COOL AID COMMUNITY HEALTH CENTRE | BRITISH COLUMBIA, CANADA

CLOSING THE LOOP: A NURSE-LED HCV ELIMINATION PROGRAM

British Columbia has one of the highest rates of hepatitis C (HCV) in Canada. The Cool Aid Community Health Centre is an inner-city, interdisciplinary primary health care centre serving more than 6000 clients living with chronic mental health comorbidities, substance use and those who are experiencing homelessness. Approximately 20% of our clients have been affected by HCV. Our nurse-led 'Seek & Treat' HCV micro-elimination programme typically targets populations in Cool Aid housing sites, shelters and on outreach, with the aim of improving screening and linkage to care for people infected with HCV.

WHY DID WE ESTABLISH THIS MODEL?

British Columbia has one of the highest rates of HCV in Canada. While the rate of new infections has declined since 2000, the rate of acute infection has remained steady

48% of our clients currently use drugs and 29% have history of injection drug use

Offering housing to people experiencing homelessness is a key part of our broader service delivery, through Victoria Cool Aid Society

Our nurse-led model of care uses the opportunity, while people are staying in local housing sites, to provide HCV care with the aim of elimination

WHO ACCESSES OUR SERVICE?

1305 CLIENT ENCOUNTERS PER WEEK^

- People who use drugs and/or alcohol
- People receiving OAT*
- People living with HIV
- People who are homeless
- People with mental health challenges

*OAT- Opioid Agonist Therapy

^In 2021/2022- figure is based on total encounters per year / 52

WHAT IS THE MODEL?

FIRST, A PLACE TO LIVE

Victoria Cool Aid Society runs 589 permanent homes in 20 locations for tenants with a wide variety of needs. Their sites include emergency shelters and transitional housing, supportive accommodation for people who have experienced long-term homelessness, and seniors accommodation. Many of the people who Cool Aid work with are people with either a lived or living experience of drug use. Housing staff are a mix of housing workers (including social workers) and people with lived experience. Cool Aid also provides primary care for a number of other local housing sites.

NURSE-LED ON-SITE VISITS

A nurse attends the housing site and recruits residents to get tested and engage with care. This may be a part of testing protocol when providing primary care or a part of other programs such as a recent peer-led point-of-care and dried blood spot testing (DBS) program.

ENGAGE HOUSING SUPPORT STAFF

Nurses also provide HCV education to housing support staff, so they can support residents with getting tested and treated and with treatment adherence.

PEER NAVIGATORS

Peers act as casual building champions, providing education and encouragement. Currently, the peer program is gaining momentum, with peers performing point-of-care testing at pop-up events, supported financially to do so.

MULTI-DISCIPLINARY CARE

Once residents are tested, they are linked with care provided by a multi-disciplinary team, including a coordinating physician, pharmacists, dietician, counsellor and outreach worker.

VICTORIA COOL AID SOCIETY HOUSING

589 PERMANENT HOMES

20 LOCATIONS

Our new hep peer testing program with people with recent lived experience of treatment has already tested more than 300 people in community. Already 6 of the 10 people found to be living with Hep C have started treatment. Having peers has created opportunities of trust and connection to get tested and reassure that treatment is easy and doable and stigma is reduced. Building relationships and trust is key to making any hep C program work effectively.

CHRIS FRASER, MD
MEDICAL DIRECTOR,
COOL AID COMMUNITY HEALTH CENTRE

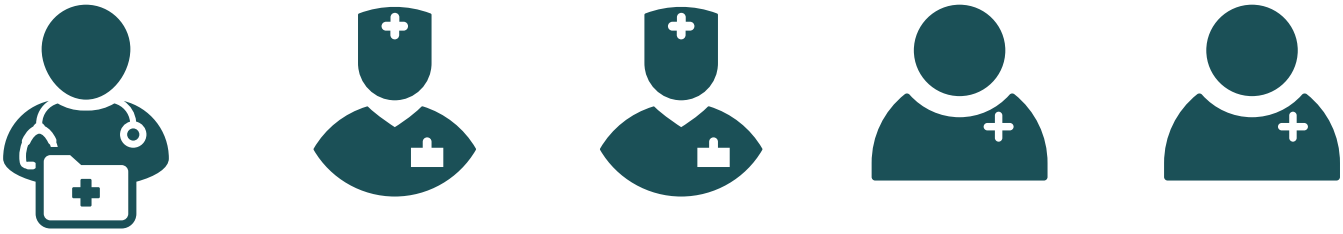
EXTENDING THE MODEL THROUGH THE COVID-19 PANDEMIC

When the COVID-19 pandemic broke out, the local government ordered that homeless people should be moved from encampments to hotels.

