

Hepatitis C Gaps Analysis: Understanding the Care Landscape in New York City

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Executive Summary

Overview

This report is the final product of a multi-year effort to identify barriers and facilitators to hepatitis C (HCV) care in New York City (NYC). In March of 2025, an advisory body made up of community-based organizations, healthcare providers, NYC Health Department staff and people with lived experience came together to develop a framework to assess barriers to ensuring people who test positive for HCV are maintained in care through treatment and cure. Between May and June of 2025, nine focus groups and seven key informant interviews were conducted using questions developed by the advisory body.

This analysis is situated within the broader context of the New York State (NYS) Hepatitis C Elimination Plan, which has established a series of targets to eliminate HCV as a public health threat by 2030. While significant progress has been made to increase testing, diagnoses, and linkage to care, several key barriers remain. This report includes an analysis of key findings and a series of recommendations to bridge gaps in care and address disparities, particularly among populations disproportionately affected by HCV (e.g., people who use drugs, people experiencing homelessness, and people who are justice involved).

Context

In 2021, the NYS Department of Health released the [NYS Hepatitis C Elimination Plan](#), a set of recommendations created by a task force and workgroups comprising individuals from diverse backgrounds and experience, including people with lived experience.

The following settings and populations were identified as key priorities for intervention with the greatest potential impact.

Priority Settings:

1. Correctional facilities, including jails, courthouses, and prisons
2. Harm reduction programs
3. Substance use treatment programs
4. Primary and routine health-care settings, including community health centers and federally qualified health centers
5. Settings serving people experiencing homelessness

Priority Populations:

1. People who use drugs
2. People currently or formerly involved in the justice system
3. Adults born between 1945-1965 (“baby boomers”)
4. People experiencing homelessness or at risk of homelessness
5. People living with HIV (including individuals with HIV/HCV coinfection and LGBTQ+ populations)

How Are We Doing?

Over the past decade, the NYS Department of Health has made great strides toward ending the hepatitis C epidemic by 2030. In June of 2020, the NYS Department of Health along with partners at the CUNY Institute for Implementation Science in Population Health designed and developed a [dashboard](#) to track elimination progress and identify critical policy and implementation achievements across NYS. This dashboard, published in May of 2022, tracks the progress of each recommendation along the HCV care continuum and shares important data for yearly diagnoses rates, cumulative percent of treated/cleared infections, and new infection rates. The following information is specific to New York City and can be found [here](#).

Hepatitis C New Diagnoses Trends:

- **Measure:** Number of individuals *newly diagnosed with HCV infection*, each year
 - a. **Definition:** Number of individuals with a positive HCV RNA test or genotype test. To diagnose someone with a new HCV infection, they must receive both an antibody test (to confirm that the virus exists in their system) and an HCV RNA test (to confirm an active infection).
- **Status: Almost on Track (76% reduction in newly reported hep C diagnoses between 2012 and 2024)**
 - a. **2030 target:** 90% reduction in newly diagnosed HCV infections by 2030

Pivotal Achievements:

1. Mandated HCV antibody to RNA reflex testing
2. Implemented universal HCV screening of all pregnant people
3. Expanded and extended the NYS HCV Testing Law

Hepatitis C Treated/Clearance Trends:

- **Measure:** Number of individuals diagnosed with HCV with evidence of treatment or viral clearance each year.
 - a. **Definition:** Number of individuals with a positive HCV RNA test or genotype test, followed by either a subsequent negative HCV RNA test or documented

treatment indicated by another data source (this indicates that there is no active infection).

- **Not on track (As of 2024, only 55.9% of individuals diagnosed with hepatitis C have been cured)**
 - a. **2030 target:** 80% increase in treatment

Pivotal Achievements:

1. Expanded access to Medicaid Health Homes for people with HCV mono-infection
2. Promoted the use of incentives to improve HCV care engagement among people who inject drugs (PWID)
3. Expanded co-location of HCV testing and treatment in syringe service programs (SSPs)

Hepatitis C New Infection Trends among people ages 18-40 (Proxy for PWID):

- **Measure:** Rate of new HCV infections among persons aged 18-40 per year, as a proxy for the rate of new HCV infections among people who inject drugs (PWID) per year.
 - a. **Definition:** Rates are calculated using the number of acute (recent) HCV cases among individuals aged 18-40 and census-based population estimates.
- **Almost on Track (4.6 new hepatitis C infections per 100,000 population in 2024)**
 - a. **Target:** 4.5 new hepatitis C infections per 100,000 pop (2024)
 - b. **2030 target:** 90% reduction in new infections from 2020-2030

Pivotal Achievements:

1. Fully legalized the possession of syringes and all non-injection drug use equipment
2. Revised the NYS Expanded Syringe Access Program (ESAP), eliminating the 10-syringe cap, advertising, and other unnecessary restrictions of the ESAP
3. Supported the evolution of NYS Office of Addiction Services and Supports (OASAS) policy away from an abstinence-only service model

Methodology:

Data Collection

Between May and June of 2025, the advisory body conducted nine listening sessions across Queens, Brooklyn, the Bronx, and Manhattan. Six consumer-focused sessions were conducted in-person, five in English and one in Spanish. These sessions were designed to highlight a first-person perspective in navigating HCV resources from prevention through treatment. Questions focused on assessing baseline knowledge of HCV risk and acquisition, prevention tools, navigation, and curative resources. The listening sessions also incorporated sections on social determinants of health, stigma (both perceived and experienced) and other barriers to achieving cure.

