Addressing Barriers to Hepatitis C Treatment Access Among People Who Inject Drugs in New York State

Executive Summary

People who inject drugs (PWID) are the priority population for the elimination of the hepatitis C virus (HCV) in New York State (NYS) by 2030. Therefore, NYS must implement innovative and coordinated strategies to increase access to HCV treatment for PWID. PWID have the highest burden of HCV, yet few receive HCV treatment. PWID experience significant barriers to accessing curative HCV treatment. Left untreated in this population, HCV will continue to be transmitted and result in devastating illness and loss of life. NYS policymakers, clinicians, public health professionals, addiction specialists and harm reductionists must engage in cross-sector work to ensure all PWID are treated and cured of HCV.

To address this issue, the State Health Department's AIDS Institute, Division of HIV and Hepatitis Health Care's Bureau of Hepatitis Health Care and Epidemiology, convened an *Advisory Group to Address Barriers to Hepatitis C Treatment Access Among People Who Inject Drugs (Advisory Group)* to identify **key strategies NYS needs to implement to markedly increase access to HCV treatment for people who inject drugs.** The Advisory Group met and completed a series of assignments from January – June 2024 to identify these key strategies including policy, funding, strategic partnerships, and care delivery settings. The work of the Advisory Group forms the foundation for this report.

Five top strategies identified by the Advisory Group to Address Barriers to Hepatitis C Treatment Access Among People Who Inject Drugs:

- Support robust and well-funded hepatitis C care coordination, navigation, and peer services in traditional and nontraditional settings.
- Fund substance use disorder treatment programs and harm reduction programs to build capacity and hire staff to provide on-site hepatitis C screening and treatment to all patients.
- Improve Medicaid reimbursement payment and/or financial incentives for treatment and care coordination in primary care, substance use, and other high impact settings.
- Implement active case finding, contact tracing, and linkage to care with the same level of urgency that New York State does for syphilis, tuberculosis, etc., with community input.
- Treat hepatitis C in Opioid Treatment Programs in New York State, including mobile medication units.

Introduction

Hepatitis C virus (HCV) is a significant public health problem nationally and in New York State (NYS). The Centers for Disease Control and Prevention (CDC) estimate 2.2 million people are living with HCV in the United States. However, an estimated 40% of people living with HCV do not know their status.[1] Between 2010 and 2022, 194,375 New Yorkers were diagnosed with HCV, yet only half of these individuals have been treated or cleared their infection.[2] In 2023 among newly reported HCV cases in NYS (excluding New York City), injection drug use was the most commonly reported risk when risk data was available.[3] With the availability of curative direct-acting antiviral (DAA) medications, HCV can be eliminated globally and in NYS. However, it must be a priority to ensure access to treatment among people who inject drugs (PWID).

PWID have the highest burden of HCV, yet they are less likely to be treated for HCV.[4] PWID experience significant barriers in accessing HCV treatment, including stigma,[5] competing priorities, social determinants of health, co-occurring mental and physical health conditions, and the lack of treatment access within their communities.[6] We must do more to get the available lifesaving medications to the people who need them, particularly those who have been disenfranchised and marginalized by traditional healthcare.

The State Health Department and community partners have engaged in significant work to increase the acceptability and accessibility to HCV treatment for PWID. This includes funding several models of care to increase access to HCV treatment, such as integrating HCV treatment into primary care settings with outreach to settings that serve PWID, low threshold models of HCV treatment, and HCV treatment and nurse care coordination in Opioid Treatment Programs (OTPs). Additionally, the State Health Department supports free HCV testing and patient navigation services in high impact settings as well as a learning collaborative focused on increasing testing and linkage to care in outpatient substance use treatment programs and OTPs. NYS has a supportive policy environment for HCV treatment, with no prior authorization or other treatment barriers for people with Medicaid, and state policies supportive of harm reduction, including syringe service programs and drug user health hubs.

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1 Lewis, K. C., Barker, L. K., Jiles, R. B., & Gupta, N. (2023). Estimated Prevalence and Awareness of Hepatitis C Virus Infection Among US Adults: National Health and Nutrition Examination Survey, January 2017-March 2020. *Clinical infectious diseases: an official publication of the Infectious Diseases Society of America*, *77*(10), 1413–1415.

2 Hepatitis C Dashboard New York https://hcvdashboardny.org/ Accessed 12/4/24.

3 New York State Department of Health. Hepatitis B and C Annual Report 2023. https://www.health.ny.gov/statistics/diseases/communicable/docs/2023_hepatitis_b_c_annual_report.pdf Accessed 12/13/24.

4 Hajarizadeh, B., Cunningham, E. B., Reid, H., Law, M., Dore, G. J., & Grebely, J. (2018). Direct-acting antiviral treatment for hepatitis C among people who use or inject drugs: a systematic review and meta-analysis. *The lancet. Gastroenterology & hepatology*, *3*(11), 754–767.

5 Muncan, B., Walters, S. M., Ezell, J., & Ompad, D. C. (2020). "They look at us like junkies": influences of drug use stigma on the healthcare engagement of people who inject drugs in New York City. *Harm reduction journal*, *17*(1), 53.

6 Valdiserri, R.O. To Eliminate HCV Among Persons Who Use Drugs: Embrace the Complexity. *Health Affairs Forefront*, May 15, 2023.

Despite these efforts, more work must be done to eliminate HCV in NYS as discussed in the NYS HCV Elimination Plan.[7]

Establishing the Advisory Group

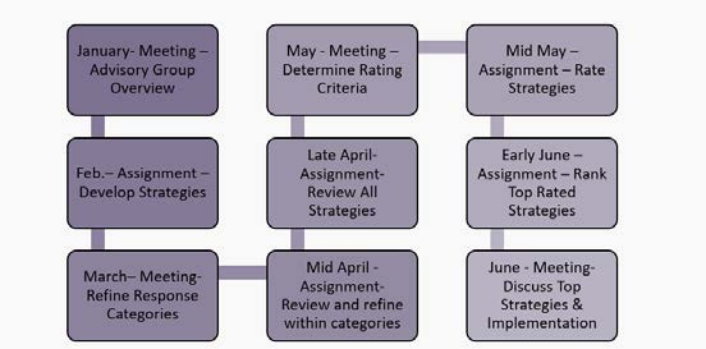
In recognition of the urgent need to develop innovative strategies to increase access to HCV treatment among PWID, a small steering committee of subject matter experts was convened to assist with selecting members for the Advisory Group, ensuring the geographic representation (upstate vs New York City; urban vs rural); a range of expertise; and different service settings (harm reduction, clinical, community-based, drug treatment). It was also important to include people with lived experience. (Attachment A- Advisory Group Membership list).