Cool Aid took advantage of this time when people were in stable housing to expand their model of care, by reaching out and offering HCV screening and linkage to care to an even wider group.

Only 40% of people were existing Cool Aid clients, and many had not had good access to care for years.

WHO DELIVERS SERVICES AT COOL AID?



15 GENERAL PRACTITIONERS

5 NURSE PRACTITIONERS*

14 NURSES

3 PHARMACISTS

2 PHARMACY ASSISTANTS

3 PEER WORKERS

2 COUNSELLORS

2 OUTREACH WORKERS

2 RESEARCHERS

**Currently unfunded by Cool Aid but work with Cool Aid staff*

HOW IS IT FUNDED?

- LOCAL HEALTH AUTHORITY FUNDING
- PHARMACEUTICAL GRANTS AND PROJECTS
- MINISTRY OF HEALTH FUNDING

Our nurse-led HCV program supports our clients to have excellent medication adherence and high SVR rates by combining on-site visits, intensive case management, peer involvement, and the encouragement of housing support staff.

TAMARA BARNETT - HEP C NURSE COORDINATOR
COOL AID COMMUNITY HEALTH CENTRE

Our program has continued to grow. We have just completed a micro-elimination project partnering with four pharmacies. They identified and provided 200 HCV point-of-care tests to clients and supported treatment adherence to explore task shifting to pharmacies for HCV testing and care.

MARION SELFRIDGE - RESEARCH MANAGER
COOL AID COMMUNITY HEALTH CENTRE

WHAT HCV SERVICES DO WE PROVIDE?

- HCV education and information
- Peer support
- HCV testing
- HCV diagnosis
- HCV treatment
- Liver disease assessment

WHAT INTERVENTIONS DO WE USE?

- **On-site phlebotomy provided by nurses**
- **Dried blood spot testing**
- **Point-of-care HCV antibody testing**
- **Telehealth**
- **Pre-test counselling and education**
- **Peer support**
- **Financial incentives**
- **Coordinated health, substance use and hepatitis treatment services**
- **Patient navigation**
- **Mobile outreach van**
- **Outreach testing in housing services and other sites**

COMPLEMENTARY SERVICES WE PROVIDE

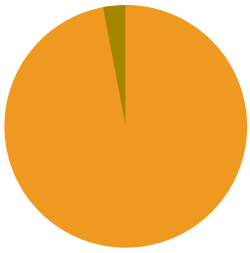
- Links to social support and housing
- Access to a primary care provider
- Access to clean needles and syringes, pipes and other harm reduction equipment
- Access to OAT
- Access to naloxone
- Access to alcohol and other drug treatment
- Access to HIV testing and treatment
- Overdose prevention sites at some buildings

WHAT WERE THE OUTCOMES?