In addition to the consumer sessions, the advisory body conducted three provider listening sessions, one in person at the Brooklyn Borough Hall and two virtually over zoom. These sessions were conducted with direct-service providers, including staff from harm reduction programs, substance use treatment programs, community health centers, and other frontline service settings. Provider sessions were focused on systemic level barriers, implementation challenges, care coordination, and capacity issues. Finally, seven key informant interviews were conducted with staff from Mount Sinai Hospital, the Department of Homeless Services (DHS), and Correctional Health Services to supplement the listening sessions and provide additional insights into facilitation of HCV care across systems.

Each focus group was conducted by at least two advisory body members, a facilitator, and a note taker. All key informant interviews were conducted via zoom, with only one advisory body member in attendance.

The questions were arranged by the following categories:

1. Hepatitis C knowledge and awareness
2. Prevention and risk awareness
3. Diagnoses and linkage to care
4. Treatment access and support
5. Key barriers to effective hepatitis C prevention and care

Participants

In total, 168 individuals participated across all listening sessions and key informant interviews. Participants represented 33 organizations operating across New York City and Long Island, including community-based organizations, health care institutions, harm reduction programs, and government agencies. Participation was voluntary, and efforts were made to ensure representation across boroughs, service settings, and roles within the hepatitis C care continuum. Participants received a \$25 visa gift card as compensation for their time.

Analysis

All listening sessions and key informant interviews were recorded (with participant consent), translated (when applicable) and professionally transcribed. The transcriptions were then reviewed for accuracy and inputted into a qualitative analysis software. A codebook was created using the facilitation guide as a template. All transcripts were independently reviewed by two master's level researchers for insights and recurring themes.

Key Findings

Set out below are major themes identified across listening session participants, including key facilitators and barriers, key observations by consumers and providers, and potential opportunities to improve the current hepatitis C care landscape.

Facilitators Identified by Providers and Consumers

1. Reduce barriers by ensuring that services are placed in easily accessible locations

Providers and consumers consistently identified the availability of comprehensive co-located testing and treatment services as necessary to ensure clients are engaged in care through treatment. This is especially important in settings like community health centers and harm reduction programs (Syringe Service Programs and drug user health hubs), where clients have established relationships of trust.

Additionally, participants noted that embedding HCV navigators within syringe service programs (SSPs) and other settings serving people who use drugs was integral in ensuring clients were linked to care and had support through the HCV care continuum.

Additionally, ensuring that clients were provided opportunities for HCV testing and treatment while engaged in the Emergency Department was consistently mentioned as a facilitator to continuity of care. Specifically, participants mentioned

the use of health educators in these settings to follow up on positive tests and encourage testing among those who initially declined. They believed this was paramount to increase testing and linkage opportunities for people who are unlikely to be otherwise engaged in healthcare.

2. Integrate data systems and services

Providers emphasized the value of connecting data systems within hospitals and other healthcare networks. These systems helped healthcare staff identify and reach out to clients who may be facing barriers to care. Both providers and consumers stressed the importance of including pharmacists as part of the HCV care team. This would reduce delays between diagnoses and receiving medication, a period where many clients drop out of care. In that same vein, listening session participants also mentioned the success of medication delivery services as an important way for people to receive and stay on treatment. This was noted as especially helpful for people who face transportation and housing challenges to help reduce barriers to obtaining medication.

3. Incentives

Incentives, like gift cards and meal vouchers, were identified as key to ensuring clients feel valued and supported. Participants suggested that this type of financial support could increase engagement in care and reduce drop off between appointments.

Barriers Identified by Providers and Consumers

1. Competing Priorities and Social Determinants of Health

Throughout the listening sessions, participants described many challenges that could make it difficult to stay connected to HCV care. Common issues included unstable housing, food insecurity, and unmet mental health or substance use needs. When people had unmet basic needs, treatment of HCV felt secondary, especially when people were asymptomatic or symptoms felt non-descript. With HCV, early symptoms can look like fatigue, loss of appetite, muscle aches, or nausea. If someone is unaware that were exposed to HCV, these symptoms could easily be attributed to other things.

Additionally, discussions revealed that persistent barriers like concerns about immigration status or fear of legal consequences related to outstanding warrants generally made it harder for folks to access consistent healthcare, further increasing barriers to treatment.

2. Care Navigation and System Fragmentation

Consumer participants described a lack of resources to navigate clients from testing to treatment. This challenge was especially common for people within large systems, like the Department of Homeless Services (DHS) and the Department of Corrections and Community Supervision (DOCCS). During the interview with a key informant from the DHS, they mentioned the lack of dedicated staff members to navigate clients who tested positive in assessment shelters through treatment once they were placed in program shelters. This was particularly troubling as an estimated 5,000 clients enter the shelter system each year with a positive HCV test.

Similar challenges were identified among individuals who were involved in the justice system. A key informant from Correction Health Services explained that "most" individuals who began treatment during their incarceration were lost to follow up after transferring back into community care.

The key informant also noted that many people with a positive HCV test frequently move between the shelter system and the corrections system. However, despite ongoing efforts, there is currently no effective system for coordinating HCV care between the two systems. This lack of coordination made it difficult for health care teams to ensure that people remained connected to treatment as they transitioned between DHS and DOCCS.

3. Gaps in Testing and Linkage Infrastructure

In emergency departments, limited staffing and insufficient HCV testing programs made it difficult to follow up with clients who received a positive test result. This could be especially problematic for people who rely on emergency departments as their main source of health care. Providers also mentioned that clients were frequently referred to specialists for HCV treatment rather than being treated in primary care settings. These referrals both delayed care and created additional costs for clients, such as specialist co-pays. Participants attributed this to a reluctance from primary care providers to treat HCV. It was also noted that integration of mental health services within HCV care teams could play an important role in ensuring that individuals felt supported throughout the treatment process. Many participants noted that referrals to outside mental health providers often posed a significant barrier to treatment as they were often unsuccessful and could be perceived as stigmatizing to clients.