Advisory Group Processes

The work of the Advisory Group was time limited. All meetings and assignments were conducted during a 6-month period (Fig. 1). From January-June 2024, the Advisory Group members participated in four virtual meetings and completed five assignments (Attachment B- Advisory Group Activity Timeline). An initial framing question (below) was foundational to the work of the Advisory Group and guided all activities. Advisory Group members were instructed to think broadly and innovatively, and include recommendations related to areas such as policy, funding, strategic partnerships, and care delivery settings.

What are key strategies that NYS needs to implement to markedly increase access to Hepatitis C treatment for people who inject drugs?

Figure 1: Advisory Group Processes



The Delphi method,[8] a structured process for reaching consensus among a group of experts, was utilized to generate and prioritize strategies. Core activities of the Advisory Group included:

7 New York State Hepatitis C Elimination Plan https://www.health.ny.gov/diseases/communicable/hepatitis/hepatitis_c/docs/hepatitis_c_elimination_plan.pdf Accessed 12/4/24.

8 Nasa P, Jain R, Juneja D. (2021) Delphi methodology in healthcare research: How to decide its appropriateness. *World Journal of Methodology.* Jul 20;11(4):116-129.

- Generating strategies in response to the initial prompt/question.
- Sorting strategies into categories and subcategories (Attachment C- Categorized Strategy List).
- Refining language and consolidating strategies
- Rating strategies on Actionability/Feasibility and Magnitude of Impact (Attachment D- Rating Assignment Scores; Attachment E- Rating Results: Top 14 Strategies), and
- Ranking strategies in order of importance (Attachment F- Ranking Results: Top Five Strategies).

This process resulted in five key strategies which were presented back to the group, discussed, and agreed upon.

Key Strategies

The following is a list of the top five key strategies recommended by the Advisory Group, along with a summary and key considerations informed by the discussion at the final Advisory Group meeting. Strategies represent a broad range of areas and activities, including essential services, funding, care delivery settings, surveillance, and reimbursement. Several overarching themes were identified in the top five strategies and discussions. These include:

- Sustainable funding is necessary to implement programs that will result in significant changes in treatment access for PWID.

- There is a need for tailored and hands-on capacity building and support for the provision of HCV services. This includes HCV treatment as well as implementation processes, workflows, billing, etc.

- Focused efforts related to client engagement, care coordination and supportive services are essential.

- Ensure access to HCV services in nontraditional settings where PWID already engage for other needs (harm reduction, substance use disorder treatment programs, etc.).

Strategy #1- Support robust and well-funded hepatitis C care coordination, navigation, and peer services in traditional and nontraditional settings.

Clinical care alone will not be sufficient to effectively diagnose and treat PWID in NYS living with HCV. There is a significant need for supportive services such as care coordination, navigation, and peer support to engage PWID through care and treatment and address social determinants of health that may create barriers to accessing healthcare including HCV services. These supportive services are critical whether care is provided in a traditional or nontraditional healthcare setting, although the roles and processes will likely differ based on setting. Advisory Group members discussed the importance of offering services in settings that are easy to access and where PWID are comfortable, supported, and free of stigma. This includes receiving HCV treatment outside of a traditional primary care or hospital setting.

- Key considerations:
    - Funding & cost effectiveness-
        - Organizations that have infrastructure to bill may need support with the practicalities of billing.
        - Organizations not able to bill, such as harm reduction settings, need sustainable and long-term grant funding to support HCV services.

        - The State Health Department should explore ways to demonstrate the long-term cost effectiveness of HCV treatment utilizing navigation, care coordination, and peer services. Showing that these services can save money and/or generate sustainable revenue has the potential to increase investment from healthcare and government.
    - Consider strategies to centralize care coordination and peer-delivered services for multiple sites to benefit.
    - It is essential to incorporate the perspectives and expertise of people with lived experience into care coordination and navigation services.
    - A program-wide emphasis on HCV testing is critical to success.

Strategy #2- Fund substance use disorder treatment programs and harm reduction programs to build capacity and hire staff to provide on-site HCV screening and treatment to all patients.

Offering HCV services such as testing, treatment, and care coordination in settings where PWID already access other services can be more comfortable for patients, minimizing stigma and also fitting more readily into their daily activities.[9] However, while these sites may be ideal in terms of increasing access to services, many do not currently have the infrastructure in terms of staffing, knowledge, resources, or licensing to offer HCV testing, treatment, and care coordination. It is essential to find ways to support organizations, including through funding, to allow substance use disorder treatment and harm reduction programs to have the confidence and ability to provide these important services.[10]

- Key considerations
    - Support is needed from NYS agencies [NYS Office of Addiction Services and Supports (OASAS), State Health Department] and Federal partners [Substance Abuse and Mental Health Services Administration (SAMHSA)] who oversee substance use and harm reduction settings.
    - Providing physical healthcare within a counseling or service-based organization will require a culture shift as well as attention to how state and federal regulations and licensing can support these services.
    - Consider offering capacity building assistance to address areas such as billing, regulations, workflow, and care coordination in these settings in real time using text or other methods.
    - Outreach to bring services to people not currently engaged in harm reduction or substance use disorder treatment is also needed.

9 Muncan, B., Jordan, A. E., Perlman, D. C., Frank, D., Ompad, D. C., & Walters, S. M. (2021). Acceptability and Effectiveness of Hepatitis C Care at Syringe Service Programs for People Who Inject Drugs in New York City. *Substance use & misuse*, *56*(5), 728–737.

10 Taki, S.L. & Roy, L. (2023) Addressing the dual epidemics of hepatitis C and opioid use. https://www.statnews.com/2024/07/16/dual-epidemic-hepatitis-c-opioid-overdose-new-role-for-addiction-treatment-centers/ Accessed 12/4/24.

Strategy #3- Improve Medicaid reimbursement payment and/or financial incentives for treatment and care coordination in primary care, substance use, and other high impact settings.

Reimbursement and financial incentives have the potential to provide a sustainable revenue source for HCV services and may be used to support the other four strategies outlined in this report. Most people living with HCV in NYS are eligible for Medicaid, although there are also individuals covered by employer-based insurance, marketplace plans, Medicare, and the NYS Essential Plan. Increased education and support are needed for settings that are currently able to bill insurance to ensure they are billing appropriately and receiving maximum reimbursement for services provided. Although more difficult to address, there is also a need for an exploration of current reimbursement rates and settings eligible for reimbursement to ensure amounts are sufficient to support and incentivize providers offering HCV services. Currently, services such as care coordination and navigation that are essential to HCV treatment are not reimbursable. Significant work takes place in the early stages of client engagement, particularly with PWID, however, billing is not possible unless the service is offered by a clinician or other billable staff.

Key considerations:

- While NYS has eliminated prior authorization and barriers within Medicaid, providers still report experiencing challenges when billing Medicare and commercial insurance. The State Health Department has limited influence over these types of plans.
- Infrastructure in terms of staffing, knowledge, and electronic medical records are necessary for an agency to effectively bill for services.
- Pharmacy reimbursement is also key, as many pharmacies do not keep HCV medications in stock due to a low profit margin.
- Medicaid innovations such as the 1115 waiver may offer additional opportunities.