Nov 2014 – Dec 2020

569

PEOPLE INITIATED HCV TREATMENT ACROSS ALL SERVICES

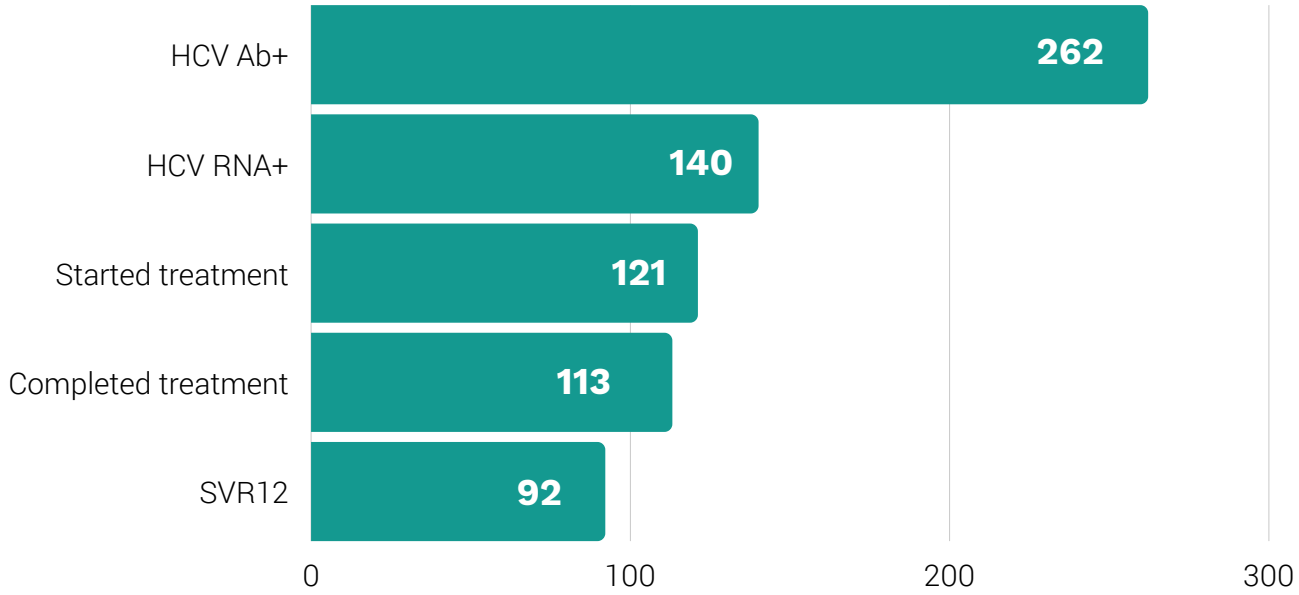


97%

COMPLETED TREATMENT

COVID SHELTERING SITE OUTREACH PROGRAM

May 2020 – October 2022



SUCCESSES

- High levels of treatment completion and SVR
- Increased engagement in primary care
- Harm reduction strategies/education regarding reinfection reinforced
- Increased client confidence to pursue other hopes and dreams
- Peer involvement reduces stigma and increases treatment uptake
- Continued outreach enables the identification of those lost to follow up

LESSONS LEARNED

- Peer recruitment and peer mentors are essential for treatment uptake
- Incentives work
- Length of HCV treatment is still an issue - engagement with clients was more difficult after 8 weeks
- In a complex testing environment, point-of-care HCV RNA testing will be valuable

WHAT WERE THE BARRIERS?

BARRIERS	SOLUTIONS
 No stable local funding from health authority or province dedicated to HCV testing and treatment.	Applied for outside funding for specific projects and joined research projects as a site to access treatment and other resources.
 Many other urgent health issues. Currently two provincial public health emergencies – COVID 19 and overdose crisis.	Adapted current plans to take advantage of funds available for crises – test and treat formerly homeless clients housed for COVID 19 mitigation. Harm reduction service delivery was scaled up as a result of the crisis, including implementation of overdose prevention sites in some settings and safer supply prescribing.
 Continued gate-keeping of HCV treatment. DAA treatment was only available to all patients March 2018.	Advocated for reduced barriers to provincially funded treatment – reduced wait times for blood work, waived genotype required during COVID 19 pandemic due to COVID restrictions and lab capacity .
 No easy data collection within existing electronic medical records system.	Hired a research coordinator and empowered staff to regularly collect data on HCV treatment to facilitate analysis and publication.
 Siloed HCV treatment within different health agencies, some who are hesitant to treat people who use drugs.	Met regularly with other primary care (and OAT) providers and community partners to educate and discuss treatment options. Educated clinical staff at local jails and worked to keep communication open.

LOOKING TO IMPLEMENT A SIMILAR MODEL?

OUR TOP 5 KEY CONSIDERATIONS

1

USE EVERYONE'S SKILLS

Enhance education and scope of practice for all people involved to their full potential.

2

LEARN FROM THOSE WITH EXPERIENCE

Learn from peers and people who use drugs about what works for them. Learn from the valuable knowledge, established relationships and novel perspectives of peers in efforts to reduce barriers and reach people who use drugs.

3

FOCUS ON EQUITY

Prioritize building an equity-based, harm reduction framework, striving to provide culturally safe, competent, flexible, low-barrier access to care.

4

FLEXIBILITY

Be open and flexible to new ideas and strategies. Offer flexible, low barrier access to HCV programs such as through self referral programs or through establishing referral relationships with other services.

5

REALISTIC EXPECTATIONS

Balance expectation of outcomes of HCV treatment with individual client life circumstances and goals. This may not be the time to start HCV treatment.

INHSU
International Network on Health and Hepatitis in Substance Users

CoolAid
everyone deserves home

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