4. Persistent Fears of Treatment

Persistent misconceptions regarding HCV treatment recurred throughout the consumer listening sessions, including persistent fear of older interferon-based treatment. Many participants indicated that friends and peers believed that older interferon-based treatments were still the norm for treating HCV and were unaware of pill-based medications. Consumer participants also indicated that there was a common belief that one must be drug or alcohol free to be treated, which was often seen as a barrier to initial testing and acceptance of treatment.

5. Insurance and Financial Barriers

Insurance barriers were raised as a concern throughout the listening sessions. This was specifically apparent to clients whose coverage is through Medicare, the Essential Plan, or private insurance. They often faced co-payments for specialist visits and/or medication. Some providers noted that the “no surprise law,” a 2022 federal law that requires providers to inform clients of potential co-pays before a visit was a barrier if the client couldn't be reached prior to the appointment. Additional barriers included ongoing “pre-approval” demands by insurers (including some Medicaid Managed Care plans) for genotype testing, FibroScans, or a primary care referral from clients with no primary care provider. Participants also noted that the AIDS Drug Assistance Program (ADAP) covers only Mavyret, not Epclusa, which created additional barriers for clients living with HIV. Finally, it was noted that it took longer for uninsured clients who relied on the Hep C Patient Assistance Program (HEPCAP), which doesn't cover medications, to begin treatment, which increased the likelihood a patient could fall out of care before being cured.

Key Observations by Consumers

1. Address Stigma and Misconceptions

Many consumers noted that stigma (both external and internal) around substance use was a barrier to pursuing testing and treatment services. One participant noted that they were made to feel “dirty” when they pursued HCV testing after sharing syringes. Some participants also mentioned that clients may seek HCV care options outside their neighborhoods due to stigma regarding HCV and risk factors.

Further, fear of past treatments, like older interferon-based treatments, is still a persistent factor in delaying HCV treatment. Participants mentioned the false belief that HCV testing was part of a standard blood panel and subsequently believed there was no need for additional testing.

When asked about possible ways to combat misinformation, consumers suggested that it would be helpful if providers started HCV education or testing conversations with the information that there is a well-tolerated cure that can be achieved in a short time. They said that this was key to ensuring individuals who test positive for HCV were comfortable starting treatment. Some participants went even further by saying that positive HCV treatment experiences had made them more open to seeking care in general.

2. Address Competing Priorities

An overarching theme throughout the listening sessions was the importance of addressing competing priorities related to basic survival needs (i.e. housing, food, substance use) that take precedence over HCV testing and treatment, all of which increase the odds that preventative care, like testing, was an afterthought, especially in the absence of symptoms.

Consumers also identified street outreach as an important step for increasing access to HCV testing, services, and basic education.

3. Support access to culturally tailored services for immigrant communities and clients who don't speak English

Consumers frequently referenced the need for Spanish-speaking providers for HCV services. Even when interpretation services were available, participants described mistranslation and a lack of cultural humility from providers as barriers to care for clients with limited English proficiency. Immigration status was also mentioned as an increasingly formidable barrier, especially for those without documented status. Participants described fears of accessing any kind of health care, and high rates of housing instability especially among newly arrived immigrants.

Key Observations by Providers

1. Address loss to care and system level gaps

Providers described a persistent challenge of people falling out of care before completing treatment. This issue occurred even in programs with successful treatment processes (e.g. opioid treatment programs) because clients often move between programs, shelters and correctional settings, which made it difficult to maintain continuity of care.

This problem was particularly common when programs were only equipped to provide testing and refer clients externally for treatment or additional services. Providers noted that each extra step created another opportunity for people to disengage in care. The discussions noted that many clients within these settings faced significant barriers that made follow up difficult, including lack of consistent phone service and permanent address. This could often make it difficult or even impossible to locate clients. Providers pointed out that, unlike clients living with HIV, there was no comprehensive system to determine if someone was receiving HCV care elsewhere.

2. Support marginalized communities by addressing barriers to care

Providers also mentioned the importance of ensuring consistent and tailored outreach to groups who faced unique barriers to care. These included new immigrants who may fear seeking health care due to concerns surrounding immigration enforcement and sex workers who may be hesitant to engage in outreach efforts due to ongoing surveillance. Additionally, many listening session participants explained that clients who rely on emergency departments for care are often perceived as simply drug seeking and turned away before their health care needs are fulfilled.

Providers indicated that much work was needed with clients to “repair their relationship with the health system” after they experienced stigma from providers or other barriers. They went on to say that welcoming and non-judgmental approaches are key for clients for whom it takes “courage” to come in for any type of help. One provider remarked that, “If there is no coordination, navigation, social work system for a clinic that treats viral hepatitis, that’s a problem.”

3. Continue supporting investment in harm reduction infrastructure

Providers, specifically those serving Staten Island and Long Island, noted that there was a need for broader access to harm reduction supplies to limit syringe sharing, a leading risk factor for HCV exposure. Access to Syringe Service Programs (SSPs)

remained a persistent issue in these jurisdictions and were key points of access for clean supplies and other harm reduction resources.

Further, while providers noted that, NYS has made an important investment in point-of-care (POC) HCV RNA devices, they noted that the associated equipment and supply costs remain prohibitive for many organizations. Providers also explained that keeping clients onsite while awaiting test results continues to be a challenge.