Strategy #4- Implement active case finding, contact tracing, and linkage to care with the same level of urgency that NYS does for syphilis, tuberculosis, etc., with community input.

Effective models for case finding and contact tracing exists for other communicable diseases, however resources and infrastructure do not currently exist for HCV. These models have the potential to be effective in finding new HCV cases within PWID communities and linking people to care in a timely manner, further limiting the spread of disease. It may be more effective for trusted community-based organizations to lead contact tracing efforts, because individuals with HCV may be more difficult to contact using traditional methods such as phone calls and letters. There may also be opportunities to utilize technology such as shared databases and client tracking systems to coordinate among care delivery settings, jails, shelters, and labs, although this would require additional resources.

Key considerations:

- Contact tracing is resource intensive. It may be necessary to focus on new “acute” HCV infections or to prioritize contact tracing activities.
- Community input is important when it comes to surveillance activities, particularly among vulnerable populations.
- Consider creation of a centralized database that includes information about previous genotype and HCV treatment history.

Strategy #5- Treat hepatitis C in Opioid Treatment Programs in New York State, including mobile medication units.

A significant portion of clients in OTPs have HCV infection, making this an ideal setting for onsite HCV screening and treatment. In NYS, among clients discharged in 2023 from NYS OASAS certified OTPs, 45% indicated a history of injection drug use. Current OASAS regulations require the offer of HCV screening at admission and annually. However, this does not ensure all clients receive testing as clients may decline testing or it may be offered by referral offsite increasing the likelihood the clients are never tested. Despite national and NYS HCV clinical guidelines recommending HCV treatment among current and former PWID, many OTPs do not treat onsite due to lack of sufficient infrastructure such as staffing, training, and capacity to bill for services.[11] According to a 2022 survey conducted by the Bureau of Hepatitis Health Care and Epidemiology of OASAS certified OTPs, 37% were offering HCV treatment onsite (up from 18% in 2017). An additional 34% indicated that they were interested in providing treatment onsite. The primary needs identified for programs to increase on site treatment capacity included financial support, staff training, and staffing to provide care coordination and treatment. More can be done to ensure accountability with testing as well as to support programs in providing onsite treatment, which has the potential to increase adherence and cure rates.

Key considerations:

- OASAS plays a key role in supporting HCV prevention, onsite HCV testing, and onsite treatment, with an emphasis on evidence-based interventions.
- Onsite HCV screening is very important - patients should leave the OTP knowing their HCV status and next steps.
- Challenges to providing HCV testing onsite at OTPs include staffing shortages, limited phlebotomy availability, lack of testing supplies, Electronic Medical Record (EMR) training needs, and understanding processes regarding specimen transport.
- More education and support are needed for OTPs to bill for HCV services, which could result in additional revenue for staff and supplies.
- Recently implemented OTP mobile medication units provide a unique opportunity to reach key populations with HCV services in their communities.

Discussion

Increased access to HCV testing, treatment, and cure for PWID is a critical public health and social justice issue. The work of the Advisory Group resulted in a detailed and comprehensive list of strategies and implementation ideas. These strategies must be advanced through additional planning efforts, policy implementation, and funding. NYS is and can continue to be a leader in national HCV elimination efforts by championing work that addresses the needs of PWID in a compassionate, patient centered, and effective way.

Attachments

- Attachment A- Advisory Group Membership List
- Attachment B- Advisory Group Activity Timeline

11 AASLD-IDSA. Recommendations for testing, managing, and treating hepatitis C. http://www.hcvguidelines.org. Accessed 12/4/24.

- Attachment C- Categorized Strategy List
- Attachment D- Rating Assignment Scores
- Attachment E- Rating Results: Top 14 Strategies
- Attachment F- Ranking Results: Top Five Strategies

Acknowledgements

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We would also like to thank all the Advisory Group members for the time, effort, expertise, and enthusiasm they invested in this process.

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Julia Hunter	United Health Services
Nirah Johnson	New York City Department of Homeless Services
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Lauren Walker	Clinical Education Initiative

Additional Participants (non-voting)

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Peggy Elmer	New York State Department of Health AIDS Institute
Colleen Flanigan	New York State Department of Health AIDS Institute
Clemens Steinbock	New York State Department of Health AIDS Institute

Framing Question and Guidance:
In your opinion, what are five strategies that New York State (NYS) needs to implement to markedly increase access to hepatitis C treatment for people who inject drugs?*
*[*NYS can include government agencies, funders, policy makers, providers, and impacted communities]*

Think broadly and innovatively. Your recommendations can include policy areas, future funding, strategic partnerships, care delivery settings, specific NYS regions, education strategies, etc.

Meeting #1	**Set the tone and direction for the advisory group** Introduction and overview of group, including timeline, topics of each meeting and homework, common terms/definitions. Outline expectations for Advisory Group participants. Review group membership and who is potentially missing, who has voting rights. Guest speakers: - Panel of people with lived experience to drive home importance and purpose of the group, raise important themes. - Content presentation to create shared knowledge base and terminologies, mobilize group.
Assignment #1	**Brainstorm open-ended responses by each participant in response to framing question** Participants have one week to provide five strategies in response to initial framing question. Conveners review & interpret responses, organize into distinctive response categories & subcategories. Send initial report out to group prior to second meeting.
Meeting #2	**Reach consensus of response categories** Present categorized responses to group, confirm that strategies were accurately included. General discussion/clarification of categories and subcategories. Assign Advisory Group members to breakout rooms to review specific categories; review and verify the categories and strategies; regroup strategies if needed; add additional strategies if needed based on discussion. Determine and clarify wording of categories; find consensus (not wordsmithing). Group includes facilitator, notetaker, and reporter who reports back from breakout group to the larger group. Conveners review notes from breakout groups, use to create new, further refined list of strategies and categories. Edit strategies to be of similar length and sentence structure.
Assignment #2	**Revise responses for each category (within small groups)** Each group member has one week to review the updated strategies and categories for the small group that they participated in during Meeting #2 (also receive small group notes). Main focus of review- is wording clear? For next step it is essential that all group members understand all strategies. Conveners review Assignment #2, create updated strategy document.

