>	Interior Health
<b>PHCN</b>	Pacific Hepatitis C Network
<b>POC</b>	Point of care (test)
<b>PrEP</b>	Pre-exposure prophylaxis
<b>PWUD</b>	People who use drugs
<b>RNA</b>	Ribonucleic acid
<b>STOP HIV</b>	Seek and Treat for Optimal Prevention of HIV/AIDS
<b>SVR</b>	Sustained virologic response (indicating cure)
<b>TB</b>	Tuberculosis