Opportunities Identified by Providers:

1. Improve systems to increase prevention, testing, and treatment

Throughout the listening sessions and key informant interviews, providers mentioned the importance of improved data and “tracking” systems to facilitate follow-up and prevent loss to care. Additionally, providers discussed the importance of true opt-out testing in emergency departments and primary care settings to help increase access to HCV testing.

Along those lines, providers recommended offering routine HCV testing in DHS program shelters and point of care testing that used the waiting time to provide HCV prevention and treatment education. They also underscored the need for incentives, like meals or monetary compensation, to keep people onsite to receive test results.

Incarceration also provided an important opportunity for testing and treatment, but despite a robust program in City jails, “systems are not sufficient to navigate people through care” due to short jail stays and loss to follow-up following discharge. This again highlighted the need for system integration.

2. Expand outreach and de-stigmatizing public information campaigns

Of note, providers mentioned the importance of street outreach that included education on HCV prevention, treatment, and where to get tested. They also emphasized the need for de-stigmatizing public information campaigns that emphasize short-term, well-tolerated treatment.

Report Recommendations:

The following recommendations are based on conversations with consumers, providers, community stakeholders and key informants across all five boroughs of NYC and Long

Island. Recommendations are organized to support both short-term and long-term goal planning:

- 1. Increase partnerships, collaboration, and coordination between the NYC Department of Homeless Services (DHS) and key stakeholders to support individuals from testing to treatment.**

Goal: Support individuals within the NYC shelter system who have confirmed positive hepatitis C diagnoses by providing treatment navigation and resources

Short term solution: Employ one or more fulltime patient navigators to support the DHS Health Service Office to identify people with hepatitis C infection in the homeless service system using DHS medical assessment data, health department and institutional referral diagnosis data, and health care provider return to care requests to conduct case finding, in-person outreach and engagement, and linkage to care and treatment.

Rationale: Several themes emerged throughout our conversations about interagency communication. Namely, the relationship between DHS, community-based organizations, and key health systems is important. DHS supports over 400+ shelter facilities in NYC.¹ Over 35,000 single adults spend a night in a NYC shelter each year², and experience substantially higher rates of serious mental illness, substance use disorders, and severe medical complications as compared with members of homeless families.³ People experiencing homelessness face layered healthcare stigma, and transient housing barriers that contribute to a broad lack of trust in systems. When an individual enters the shelter system, they undergo an intake process to determine eligibility for shelter and are subsequently placed in an assessment shelter. During the assessment, individuals are offered an optional/voluntary medical assessment. Most often, the provider at the assessment shelter will receive the medical assessment results after the person has been placed in a program shelter, leaving little opportunity to track the patient down to initiate treatment. It is estimated that over 5,000 individuals enter the shelter system each year with a positive test for hepatitis C antibodies.⁴ Almost everyone within the DHS who is linked to treatment is referred to an external provider (outside of the shelter system). However, due to the fragmented nature of the shelter system, many people are lost to care during or even before treatment, due to transitions in placement or lack of contact information. A navigator, positioned in

¹ [NYC Homeless Shelters Rise 50% Since 2022](#)

² [State of the Homeless 2025 - Coalition For The Homeless](#)

³ [Basic Facts About Homelessness: New York City - Coalition For The Homeless](#)

⁴ Key Informant Interview with Official from the Department of Homeless Services (DHS)

the NYC Department of Health and Mental Hygiene, could support continuity of care by tracking individuals throughout the shelter system and provide support in navigating treatment for individuals with a positive hepatitis C diagnosis.

Long-term solution: Create and disseminate a hepatitis C strategic plan within the Department of Homeless Services with holistic guidance to support individuals experiencing homelessness through the HCV care continuum.

Rationale: Drug related deaths remain the most common cause of death in New York City shelters. However, in 2024, overdose deaths within the shelter system fell by 27% even as the daily number of people residing in shelters increased by 31% (from 66,000 to 86,000).⁵ This is largely due to an increase of harm reduction protocols outlined within a comprehensive [harm reduction strategic plan](#). Building on the existing harm reduction strategic plan in shelters, which includes comprehensive documents outlining steps to support communication and linkage to care, a Hepatitis C strategic plan would strengthen continuity of care and improve cure rates.

Supportive quote: The medical director for DHS and some of her team have tried to kind of work out a system. It's hard because of the way the shelter system is set up [...] It's unfortunately kind of very disjointed and contracts and contracted, and this and that. So, that's something that's kind of ongoing, thinking how we can collaborate more closely. But, that would be huge if we could figure something out that would work.⁶

2. Increase true opt-out hepatitis C testing and ensure linkage-to-treatment protocols within emergency departments across New York City.

Goal: Increase treatment options for individuals who aren't engaged in primary or specialty care to ensure SVR.

Short term solution: Hire additional health educators to support education, testing and linkage within Emergency Departments.

Rationale: Health educators play a pivotal role in ensuring that emergency department clients receive education on hepatitis C, are tested, and if positive, are linked to care. Employing [340B funding](#), the Mount Sinai Liver Education and Action (LEAP) program has employed educators and care coordinators to support clients from testing to treatment.

[Hong, J \(2025, April 23\) Drug-related deaths dropped in NYC shelter system, even as population boomed. Gothamist.](#)

⁶ Key informant, Med Span Program, Correctional Health

Long term solution: Allow all advanced practice providers, including nurse practitioners, to prescribe Direct Acting Anti-Viral (DAA) therapy to clients who meet simplified treatment criteria within emergency department settings.