Assignment #3	**Review all strategies** All Advisory Group members receive a document listing all strategy and categories, ask to read fully and consider strategies so they are prepared for discussion at upcoming meeting and, ultimately, ranking. Conveners hold virtual "office hours" where Advisory Group members can log on to discuss strategies or ask questions; can also submit questions via email.
Meeting #3	**Agree upon rating/ranking system and criteria** Present and discuss final categories and strategies. Conveners present 2-3 pre-developed rating and ranking criteria and definitions; group discusses and comes to consensus on criteria (can suggest changes or additions).
Assignment #4	**Rate strategies within each category** Group members rate each strategy on a scale of 1 (least) to 5 (most) for each agreed upon criteria- magnitude of impact and actionability/feasibility. Conveners calculate averages (individual criteria and combined), review and discuss scores. Develop system to pull out top rated 2-3 strategies from each category.
Assignment #5	**Rank top rated strategies to determine overall top five** Group members receive list of top 10-15 strategies based on results of Assignment #4. Select top five and rank these from most important to least important. Conveners create report based on ranking scores, highlighting top five strategies, share with group.
Meeting #4	**Consensus on top strategies, discuss implementation** Present results of 5th homework assignment, top strategies. Group discussion- did this process result in the "correct" top five? Implementation discussions focused on each of the top five strategies. Thank Advisory Group members for their work.

QUESTION: In your opinion, what are five strategies that New York State needs to implement to radically increase access to hepatitis C treatment for people who inject drugs? Think broadly and innovatively. Your recommendations can include policy areas, future funding, strategic partnerships, care delivery settings, etc.

CONDUCT PROVIDER EDUCATION AND CAPACITY BUILDING ACTIVITIES

Increase provider capacity.

1. Get more providers on board with treating hepatitis C virus (HCV).
2. Educate providers to begin treatment without Fibro-sure result prior to treatments and review the result later; review the minimum lab requirements for treatment which will help when clients are "hard draw" and unable to give enough blood; provide this information to HCV providers.
3. Increase access. Create a cohort of physicians who can use a shared slide deck to deliver high-quality, evidence-based education about HCV and its treatment to all medical schools and residency programs in New York State (NYS).
4. Partner with individual providers to blast the healthcare system to create visuals that help break stigmas associated with interferon.
5. Increase access. Develop a Project ECHO (Extension for Community Health Outcomes) for outpatient substance use disorder programs in general or opioid treatment programs (OTPs) specifically to build HCV provider capacity and overcome logistical and other treatment barriers.
6. Offer HCV treatment implementation teams through the NYS Department of Health or Office of Addiction Services and Supports (OASAS). Their goal would be to provide technical assistance to treatment programs as they try to work through the stages of developing an HCV Treatment program - training providers, setting up lab ordering, Electronic Medical Record (EMR) issues, pharmacy relationships.

Increase provider educational activities.

7. More education to non-specialist providers about HCV.
8. Make training in the testing/treatment of HCV mandatory for all NYS licensed physicians and advance-practice providers (‘*like is done for pain*’).
9. Expand provider education to promote streamlined (minimal monitoring) approach to HCV treatment to reduce appointments and unnecessary blood work and radiology visits for non-cirrhotic patients. Unnecessary blood work and radiology visits or off-site testing is a barrier to HCV treatment for people who inject drugs (PWID).
10. Work to incorporate HCV evaluation and treatment in primary care residency programs and fellowships.
11. Strengthen clinical capacity (i.e., human resources for health) to deliver HCV screening, care and treatment at OTPs.
12. Need more engagement with both obstetrics and pediatrics in terms of education regarding screening and treatment. Would also identify champions from these disciplines to have leadership roles on advisory committees.

Decrease stigma.

13. More funding and education aimed towards stigma reduction and the lack of trust PWID have in the health care system.
14. Target providers so that they treat people living with HCV as they would any other patient. More anti stigma work.
15. Provide safe non-stigmatizing environments for PWID to get screened, tested and treated.

CONDUCT CLIENT AND COMMUNITY EDUCATION ACTIVITIES

Provide educational activities targeting young adults.

1. NYS should expand culturally competent programs designed to reach young PWID.
2. High schools: Junior high school students in the seventh and eighth grades may be more in tune with the drug problems. I would venture to say that the lower would also be in tune but there is a possibility of push back from some parents. I believe that there would be less push back about HCV for the upper grades than the lower. Small groups could be held within a particular class. Some teachers might be interested in receiving training on how to broach the topic without making students feel uncomfortable. Some may not want to disclose in front of the entire class but if the topic is approached in a non-threatening manner, e.g., providing phone number just in case the student may know or want to talk to someone.
3. Some high school students may be more comfortable discussing the issue with some of their peers or may choose to talk with a prevention counselor if they are fortunate to have one or more in their school, others may choose to write something and hand it in at the end of the meeting. It's all in how the teachers know or understand their students.
4. Higher Education Institution. Given the current state of drug overdoses and deaths educational institutions, such as high schools and colleges would be ideal for getting the word out and possibly getting some young people into treatment. Some may be walking around with the "big secret' that someone in their family is using or may be using, a friend or someone they know or the actual student his or herself. This is particularly true with the Black and Hispanic communities. Secrets are kept for fear of shame embarrassment or fear of rejection. High schools and colleges are prime contenders for inserting information into their world. Having a non-threatening social gathering and incorporating a message about HCV would encourage students to talk among themselves or family. Literature about where someone can go for testing or having a mobile unit in front of the institution on a given day for anyone who would like to be tested or have a nurse available for blood donations and offer HCV testing as well.

Conduct client and community educational activities.

5. Partnering with education systems to educate from young ages.
6. Education about direct acting antiviral (DAA) medications and their benefits.
7. More ways to get the message out about the dangers of HCV.
8. Educate widely that the new treatments are easy and work.
9. Integrate consumer-facing education materials (more than just brochures; more "exciting" things like stickers, buttons, others?) into existing and planned state-wide

harm reduction initiatives, vending machines in particular. Expand beyond New York City (NYC).
10. Continuous education regarding reinfection.
11. Hold monthly educational seminars in community meetings.
12. Give real reasons on why it is so important to be tested. Also, why they should get on the medications.
13. Promote HCV treatment in opioid treatment and other substance abuse programs.

Initiate a campaign.

14. Conduct a Marketing Campaign that HCV treatment is not optional/choice from the provider perspective ('*would you let your doctor withhold breast cancer treatment?*').
15. Reactivate a Know Your Status campaign.
16. Partner with community activists/officials to spread awareness (campaign).
17. Statewide public campaign with media advertising.

