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There are no hard-to-reach patients – only hard-to-reach health care

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In high-income countries, hepatitis C mainly affects people who inject drugs. Achieving WHO targets for HCV elimination requires alternative care models to effectively engage vulnerable populations in treatment. HCV can be effectively cured with antiviral treatment; however, barriers such as stigma, unstable housing, and complex healthcare systems often hinder access to this treatment. While exploring low-threshold HCV care models in New York City through the Harkness Fellowship, healthcare providers highlighted the importance of building trust and offering comprehensive services. Engaging with vulnerable populations requires a shift in our approach—meeting people where they are and dismantling the logistical and social barriers that hinder their access to treatment is essential. Our focus should be enhancing coordination and providing care in easily accessible locations that resonate with those we aim to serve.

In high-income countries like Norway and the United States, the Hepatitis C virus (HCV) disproportionately affects people who inject drugs. These individuals are often marginalized due to their ongoing drug use, psychiatric comorbidities, health illiteracy, or socioeconomic instability. While some attempt to seek treatment, they often become lost within a complex system that is not designed to meet their needs. Others might resist help altogether, sometimes because of traumatic life experiences that are challenging to imagine. All deserve our respect and care.

Newer antiviral medications, which are taken for eight to twelve weeks, can cure approximately 95% of patients with HCV, making the elimination of hepatitis C as a public health threat feasible. However, helping people who inject drugs obtain and adhere to treatment presents significant challenges and barriers to care.

To achieve HCV elimination, we need alternative models of care that effectively engage vulnerable populations in treatment. How do we reach patients who do not have a permanent address or phone? How can we follow up with individuals who miss regular appointments? These questions occupied my thoughts prior to starting the Harkness Fellowship.

Delivering more effective HCV care

As a founding member of the Centre for Elimination of Hepatitis in Norway, I have worked with innovative HCV treatment models for people who inject drugs. One such model was a mobile clinic run by peers, targeting people who inject drugs living in rural areas of Norway (1). This clinic offered point-of-care confirmatory hepatitis C testing and liver assessments using portable devices, creating opportunities to initiate same-day treatment with a provider accessible via telephone. Another model involved providing immediate treatment for hospitalized people who inject drugs with HCV, as opposed to the traditional standard of care that involves referral to an outpatient clinic (2).

The primary goal of my fellowship was to explore HCV treatment models in New York City, specifically examining barriers to care and identifying elements of care models that effectively address these challenges. While significant structural and cultural differences in healthcare exist between Norway and the US, the HCV population faces similar needs in both countries, offering an opportunity for healthcare professionals to learn from one another in delivering more effective HCV care to marginalized populations.

Insights from HCV care models in New York City

From 2021 to 2022, I conducted interviews with 16 healthcare providers in New York, representing ten different organizations that deliver low-threshold HCV treatment (3). These organizations include community health centers, mobile units, harm reduction programs, and methadone clinics, with significant peer involvement in the treatment process.

Competing priorities

I found that many barriers to HCV care are similar in the US and Norway. Stigma associated with substance use disorder, along with competing personal factors such as lack of housing and ongoing substance abuse, are prevalent regardless of nationality. The term "chaos" often comes to mind; it can be difficult to initiate HCV treatment when individuals face numerous pressing problems.

Low-threshold HCV programs

While no clear definition of a low-threshold care model exists yet, discussions with providers in New York City-based programs revealed that these initiatives must work to overcome the stigma associated with the disease. Successful HCV treatment hinges on building trust with patients. An open-door policy, where appointments are not required, is another key success factor for low-threshold programs. The more services these programs can provide in one location, the better. For example, why not address patients' wounds and manage their diabetes while simultaneously treating their HCV infection?

Another effective approach involves locating healthcare services close to the marginalized patients who need them. One example is the Accessible Care Program, which co-locates an HCV care program within a syringe exchange program in New York City (4).

Staffing is a crucial component

Care models can significantly enhance outreach efforts and improve care coordination through adequate staffing. It is essential to bring healthcare to areas where it is most needed, ensuring patients have various options for connection—whether through walk-ins, telemedicine, or outreach activities.