Rationale: As hepatitis C is often asymptomatic, many individuals will receive a diagnosis through routine bloodwork. In 2024, 71.2% of individuals newly diagnosed with chronic hepatitis C in New York City were identified via routine bloodwork.⁷ Populations at higher risk of acquiring hepatitis C are more likely to engage with care providers in the emergency department over outpatient care. Currently, many emergency departments require clients to attend an additional appointment to receive a course of DAAs. The fragmented nature of this process can often result in loss to follow up before treatment is initiated. Reducing logistical barriers for treatment, especially for people who use drugs, could increase access and adherence to treatment regimens. This strategy has been proven incredibly effective in other jurisdictions. For example, the University of Kentucky Health Center Emergency Department (UKHC ED) tested the efficacy of providing treatment to ED clients found a 42% increase in cure rates (identified by clients achieving SVR), and a significantly shorter median time between testing and treatment (421 days to 17 days).⁸

Supportive quote: An issue that I've had for years is that I think that the folks who have hep C now, it's not anymore the baby boomers who've had it for decades, who knew they had it and then were eager to get treated. That's not really who needs treatment now. I think it's really challenging to ask the people who have hep C now to come and engage with the healthcare system and the rigid ways that it exists.⁹

3. Expand co-location of testing and treatment in non-traditional settings

Goal: Reduce loss to follow-up between hepatitis C testing and treatment initiation and improve continuity of care through completion of treatment and achievement of Sustained Virologic Response (SVR).

Short Term Solution: Employ one or more additional HCV coordinators in the NYC Department of Health to support tracking and follow up with clients who test positive for Hepatitis C to ensure consistent linkage through treatment initiation.

⁷ [Hepatitis A, B, and C Surveillance Annual Report 2024](#)

⁸ [Implementation of a novel framework for hepatitis C diagnosis and treatment in an academic health system | American Journal of Health-System Pharmacy | Oxford Academic](#)

⁹ Key Informant, Liver LEAP team, Mt Sinai

Rationale: According to the NYS HCV dashboard, among 203,442 New Yorkers diagnosed with HCV between 2010 and 2024, only 55.9% have been treated/cleared the infection.¹⁰ While this is an improvement from 2023, NYS is not on track to meet the 2030 goals of the 80% cure rate. Findings from this gaps analysis showed several persistent breakdowns along the care continuum, namely from initial diagnoses to treatment follow up. Key barriers, highlighted by providers and key informants, included frequent loss to follow up and capacity to find clients who disengage from care, especially those with competing priorities, i.e. those experiencing homelessness, substance use, food insecurity, etc. The presence of a dedicated coordinator within the department of health could support community organizations and providers, by providing additional navigation support and ensuring clients are linked to care.

Long Term Solution: *Meet AIDS Institute recommendations by ensuring that all Syringe Service Programs (SSPs) provide on-site hepatitis C testing, treatment and pharmacy services.*

Rationale: People who use drugs are at an increasingly higher risk than the general population of acquiring hepatitis C in their lifetime and face significant structural and psychosocial barriers to accessing care in traditional healthcare settings. This results in a significant percentage of loss to follow up between initial testing and treatment. Co-locating hepatitis C testing, treatment and pharmacy services at SSPs has proven to be more effective than traditional referral-based care models. For example, at The Lower East Side Harm Reduction Center (LESHRC) The full integration of hepatitis C care increased cure rates among clients by more than 40%. The full integration of care and treatment into non-traditional settings, like Syringe Service Programs, allows clients to receive care in a place where they've already established trust, allowing for continuity and limiting loss to follow up.

Supportive quote: Our experience is that they're being tested, but treatment is not offered on site. We know of a lot of cases, or at least the numbers show that, but getting them into the clinic, unless we have a really solid relationship where there's staffing permits for them to be escorted here, they're being tested but not treated.¹¹

<https://hcvdashboardny.org/data/>

¹¹ Provider, Virtual Provider Listening Session

4. Increase hepatitis C testing and treatment in carceral settings

Goal: *Ensure every individual involved in the justice system has access to hepatitis C testing and treatment, or linkage to treatment).*

Short Term Solution: *Ensure all individuals receiving medication for opioid use disorder (MOUD) receive true opt-out hepatitis C testing in jails across New York State.*

Rationale: Individuals who inject drugs experience higher rates of incarceration and an increased risk of HCV infection. The group most likely to receive MOUD during incarceration are individuals with a history of injection drug use. Many individuals are infected with HCV prior to entering a carceral facility and may be unaware of their status. Opt-out HCV testing, particularly among individuals with a history of injection drug use, is key in early detection and linkage to care.

Supportive quote: You guys have to understand. Addicts don't get tested at all unless they go to jail.¹²

Long Term Solution: *Ensure true-opt out testing and, for those who test positive, initiate hepatitis C treatment throughout all New York jails, prisons and alternative to incarceration programs.*

Rationale: It is estimated that approximately 30% of individuals living with hepatitis C will spend at least part of the year in a correctional facility.¹³ According to the 2024 NYC Hepatitis ABC Annual Report¹⁴, only 42% of individuals who received a medical intake opted for a voluntary hepatitis C test. Opt-out testing is an effective tool to ensure increased testing and subsequent linkage to services for individuals who test positive. Ensuring that every justice involved individual has access to effective testing and treatment services is a crucial step in eliminating hepatitis C as a public health threat by 2030.