INTEGRATE HCV SERVICES INTO SUBSTANCE USE DISORDER TREATMENT PROGRAMS

1. Mobile medication units (MMUs): It has become increasingly dire. It is for this reason that I immediately thought of the HIV Early Intervention Services (EIS) providers and the MMUs. Thus far these units are connected to OTPs but also allow for people who live in areas where there are very few if any type of service for opioid addiction or HCV without travelling long distances. With the MMUs there is more chance of reaching a larger number of people in need of treatment and HCV testing services. More importantly both needs would be met within one location with a medical staff on board. Presently there are two mobile units in NYC and eleven more are planned. These units will be provided throughout the state. The units would be able to provide dispensing as well as HCV testing.
2. Work with OASAS! Methadone maintenance (MMT) programs should be treating HCV.
3. Work with MMUs.
4. Increase testing. Advise OASAS to revise their PART 822 General Service Standards for Substance Use Disorder Outpatient Programs (which cover OTPs and other outpatient clinics) to recommend annual testing for HCV. Currently, testing for HCV is only recommended on program admission.
5. HIV EIS Providers: There are fifteen providers who are funded by OASAS to conduct HIV testing and referral. Initially these providers were funded by Substance Abuse and Mental Health Services (SAMHSA) because New York was classified as an at-risk state. Since that time, we were hit by Covid, and OTPs were not as open to letting these providers come in test. With some creativity several of the providers began providing information and educational groups. On one hand these offerings seemed to get the attention helped encourage some patients to get tested. On the other hand, some other OASAS certified programs decided to start testing on their own. Within the EIS providers there are some who have street outreach experience and would be invaluable to getting hard to reach people to consider getting tested. Currently there are a few, Probably four who are testing for the NYS Department of Health. Since that time to the best of my knowledge no one else has volunteered to test for HCV.

6. OASAS needs to push the addiction clinics to enforce mandatory screening. This will likely need to involve incentives/disincentives for proper screening (i.e., reflex testing).
7. Decrease transmission. Recommend that OASAS provide financial, educational, and technical support for existing programs to add Second-Tier Syringe Exchange Programs to their services.
8. Make money available to OTPs and rehabs to partner with providers who treat HCV.
9. In many high impact settings, such as substance use treatment programs, PWID and people who are living with HCV have providers who know their status but see HCV treatment as “optional.” NYS should encourage medical directors of substance use treatment programs to provide timely HCV treatment initiation or linkage to care for patients who are known to be HCV positive.
10. Expand detox-based treatment programs.
11. Pair methadone dispensing with HCV treatment.
12. Establish a system to track referrals for HCV screening and treatment for people at substance use programs where onsite care is not available.

EXPAND HCV SERVICES IN CORRECTIONAL SETTINGS

1. Carceral community partnerships to facilitate linkage to care.
2. Expand HCV screening and treatment in correctional settings. Require jails, prisons and re-entry programs to provide HCV screening, linkage to care, and continuity of care for people newly released from correctional facilities.
3. More effective treatment opportunities for individuals in systems such as jails/prisons/long term treatment.
4. Engagement with local jails to start a "screen on the way out" strategy and utilization of peers/community health workers to facilitate linkage.

INTEGRATE HCV SERVICES FOR PERSONS UNHOUSED OR UNSTABLY HOUSED

1. Support a new HCV navigation program at the NYC Department of Homeless Services (DHS) to conduct outreach and linkage to treatment system wide.
2. Expand HCV screening and treatment for people who are unstably housed or unhoused and living with HCV. NYS should support efforts to co-locate health care services, including the capacity for HCV screening and testing, in homeless shelters. Establish referral and communication platform between HCV treating providers and shelters to follow up on patients. Establish housing programs for people with HCV who are unhoused without punitive measures if they are actively using drugs. NYS should also support street medicine models that provide HCV care and treatment for PWID who are unhoused.

EXPAND HCV SERVICES IN PRIMARY CARE SETTINGS

1. Provide additional grant funding to develop HCV treatment programs including case management in federally qualified health centers (FQHCs) and other health centers.
2. Promote HCV treatment in primary care (where most patients who inject drugs are treated).
3. Funding to care providers who serve the population who used drugs via injection.
4. More primary care programs with HCV champions and treatments.

5. Primary Care Physicians (PCPs) often encounter clients in need of HCV treatment, clients report either stigma, discrimination, long wait times for appointments and lack of support preventing treatment. Create funding for clinical or navigator support in PCP offices. PCP also would benefit from hands on visits to syringe service program (SSP) sites or with a navigation program.

WORK WITH OTHER HIGH-IMPACT SETTINGS

1. NYS should explore approaches to expand HCV screening, rapid start HCV treatment, and linkage-to-care for treatment and harm reduction services for PWID in emergency department (ED) settings.
2. Conduct outreach at EDs and harm reduction agencies for HCV rapid testing.
3. ED-based/hospital-based screening and treatment initiation
4. Require hospitals to start HCV meds on patients while they are hospitalized and prescribe on discharge.
5. Expand on-site capacity to screen for and treat HCV at high impact settings commonly accessed by PWID, such as substance use treatment and harm reduction programs. NYS should ensure that all substance use treatment centers and harm reduction programs have the capacity to provide on-site HCV screening and treatment to all patients—or can successfully refer patients for treatment. Many substance use treatment programs were established as behavioral health programs and have limited medical capacity. This strategy should include new funding for participating programs to expand medical capacity, peer and patient navigation services, and point of care testing and treatment, as well as additional resources for capacity building, clinical education, and monitoring and evaluation.
6. De-centralized care delivery. HCV care in mobile units, within MMTs, homeless shelters or locations where safe injection is monitored.
7. Fund drug user health hubs appropriately so providers are available.
8. Integration of HCV services in high impact places where PWID congregate. .
9. Promote and finance HCV evaluation and treatment during inpatient stays, rehab, and incarceration with linkage to HCV treatment when discharged from those settings.
10. Enhanced efforts to create more "medical homes" where HCV treatment can be co-located with drug user health..
11. Have conversations with the NYC Department of Health and Mental Hygiene to expand their sexual health clinics to include drug user health.
12. HCV treatment at medication for opioid use disorder (MOUD) programs.
13. Go where the drug users are, OTPs, EDs, harm reduction agencies, SSPs, etc.

IMPLEMENT LOW THRESHOLD HCV SERVICE MODELS

1. Establish and expand a rapid initiation test and treat model, including starter packs of HCV Direct Acting Antiviral medications (DAAs), for HCV treatment in traditional care delivery and high impact settings. Rapid initiation of HCV treatment has been shown to increase sustained virologic response (SVR) rates among young PWID, when compared with usual care. (Citation: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9272437/). Due to short lengths of stay in high impact settings, such as homeless shelters, substance use treatment programs, and reentry programs, rapid initiation HCV treatment, along with peer and care navigation services for PWID, can markedly improve initiation of

treatment and SVR rates. NYS should also explore aligning HCV DAA clinical guidelines with the guidelines for rapid initiation of HIV antiviral treatment. (Citation: https://www.health.ny.gov/diseases/aids/providers/treatment/ria.htm)
2. Establish state-managed mobile screening and treatment option; target priority regions (areas with high prevalence, areas where people who use drugs congregate).
3. Mobile treatment going out into the community/take the treatment to them.
4. Make screening, testing and treatment as low threshold as possible.
5. Increase staffing for "walk in" service to begin the HCV treatment process. My best practice when a client takes the time to inquire is to stop and meet then. This again shows individual personalized care as the client-Navigator relationship begins, clients do not experience this from providers in the past.
6. HCV mobile units-- rural and city PWID.
7. When federally approved, incorporate point-of-care ribonucleic acid (RNA) testing into state-level policies. Prioritize non-traditional healthcare settings for implementation.
8. Immediate starts (can NYS buy a certain amount of HCV meds?).
9. Help streamline the process for navigating through care - Test/confirm/medication can be done with greater efficiency.
10. Community based directly observed therapy (DOT) care locations for individuals who don't have a secure place to keep their medications and can come daily or weekly for HCV medication.
11. Expansion of pharmacist- and nurse-led testing and treatment initiatives