Available but not accessible

One major barrier to HCV care in the US, absent in Norway, is the requirement for prior authorization, or insurance approval, before starting treatment (5). These additional steps can quickly lead patients to drop out of care. Imagine a motivated patient eager to receive HCV treatment, only to be delayed by the need for prior authorization. For patients without stable housing or access to a phone, ensuring they receive medication once authorized can be exceptionally challenging.

In the US, while HCV treatment is available, it is not accessible for all patients and it needs to be both. One way to address prior authorization challenges is to assign peer navigators to assist patients in obtaining necessary care. Another approach could involve providing patients with a medication starter pack while they await their prescription (6).

Is there an optimal treatment model?

My experience at the Centre for Elimination of Hepatitis in Norway, combined with my fellowship year, provided invaluable insights into the essential elements for an optimal treatment model that can overcome barriers to HCV care. Together with my mentors, we published a comprehensive review

on this topic, highlighting effective strategies and innovations that significantly enhance access to treatment for marginalized populations (7). We aim to contribute to a better understanding of how to engage and support individuals affected by hepatitis C, ultimately advancing the goal of elimination.

We concluded that rapid treatment initiation is a promising approach to increasing HCV treatment uptake among marginalized populations. Rapid models rely on innovations in HCV diagnosis and treatment, such as point-of-care confirmatory testing, decentralized treatment locations, and simplified treatment algorithms. Access to medication remains a significant barrier, and these rapid models are best suited for environments where medication is readily available. Addressing medication access issues and expanding point-of-care testing methods could facilitate broader implementation.

A new treatment model in Norway

During my fellowship year, I participated in a task force that updated the national guidelines for treating hepatitis C in Norway. A new model was incorporated into the Norwegian HCV treatment guidelines in June 2022 (8). Traditionally, Norway's approach has involved referring patients to outpatient care, often leading to delays and missed appointments. In the updated guidelines, we recommend that if a patient tests positive for hepatitis C and is unlikely to benefit from the traditional treatment model, healthcare providers should simplify the process and initiate rapid treatment. This method has proven both safe and efficient, with a primary focus on engaging people who inject drugs and ensuring they receive necessary care without unnecessary barriers.

Transforming health care to meet the needs of a vulnerable population

Norway's healthcare system, with its strong emphasis on accessibility and comprehensive support, facilitates the effective implementation of treatment models for hepatitis C. In contrast, the US healthcare system poses significant challenges to such implementation, due to complexities like varying state regulations and the requirement for insurance approval, which can impede access to treatment for marginalized populations. A failing safety net limits the success of low-threshold HCV care models.

In exploring the challenges associated with public health initiatives, particularly concerning hepatitis C elimination, it is crucial to consider the insights of healthcare professionals who are engaged directly in the system.

One provider I interviewed in New York expressed deep skepticism about the feasibility of achieving elimination due to systemic issues within their healthcare framework. They stated, "I'm skeptical that elimination will be achieved. And it's partly because we don't believe that people have a right to basic healthcare, housing, or mental health care. We lack universal healthcare, and, at least in the short term, we probably never will. I think Hep C elimination in the United States or New York is not possible without a comprehensive restructuring of our healthcare system."

This perspective highlights a significant barrier to public health progress: comprehensive healthcare reforms must tackle the underlying inequalities that hinder effective disease elimination strategies.

Transforming healthcare requires grit — a determination to persevere when faced with complex challenges. While some may be born with grit, it can also be cultivated through life experiences.

By uprooting my life and moving to New York City for a year, I left with more grit than I had upon arrival. The shift from Norway, with a total population of 5.5 million, to the bustling environment of New York City, with 8.8 million residents, was substantial. Gaining firsthand knowledge from a different healthcare setting has enriched my perspective. I witnessed remarkable determination and resilience in communities that deliver care to vulnerable populations in New York City. I learned from innovative care models run by engaged and compassionate providers who are working against structural barriers.

No one has yet devised a perfect HCV care model that can be implemented universally across all healthcare systems. We must continue sharing problems and solutions; this knowledge is key to innovation and change. Healthcare will improve as we address each barrier one at a time.

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