Supportive quote: In the setting where I work and you know not to pat or use Medspan to pat ourselves on the back, but we have a pretty robust program. Again, universal opt-out screening for everyone coming in. Folks who opt out usually at some point usually get reoffers in different settings in these facilities. I think in other

¹²Client, Sunriver Health Queens

¹³ [Addressing Hepatitis C in the American Incarcerated Population: Strategies for Nationwide Elimination](#)

¹⁴ [Hepatitis A, B, and C Surveillance Annual Report 2024](#)

carceral settings and me not having worked in any other one except the one I currently work in, from what I understand, it sounds like funding sometimes is an issue. It sounds like staffing sometimes is an issue to be able to offer more testing and for more screening, and to offer more education.¹⁵

5. Reduce insurance-related barriers to Direct Acting Anti-Viral (DAAs) medications.

Goal: Eliminate all unnecessary insurance related barriers to hepatitis C treatment access for clients who meet simplified treatment criteria.

Short Term Solution: Expand the ADAP formulary to cover all hepatitis C treatments, including Epclusa.

Rationale: It is estimated that between 20-30% of individuals living with HIV are also living with hepatitis C.¹⁶ The New York State Uninsured Care Program's AIDS Drug Assistance Program (ADAP) supports uninsured individuals who are HIV positive as well as individuals who are insured but need support with co-pays. The ADAP formulary covers certain Direct Acting Anti-viral (DAA) medications, including Zepatier, Viekira Pak, and Mavyret. While these medications are effective treatment options, they either require an individual to take multiple medications (Zepatier or Viekira Pak) or require the patient to take multiple pills a day (Mavyret). Expanding the formulary to include Epclusa, a medication only taken once per day, increases options for clients and providers and decreases daily medication requirements.

Long Term Solution: Eliminate unnecessary insurer requirements, including genotype testing, FibroScans and primary care referrals for clients to receive DAAs.

Rationale: Insurance remains a substantial barrier to ensuring individuals are treated for hepatitis C. While New York State Medicaid has removed prior authorization requirements for hepatitis C Treatment,¹⁷ barriers persist in ensuring timely initiation of treatment. In some cases, clients will be required to undergo genotype testing and FibroScans, that can often require an additional appointment to complete. This can be challenging, particularly for clients who may not be established in care, as it requires an additional step before initiation of treatment.

¹⁵ Key informant, Med Span Program, Correctional Health

¹⁶ [HIV and Hepatitis C | NIH](#)

¹⁷ [New York Increases Access to Hepatitis C Treatment for Medicaid Clients - Center For Health Law and Policy Innovation](#)

Removing unnecessary testing barriers allows for streamlined access to treatment and increases the likelihood that a patient will complete treatment.

Supportive quote: Even though insurance is supposed to approve – even though these medications are pan-genotypic, they still require genotype, and that’s still a thing. Even though they’re not supposed to, yes, and also the FibroScans. They ask for FibroScans. Not all insurances push back, but some of them do.¹⁸

6. Increase opportunities for HCV testing and linkage for LGBTQ+ individuals, particularly men who have sex with men (MSM) and transgender women.

Goal: Fund innovative outreach strategies to test and link MSM and transgender women to culturally informed hepatitis C care.

Short Term Solution: Integrate opt-out HCV testing into routine blood panels in LGBTQ+ affirming sexual health clinics.

Rationale: According to NYC Department of Health surveillance data from 2024 on hepatitis C among NYC residents, men who have sex with men (MSM) was indicated as the primary risk factor in 22.7% of newly reported chronic cases and 39.2% of acute cases of hepatitis C – the second highest reported risk factor for chronic cases and the number one reported risk factor for acute cases.¹⁹ While it is important to note that HCV risk is not determined by identity alone, many LGBTQ+ individuals, specifically MSM and transgender women face disproportionate risk due to increased rates of housing instability, HIV co-infection, survival sex work and injection drug use.²⁰ As mentioned in a previous recommendation, a majority of chronic hepatitis C cases are identified via routine bloodwork,²¹ underscoring the essentiality of increasing opportunities for testing.

Supportive quote: I believe, from what I've seen and experienced all these years I've been living in this country, people are arriving here all the time, new people, new immigrants, and we need to give them follow-up and information. For example, I belong to the LGBTQ+ community, and I have a lot of information because I've worked and because I'm in the community, and the information is more accessible, and because I suffer from a virus that affects people worldwide. That makes me

¹⁸ Key Informant, Liver LEAP team, Mt Sinai

¹⁹ [New York City Department of Health and Mental Hygiene. 2024 Hepatitis A, B, and C Annual Report. February 2026.](#)

²⁰ [Jin F, et al. Prevalence and incidence of hepatitis C virus infection in men who have sex with men: a systematic review and meta-analysis. Lancet Gastroenterol Hepatol. 2021 Jan;6\(1\):39-56.](#)

[New York City Department of Health and Mental Hygiene. 2024 Hepatitis A, B, and C Annual Report. February 2026.](#)

more informed, but there are many people who come to this country and don't have the exact information that could help them.²²

Long Term Solution: Fund late-night outreach initiatives that support hepatitis C testing opportunities within LGBTQ+ nightlife settings.

Rationale: Innovative outreach was a key topic that emerged throughout each listening session. Specifically, engagement and outreach beyond traditional healthcare settings. Many LGBTQ+ individuals face sustained structural and social barriers to traditional healthcare in clinical settings. Expanding testing opportunities in non-traditional settings such as nightclubs, sex parties and other low threshold spaces provides a unique opportunity to promote early detection and linkage to hepatitis C services while also providing the opportunity to teach real time harm reduction strategies for hepatitis C prevention.