UTILIZE TELEHEALTH TO IMPROVE ACCESS TO HCV TREATMENT

1. Establish state-wide telehealth network to link telehealth sites with treatment providers.
2. Create a request for applications (RFA) for telemedicine to address OTPs and rehabilitation facilities that are identifying but not treating HCV.
3. Improve outreach to PWID through telemedicine.
4. Improve telemedicine processes (e.g., transportation support for laboratory testing) for patients/clients of substance use disorder treatment programs, SSPs or health hubs.
5. Increase access. Expand treatment to jail settings through the use of telehealth, care coordinators, and a network of providers who can continue medications upon release.
6. Expansion of peer + telehealth medical treatment.
7. Create a centralized telemedicine program to serve participants of inpatient drug treatment programs, SSPs, OTPs, shelters, and other settings where traditional referrals may be insufficient.

DEVELOP AND IMPLEMENT BILLING AND REIMBURSEMENT MODELS THAT SUPPORT HCV

1. All 1st line DAA medications without need for prior authorization and insurances mandated to cover.
2. Help reduce barriers to prior authorization for primary care physicians and non-physician clinicians (some commercial insurances still deny prior authorization to non-specialists).
3. Reimbursement needs to be increased/dealt with for HCV- so that OTP, primary care wants to do this.
4. Eliminating Prior Authorizations for retreatment.

5. Ongoing work with insurance providers to take away barriers preventing PWID accessing treatment.
6. Availability of DAAs without cost.
7. Improve Medicaid reimbursement payment for HCV treatment and/or HCV-related care coordination.
8. Expand the NYS HCV Patient Assistance Program (HepCAP) by adding additional sites in NYC.
9. Remove prior authorization barriers to re-treatment.
10. Makes point of care HCV testing widely available (including pharmacies) by having NYS cover the costs of the tests and/or ensure adequate reimbursement for when tests are performed the cost of the medication is making it difficult to stock DAAs - yet to make treatment easier we need most pharmacies to be able to fill.
11. Uninsured program – e.g., AIDS Drug Assistance Program (ADAP), Buprenorphine Assistance Program (BUPE-AP).
12. Provide reimbursement for participation in future research (especially among recently incarcerated individuals, PWID, people experiencing homelessness).
13. Offer financial incentives through a billing code for treating HCV (like is done for smoking cessation or depression screening).
14. Incentives for primary care doctors to treat HCV.
15. Incentivize (or un-disincentivize?) MMTs to test for HCV, evaluate HCV on-site, and dispense HCV-medications for treatment.
16. Develop reimbursement for HCV treatment in all OASAS regulated addiction treatment programs - “detox/rehab, intensive outpatient, OTPs”.
17. Offer reimbursement per visit to OTPs specifically for treating HCV on site.
18. Incentivize/fund methadone clinics to treat their patients.

ENHANCE HCV CLIENT OUTREACH, NAVIGATION, AND SUPPORT SERVICES

Engage peers and build navigation & outreach activities.

1. Client communication, provide phones with data for 6 months until cure. Personally, I use my cell and have over 1,100 client contacts where I always answer the phone. As part of a medical team provide 24-hour availability, clients have never received this type of support which benefits HCV care cascade and improve quality of life. Provide funding for this service to maintain relationships is essential.
2. Peers as part of the care team.
3. Expand culturally and linguistically responsive peer and patient navigation and care coordination services for PWID, particularly in communities with low engagement in HCV care. Explore opportunities to allocate NYS funding for community programs and Medicaid and Medicare reimbursement for Community Health Worker services.
4. Navigators that can do direct community outreach including street outreach and going to NYC DHS shelters.
5. Having more people with lived experience working with the clients.
6. Expanded peer education with state guidance/support on policies, protocols.
7. Utilize peers in harm reduction settings to help patients engage in and navigate treatment.
8. Street Outreach Workers.

9. Identify the locations (geographical) and increase targeted outreach through harm reduction programs with more funding available to make the outreach efforts sustainable.
10. Conduct decentralized (community/street-based) confirmatory testing.
11. Person Centered client relationship trainings and surveys for navigators and providers.
12. Care coordination services post discharge from detox/rehab or hospitalization to assist in getting HCV meds to patients (i.e., provider writes prescription, care coordinator follows up to make sure patient gets the meds, assists with PAs or delivery issues if they don't).

Provide client incentives.

13. Offer incentives (financial or otherwise) to any patient completing HCV treatment with extra reimbursement for SVR12 testing/results.
14. NYS should support access to HCV treatment for PWID by providing funding for transportation, meals, other basic needs, and unrestricted benefits (in other words, incentives that are not gift cards to specific vendors) to incentivize ongoing engagement in treatment.
15. Routine sites for clients at risk being SSPs, OASAS, MOUD, release from incarceration, homeless and shelters. The common denominator being the client, suggest incorporating clients to refer their peers/friends and offering incentives for promoting the program. Also funding for "Community Advisory Board" meetings, this will allow for real life suggestions and barriers experienced. Also provide funding to hold and provide incentives to participants who have been treated, need treatment this would be a platform to provide information to enhance the programs.
16. Financial incentives for patients to achieve cure and stay free of re-infection.

ENHANCE HCV DATA AND SURVEILLANCE ACTIVITIES TO SUPPORT HCV TESTING, LINKAGE TO CARE AND TREATMENT

1. Implement active case finding, contact tracing, and linkage to care with the same level of urgency that we do for syphilis, tuberculosis, etc.
2. Universal statewide reported positive and negative HCV viral load surveillance.
3. Support data match between DHS client registry and NYC Department of Health and Mental Hygiene surveillance data to identify people HCV RNA positive in need of treatment.
4. Engagement with Medicaid and commercial payors to utilize Artificial Intelligence or another modality to identify members who have been screened but not linked for treatment. Demonstrate the economics and immediate cost savings related to identification of these individuals and treatment initiation.

IMPROVE HEALTH SYSTEMS TO SUPPORT HCV

1. Work with commercial labs and payors (Medicaid specifically) to eliminate the ability to order standalone HCV antibody testing and promote reflex testing.
2. Support health care facilities serving communities with a high prevalence of PWID to build HCV treatment capacity, by implementing changes to EMR systems, integrating order sets, and making other clinical workflow changes to improve treatment and cure rates.

3. Develop statewide database through pharmacy records and laboratories to track prescriptions for HCV treatment and reaches out to prescribers about status of prescriptions and allows prescribers to get data to inform progress/status/history .
4. Universal opt-out testing EMR prompts.

