The North Carolina HIV Bridge Counselor Program

Programming Connection

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Evidence brief

The North Carolina State Bridge Counselor (SBC) Program, increases participant motivation to overcome barriers to care.¹ The SBC program successfully links people newly diagnosed with HIV to care, and re-engages people living with HIV who had been lost to care. Within one year, care was initiated for 83% of newly diagnosed clients, 68% were retained in care and 69% achieved viral load suppression. Within one year, care was re-initiated for 46% of clients who were lost to care, 50% were retained in care and 51% achieved viral load suppression.²

State Bridge Counsellors²

The SBC program is a statewide intervention developed to link people newly diagnosed with HIV to care; and re-engage into care people with HIV who had fallen out of care. Standard protocols were developed for service delivery and coordination for SBCs to provide services across multiple counties.

The SBCs received training in:

- ARTAS (an evidence-based program that uses strengths-based counselling and case management to increase linkage to care)
- substance use and mental health
- addressing barriers to care.

The SBCs provided services to people newly diagnosed with HIV; people from out of state new to care in North Carolina; people out of care; and high-risk clients in need of urgent care (such as pregnant women).

The SBCs provided brief assistance (one to two contacts) to ensure linkage and re-engagement. This included assistance addressing barriers to care by providing services or supports such as:

- medical appointments
- financial or insurance coverage
- housing
- transportation
- referrals to other services (for example, mental health)
- language issues
- childcare
- partner violence counselling.

People newly diagnosed with HIV were referred to SBCs by public health after they made an initial HIV care appointment. SBCs then confirmed attendance at the appointment by contacting the patient or clinic, or by documentation of a viral load test. If the patient did not attend the appointment, the SBC located the client and helped to address their barriers to care.
Clients who had not kept medical appointments for more than six to nine months were determined to be lost to care and referred to SBCs by public health for follow-up. For these clients, SBCs attempted to locate the client with up to three phone calls and three visits. If the client was contacted, SBCs provided strengths-based counselling to address the reasons for disengaging from care. For clients willing to re-engage in care, appointments were booked and the SBCs confirmed they attended these appointments. A case was closed when a client was linked to care, refused services, died or could not be located after trying for 90 days.

Results

All activities by the SBCs were recorded in a database and service data was analyzed between January 2013 and June 2015 to determine the characteristics of the clients who were referred to the SBCs, and the proportions who were linked to or re-engaged with care and/or achieved viral suppression.

People who received linkage services

There were 1,173 people who were newly diagnosed with HIV and referred to SBCs for linkage to care between January 2013 and June 2015. Of these, 299 (25.5%) people received services. Among the 874 people who were not linked to services, 79% were found to be already in care, 11% could not be found and 10% were not eligible for the intervention because they had been imprisoned, died or moved out of state.

The number of SBC linkage referrals increased from 34 clients in the first quarter of 2013 to 208 in the second quarter of 2015. Overall, SBCs provided 1,327 services for linkage of newly diagnosed clients. Services provided included:

- appointment scheduling and attendance (43%)
- financial or insurance assistance (19%)
- transportation (14%)
- housing (6%)
- mental health, substance use or intimate partner violence counselling (7%)
- language assistance (1%)
- childcare (1%)
- other (10%).

There was a median one contact and two services per client. The total median time spent on each client was 30 minutes.

Care was initiated within 90 days of referral for 63% of clients and within one year for 83% of clients. Within one year of referral, 68% were retained in care and 69% achieved viral load suppression.

People who received re-engagement services

There were 2,099 referrals to SBCs for re-engagement services between January 2013 and June 2015. Services were provided to 606 (28.9%) people. Among the 1,493 people who did not receive services, 56% were found to be already in care, 31% could not be found and 13% were not eligible for the intervention because they had been imprisoned, died or moved out of state.

The number of SBC re-engagement referrals increased from 18 in the first quarter of 2013 to 302 in the second quarter of 2015. Overall, SBCs provided 2,640 services for re-engagement. Services provided included:

- appointment scheduling and attendance (35%)
- financial or insurance assistance (17%)
- transportation (12%)
- housing (5%)
- mental health, substance use or intimate partner violence counselling (5%)
- language assistance (1%)
- childcare (1%)
- other (8%).
There was a median one contact and three services per client. The total median time spent on each client was 39 minutes.

There was re-initiation of care within 90 days of referral for 46% of clients and within one year for 78%. Within one year of referral, 50% were retained in care and 51% achieved viral load suppression. In a qualitative study participants shared that the SBCs increased their motivation to return to HIV care and to overcome barriers associated with re-engaging in care. SBCs described that the strength based approach focused on engagement (e.g., meeting clients where they were in life, attempting to identify skills, talents and abilities, and informing client of rights at every opportunity) helped to facilitate HIV care re-engagement.

What does this mean for Canadian service delivery?

People with HIV in Canada are not optimally engaged in care. The SBC Program was successful at linking people newly diagnosed with HIV to care and re-engaging people in care who had fallen out of care by helping address the barriers to care people may face. This was achieved with limited time interaction with each client, and building on the existing public health infrastructure. This was a statewide intervention that included rural areas, and is an example of an intervention that can successfully engage people in care in rural areas. A strengths based approach that focuses on engagement may inform the development of effective HIV navigation programs to re-engage people with HIV who have fallen out of care and require re-engagement mechanisms that fall out of the norm (e.g., emails, phone calls).

References

Disclaimer

Decisions about particular medical treatments should always be made in consultation with a qualified medical practitioner knowledgeable about HIV- and hepatitis C-related illness and the treatments in question.

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