Supportive Quote: When we're talking about how to eliminate hepatitis C and what clients are left, all the clients that are left are the ones that haven't received care for all these other reasons that's not their actual - not the actual disease and how do we meet them where they're at. The current healthcare system is not working for that.²³

Conclusion

NYS has made significant progress in achieving measures set forth by the Hepatitis C Elimination Plan. However, additional efforts are still needed to prevent loss to follow up and ensure individuals who test positive for hepatitis C have access to treatment and supportive resources. Reducing barriers to treatment remains a critical step in reaching the elimination targets for 2030. This cannot be done without increased coordination between social service and public health infrastructure as well as a renewed and expanded commitment to ensuring access and support for harm reduction services.

²² *Client*, Latino Commission on AIDS

²³ *Key informant*, Mt Sinai

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Appendix:

Glossary:

AIDS Drug Assistance Program (ADAP): A New York State program that helps people living with HIV access medications, including some hepatitis C treatments, by covering costs such as prescriptions and co-pays.

Co-location of Services: The practice of offering multiple services in one location. This is often used as a way to limit barriers to care by offering convenience and accessibility.

Direct-Acting Antivirals (DAAs): Medications used to treat hepatitis C that are highly effective, typically well-tolerated, and taken for a short period of time. There are currently several brands of DAAs on the market including; Zepatier, Viekira Pak, Mavyret and Epclusa

Syringe Service Program (SSP): A New York State program that allows the sale and distribution of syringes without a prescription to reduce the transmission of HIV and hepatitis C.

Federally Qualified Health Centers (FQHCs): Community-based healthcare providers that offer primary care services and are typically subsidized by the federal government.

Genotype Testing: A laboratory test used to determine the specific strain of hepatitis C virus a person has.

Harm Reduction: A set of policies and strategies that reduce the negative consequences associated with drug use, thereby centering individuals and putting them first. Injection drug use is one of the leading risk factors for HCV. HCV elimination cannot be achieved without effective harm reduction infrastructure.

HCV Antibody Test: A blood test that shows whether a person has ever been exposed to hepatitis C.

HCV RNA Test: A blood test that confirms whether the hepatitis C virus is currently active in the body.

HCV Care Continuum: The steps of hepatitis C care, including testing, diagnosis, linkage to care, treatment, and cure.

Hepatitis C (HCV): A blood borne viral infection commonly transmitted through exposure to infected blood and can lead to chronic liver disease and other adverse health effects, including liver cancer, if left untreated.

Hepatitis C Patient Assistance Program (HEPCAP): A program that provides hepatitis C medications at low or no cost to uninsured or underinsured individuals.

Linkage to Care: The process of connecting a person who has tested positive for hepatitis C to medical care and treatment services.

Loss to Follow-Up: When a patient disengages from care after testing or starting treatment and cannot be contacted or does not complete treatment.

Medication for Opioid Use Disorder (MOUD): Medications such as methadone or buprenorphine used to treat opioid use disorder.

Opt-Out Testing: A testing approach in which clients are informed that testing will be performed unless they decline, increasing the likelihood of routine screening.

Point-of-Care (POC) Testing: Testing performed at the time and place of patient care that provides rapid results, often during the same visit.

Prior Authorization: A requirement from some insurance providers that approval must be obtained before certain treatments or medications will be covered.

Referral-Based Care Model: A system where clients are sent to another provider or location for additional services, which can create barriers to care.

Reinfection: When a person who has been cured of hepatitis C becomes infected again.

Social Determinants of Health (SDOH): Non-medical factors, such as housing, food access, income, and social support, that influence health outcomes and access to care.

Sustained Virologic Response (SVR): The absence of detectable hepatitis C virus in the blood after completing treatment, indicating that a person is cured.

SVR8 / SVR12: Measures of cure based on whether the virus is undetectable 8 or 12 weeks after completing treatment.

Patient Navigation: Support services that help individuals move through the healthcare system, including scheduling appointments, accessing treatment, and overcoming barriers to care.

Recommendation Summary:

Goal	Priority Setting/Population
Support individuals within the NYC shelter system who have confirmed positive hepatitis C diagnoses by providing treatment navigation and resources	Settings serving the homeless
Increase treatment options for individuals who aren't engaged in primary or specialty care to ensure SVR8.	Primary and routine health care offices, community health providers, and federally qualified health centers
Reduce loss to follow-up between hepatitis C testing and treatment initiation and improve continuity of care through completion of treatment and achievement of Sustained Virologic Response (SVR) at 2 months (SVR8)	Drug/substance use treatment program sites
Ensure every individual involved in the justice system has access to both hepatitis C testing and treatment (or linkage to treatment)	Correctional facilities, including jails, courthouses, prisons
Eliminate all unnecessary insurance related barriers to hepatitis C treatment access for clients who meet simplified treatment criteria.	HIV+ individuals (including HIV/HCV coinfection and LGBTQ+ populations)
Fund innovative outreach strategies to test and link MSM and transgender women to culturally informed hepatitis C care	HIV+ individuals (including HIV/HCV coinfection and LGBTQ+ populations)

Codebook

Client codebook

Theme	Sub-Theme	Definition	Example Quote:
Prevention	Awareness Risk/Aquisition	Individual states awareness level (knowledge or lack of...) about HCV acquisition	First, you have to ask yourself: what risk is there of contracting hepatitis C if I'm going out and having partners? If I'm not using protection? I'm the first person who has to ask myself those questions. And if I have doubts, I need to go and get tested—that's the only way I'm going to know if I'm infected or not with that virus.
	Awareness Outreach	An individual suggests an outreach strategy	There's not only that, there's street outreach teams that come from Housing Works, they come from the Alliance, they come from the Lower East Side housing, Acacia center and they go around and they pass out materials, but it would be great if they pass out information flyers like, "Hey, do you want to go get tested? Here's where you go to tested," along with the materials that they're passing out.
	Strategies	Individual mentions prevention strategies and targets	I probably want to tell you I don't think that they should specifically focus on the immediate at-risk community where you just brought it and just offer testing to people, because you might not know. There might be people from different demographics, you know what I mean, that don't know about testing, but that might be at-risk. I guess including the at-risk population, but don't just focus on them.