MISCELLANEOUS

1. Aftercare so people don't get re-infected.
2. Similar to Egypt national elimination plan - collaboration from government, other civil society organizations, and pharma companies to increase screening and delivery of treatment.
3. NYS should remove barriers to retreatment for HCV for PWID and people with substance use disorder. Current barriers may include policy or paperwork barriers or hesitancy among providers to retreat a patient for HCV.
4. NYS should encourage approaches to retreatment that connect patients with additional health, mental health, substance use treatment, and harm reduction services.
5. On an annual basis, NYS should partner with city and county health departments and community providers in traditional care delivery and high impact settings to identify the top drivers of retreatment to develop interventions to improve the HCV prevention and care system. Develop and disseminate to health care facilities a protocol for following up at regular intervals with patients cured of HCV who are at ongoing risk of exposure to HCV to help prevent reinfection and navigate patients to needed social services.
6. Normalize testing so getting an HCV test is not stigmatizing.
7. Decriminalize drug use and use the savings to pay for better HCV services. As long as you're asking!
8. Work on safe supply issues.
9. Pharmacy mail order for rural.
10. Development of point of care assay for HCV.

Advisory Group to Address Barriers to Hepatitis C Treatment Access Among People Who Inject Drugs
Attachment D- Rating Assignment Scores

Strategy	Impact Avg.	Actionability Avg.	Combined Avg.
IMPEMENT CLIENT-CENTERED AND LOW THRESHOLD HCV SERVICE MODELS			
Establish and expand a hepatitis C rapid test and treat initiation model in traditional care delivery systems and high impact settings.	4.41	3.64	4.02
Establish a state-managed mobile hepatitis C screening and treatment program targeting priority populations and regions.	3.86	3.48	3.67
Incorporate point-of-care hepatitis C confirmatory RNA testing into state-level policies with focus on nontraditional healthcare settings.	4.39	3.61	4.00
Expand pharmacist-led hepatitis C testing and treatment initiatives in community and chain pharmacies.	3.09	2.77	2.93
Support robust and well-funded hepatitis C care coordination, navigation, and peer services in traditional and nontraditional settings.	4.35	4.00	4.17
Fund transportation, meals, and other basic needs to incentivize ongoing engagement in hepatitis C treatment and address social determinants of health.	3.52	3.04	3.28
Fund Consumer Advisory Board meetings to increase engagement and gain additional information on real life experiences, recommendations, and barriers.	3.04	3.91	3.48
CONDUCT PROVIDER EDUCATION AND CAPACITY BUILDING ACTIVITIES	**Impact Avg.**	**Actionability Avg.**	**Combined Avg.**
Expand and promote access to provider training resources statewide, including education on how to provide low threshold treatment.	3.43	4.09	3.76
Utilize a cohort of physicians to deliver ongoing high quality, evidence-based hepatitis C education (such as the clinical education initiative (CEI)).	3.48	4.26	3.87
Develop a Project ECHO (telementoring) for priority settings to build hepatitis C provider capacity.	3.57	3.65	3.61
Create hepatitis C treatment implementation teams to provide technical assistance to develop a hepatitis C treatment program in priority settings.	4.09	4.04	4.07
Engage obstetrics and pediatrics providers regarding hepatitis C screening and treatment.	3.39	3.26	3.33
Support health care facilities in high prevalence communities to build hepatitis C treatment capacity through clinical workflow changes (electronic health records,	3.70	3.52	3.61
Incorporate hepatitis C into all New Yorks State medical schools, advanced practice providers schools, primary care residency programs and fellowships and other non-	3.91	3.57	3.74

top 2 combined avg. in category

top 15 impact avg.

top 15 actionability avg.

top 15 combined avg.

top impact avg. in category, not already included

highest impact avg. of strategies in top 15 across all three criteria

Make training in the testing/treatment of hepatitis C mandatory for all NYS licensed physicians and advanced practice providers.	3.96	3.22	3.59
Identify champions from across prioritized disciplines to have leadership roles on advisory committees.	3.39	3.61	3.50
Partner with healthcare providers to create educational materials that help break stigmas associated with having and treating hepatitis C.	3.22	3.78	3.50
Develop criteria and an assessment tool to help create a safe non-stigmatizing environment and use it to evaluate sites providing care to people who inject drugs.	3.13	3.39	3.26

CONDUCT CLIENT AND COMMUNITY EDUCATION ACTIVITIES	**Impact Avg.**	**Actionability Avg.**	**Combined Avg.**
NYS should expand culturally competent programs designed to reach young people who inject drugs.	3.96	3.43	3.70
Integrate innovative/exciting consumer-facing education materials into existing and planned state-wide harm reduction initiatives, such as vending machines.	3.70	3.83	3.76
Hold educational seminars in non-medical community settings (community centers, religious centers, local health departments, health fairs, etc.).	3.04	3.78	3.41
Launch a statewide public campaign with media advertising to prioritized communities; partner with community activists and officials to promote.	3.70	3.70	3.70
Conduct a Marketing Campaign that HCV treatment is not optional/choice from the provider perspective (‘*would you let your doctor withhold breast cancer treatment?’*).	3.78	3.87	3.83

EXPAND HCV SERVICES IN HIGH IMPACT SETTINGS	**Impact Avg.**	**Actionability Avg.**	**Combined Avg.**
Require jails, prisons and re-entry programs to provide hepatitis C screening, linkage to care, peer support, and continuity of care for people newly released from correctional facilities.	4.70	3.52	4.11
Expand hepatitis C screening, treatment, and coordination for people who are unstably housed or unhoused and living with hepatitis C.	4.39	3.22	3.80
Provide additional grant funding to develop hepatitis treatment programs including navigation and case management to be made available to patients who use drugs and who are treated in	3.87	3.57	3.72
Expand screening, rapid start treatment, and linkage-to-care and harm reduction services in emergency room and other hospital-based settings.	4.13	3.30	3.72
Require hospitals to start hepatitis C medications on patients while they are hospitalized and prescribe on discharge.	3.86	2.68	3.27
Fund substance use treatment centers and harm reduction programs to build capacity and hire staff to provide on-site HCV screening and treatment (or linkage to care) to all patients.	4.48	3.87	4.17

Fund drug user health hubs appropriately to allow health care providers to be available to treat hepatitis C.	4.65	3.74	4.20
Co-locate hepatitis C and substance use treatment with obstetrical care.	3.52	2.96	3.24
Expand sexual health clinics to include drug user health and hepatitis C testing, linkage to care, and treatment.	3.87	3.48	3.67

INTEGRATE HCV SERVICES INTO SUBSTANCE USE DISORDER TREATMENT PROGRAMS	**Impact Avg.**	**Actionability Avg.**	**Combined Avg.**
Treat hepatitis C in Opioid Treatment Programs in New York State, including mobile medical units.	4.78	3.70	4.24
Advise NYS Office of Addiction Services and Supports to revise General Service Standards for Substance Use Disorder Outpatient Programs to require onsite annual testing for hepatitis C.	4.35	3.96	4.15
Fund navigators or care coordinators in substance use disorder treatment programs to support hepatitis C linkage to care.	4.23	4.14	4.18
Employ Implementation Teams to set up hepatitis C clinics within Opioid Treatment Programs.	4.26	3.22	3.74
Establish a hepatitis C testing quality indicator to be monitored during annual field audits to substance use treatment programs.	3.86	3.73	3.80
Allow NYS Office of Addiction Services and Supports Early Intervention Specialist providers to provide hepatitis C testing.	3.96	3.96	3.96
Recommend NYS Office of Addiction Services and Supports provide financial, educational, and technical support for existing programs to become Second-Tier Syringe Exchange Programs.	3.61	3.30	3.46
Expand hepatitis C testing and treatment in inpatient substance use treatment programs.	4.43	3.83	4.13

ENHANCE SYSTEMS TO IMPROVE ACCESS TO HCV TREATMENT	**Impact Avg.**	**Actionability Avg.**	**Combined Avg.**
Establish a centralized state-wide telehealth network to link clients from high impact settings with clinical care, including supportive services.	4.22	3.39	3.80
Improve Medicaid reimbursement payment and/or financial incentives for treatment and care coordination in primary care, substance use, and other high impact settings.	4.30	3.30	3.80
Implement active case finding, contact tracing, and linkage to care with the same level of urgency that NYS does for syphilis, tuberculosis, etc., with community input.	4.26	3.39	3.83
Support data match between relevant data sources and NYC/NYS surveillance data to identify people HCV RNA positive in need of treatment.	4.22	3.35	3.78

Use data to identify geographical locations and increase targeted outreach through harm reduction programs with sustainable funding.	3.70	3.30	3.50
Work with commercial labs and payors (Medicaid specifically) to eliminate the ability to order standalone HCV antibody testing and require reflex testing on the same specimen used for	4.09	3.78	3.93
Develop statewide database using pharmacy records and laboratories to track prescriptions for HCV treatment and update prescribers about status of prescriptions.	3.57	3.13	3.35

Framing Question: In your opinion, what are key strategies that New York State needs to implement to markedly increase access to hepatitis C treatment for people who inject drugs? Think broadly and innovatively. Your recommendations can include policy areas, future funding, strategic partnerships, care delivery settings, etc.

Top 14 Strategies, June 3, 2024

1. Establish and expand a hepatitis C rapid test and treat initiation model in traditional care delivery systems and high impact settings.

2. Support robust and well-funded hepatitis C care coordination, navigation, and peer services in traditional and nontraditional settings.

3. Utilize a cohort of physicians to deliver ongoing high quality, evidence-based hepatitis C education (such as the clinical education initiative (CEI)).

4. Create hepatitis C treatment implementation teams to provide technical assistance to develop a hepatitis C treatment program in priority settings.

5. Integrate innovative/exciting consumer-facing education materials into existing and planned state-wide harm reduction initiatives, such as vending machines.

6. Conduct a Marketing Campaign that hepatitis C treatment is not optional/choice from the provider perspective ('*would you let your doctor withhold breast cancer treatment?*').

7. Fund substance use treatment centers and harm reduction programs to build capacity and hire staff to provide on-site hepatitis C screening and treatment to all patients.

8. Fund drug user health hubs appropriately to allow health care providers to be available to treat hepatitis C.

9. Treat hepatitis C in Opioid Treatment Programs in New York State, including mobile medication units.

10. Fund navigators or care coordinators in substance use disorder treatment programs to support hepatitis C linkage to care.

11. Implement active case finding, contact tracing, and linkage to care with the same level of urgency that NYS does for syphilis, tuberculosis, etc., with community input.

12. NYS should expand culturally competent programs designed to reach young people who inject drugs.

13. Require jails, prisons and re-entry programs to provide hepatitis C screening, linkage to care, peer support, and continuity of care for people newly released from correctional facilities.

14. Improve Medicaid reimbursement payment and/or financial incentives for treatment and care coordination in primary care, substance use, and other high impact settings.

Methodology for arriving at top 14 strategies:

- All active advisory group participants responded to the rating survey in May 2024. Participants rated each of 47 strategies using two criteria: “Magnitude of Impact” and “Actionability/Feasibility.”
- Each strategy received three summary scores:
    - Average “Magnitude of Impact” score.
    - Average “Actionability/Feasibility” score.
    - Average combined score.
- Process to arrive at 14 top strategies:
    - Included the two strategies with the highest combined average scores from each of the six categories.
    - Eliminated one strategy that is already in progress [Work with commercial labs and payors (Medicaid specifically) to eliminate the ability to order standalone HCV antibody testing and require reflex testing on the same specimen used for HCV antibody testing.].
    - Included three strategies that had the highest average Magnitude of Impact score in their category but were not already captured through the combined average score. When considering the original framing question, Magnitude of Impact is the most meaningful criteria.
    - Minimal re-wording to distinguish selected strategies from one another.

Ranking Assignment Results, June 2024

Support robust and well-funded hepatitis C care coordination, navigation, and peer services in traditional and nontraditional settings. (55)

Fund substance use disorder treatment programs and harm reduction programs to build capacity and hire staff to provide on-site hepatitis C screening and treatment to all patients. (47)

Improve Medicaid reimbursement payment and/or financial incentives for treatment and care coordination in primary care, substance use, and other high impact settings. (43)

Implement active case finding, contact tracing, and linkage to care with the same level of urgency that New York State does for syphilis, tuberculosis, etc., with community input. (43)

Treat hepatitis C in Opioid Treatment Programs in New York State, including mobile medication units. (36)

Establish and expand a hepatitis C rapid test and treat initiation model in traditional care delivery systems and high impact settings. (27)

Fund drug user health hubs appropriately to allow health care providers to be available to treat hepatitis C. (26)

Require jails, prisons and re-entry programs to provide hepatitis C screening, linkage to care, peer support, and continuity of care for people newly released from correctional facilities. (26)

Create hepatitis C treatment implementation teams to provide technical assistance to develop a hepatitis C treatment program in priority settings. (21)

Conduct a Marketing Campaign that hepatitis C treatment is not optional/choice from the provider perspective (‘would you let your doctor withhold breast cancer treatment?’). (12)

Fund navigators or care coordinators in substance use disorder treatment programs to support hepatitis C linkage to care. (7)

New York State should expand culturally competent programs designed to reach young people who inject drugs. (3)

Integrate innovative/exciting consumer-facing education materials into existing and planned state-wide harm reduction initiatives, such as vending machines. (1)

Utilize a cohort of physicians to deliver ongoing high quality, evidence-based hepatitis C education (such as the clinical education initiative (CEI)). (0)