Theme	Sub-Theme	Definition	Example Quote:
			Just expand it a little bit, you know what I mean?
	Education Hepatitis C	An individual mentions any education they've received or general education strategies around hepatitis C	I think now we're more aware of how you get hepatitis and what you could do about it. It's not a death sentence like it was, like in my younger days, people just had it and died. They didn't even have a cure. So, people were even scared to take the test because they were scared if they found out they got it, they didn't know what to do. Now the education is teaching us, there's a cure for some of it, and a lot of us could be treated.
	Education Harm Reduction	An individual mentions anything related to education around harm reduction strategies including; syringe related transmission, intravenous drug use, support within SSPs	Yes, I definitely think it needs to be a requirement in any harm reduction program, and in any drug program, I think it needs to be a requirement. I don't care. Anything that has to do with drugs, it needs to be implemented. Yes. Outreach is good because I think one of the biggest factors for HIV that really brought it to the front was outreach. People knew what they were doing and stuff like that. They had needle exchange and stuff like that because of the HIV. I think outreach would be good for hepatitis C to let people know that, along with HIV, there's another thing that you need to look at, which is just as serious. When I got outreach about HIV, they wouldn't say nothing about hepatitis C. They were just so

Theme	Sub-Theme	Definition	Example Quote:
			focused on HIV. I think if they're going to do outreach, they need to let people know about all the things that doing drugs can bring on as far as diseases and stuff.
	Access Harm Reduction	Individual mentions access (either issues or resources) related to harm reduction supplies (i.e. clean syringes, pipes, etc)	My population is IV drug users, and most of them know, like, they've been educated. I think it's just them having easy access to harm reduction supplies.
Diagnosis and Linkage to Care	Testing Strategies	Individual states a specific hep C testing strategy that has been effective or they think would be effective	When you are testing a new person or whatever, it's probably good to announce that there's a cure pretty fast. That's like we got to use terms like functional cure and stuff with HIV, but you can actually say there's a cure for hep C. Leading with that is probably the first disarmer, but for someone like me who works in this space where we are dealing with both, I want to be very knowledgeable of the differences in terms of how they're contracted and tested
	Testing	Individual provides any mentions of testing policy and/or procedure	Like, 9:00, 10:00 in the morning, you see what I'm saying, just a random day. "Okay. Well, let me go get tested." I don't have to wait an extra amount of time for results and something because I just put that thing and I can find out there and then take care of it from there. I don't have to wait and be like, "Okay. Well, you got tested two weeks ago and this is what we

Theme	Sub-Theme	Definition	Example Quote:
			found out.” You know what I mean? Moderator: You’re talking about Point-of-Care testing, yes? Respondent: Yes.
	Awareness Hep C Status	Individual mentions barriers to care related to knowledge/awareness of hep C status	Oh, this thing I want to share here, like really, really. When I receive the news, of the Hep C? I never feel symptoms. I want to say that, for that like in this moment, I don't care nothing. I'm feeling nothing
	Word of Mouth	An individual mentions social circles, word of mouth or community sourced resources	You’re going to take a certain set amount of materials and it’s just, “Well, okay. This is the area that we’re going to do for today, let’s just pass it out and who’s interested,” because you never know, the word to get around and you never know. Somebody might know somebody that needs it. You’ll never know.
	Peer Support	An individual mentions the role of peers in hep C diagnoses, testing and linkage to care	Yes. [with peers] We were able to meet a lot of more people on the street with hep C things going, having people who were specifically assigned for hep C outreach, hep C related. Where we’re specifically looking for people.
	Structural Barriers	Individual mentions structural barriers that made it harder to access care for HCV exc. Any mention of treatment access	Some of them might have a conversation and be told you have hep C, go follow up with your primary care provider and not be given any support.

Theme	Sub-Theme	Definition	Example Quote:
HCV Care and Treatment Access and Support	Access	Individual mentions barriers or facilitators to accessing HCV treatment inc. Mention of DAAs or interferon	Well, first, I'm going to tell you how they did it with me, right? First, they asked me all kind of questions, what kind of medication I take, what I'm allergic to. Then they took a blood sample, and they got different types of hepatitis C. They got different categories, and they told me where I was fit at, and then they gave me Mavyret, I think it was, for 90 days. I took it for 90 days, and I've been cured ever since.
	Public Awareness	An individual mentions public awareness of treatment, inc. Perception, lack of awareness (related to treatment), general public awareness of hep c treatment	Yes. That's why public information would be so important because it could show people these are the modern treatment techniques and show people how non-invasive it is and maybe more people will be willing to get tested.
	Strategies	Individual mentions strategies that supported access to HCV treatment	When I took my pills, I had an alarm clock, and I put it for 3:00 in the afternoon because I knew I was going to forget some days, and you cannot double up. 3:00 came, the alarm ring, I knew what I had to do. I did that all the way up to finished.
	Barriers to cure	Patient mentions barriers to hepatitis C treatment and cure inc. Mentions of Adherence, SDOH barriers, etc.	They might lack the safety of stability, housing, or there might be something situational that's keeping from adhering as well. Maybe they have a crisis during the test, you know, quality of life, living standards...
	Insurance	Mentions of insurance (i.e. barriers, coverage, perceptions of coverage)	Some people think that they can't go to the doctor if they can't pay for it. That's not true. A lot of places just besides

Theme	Sub-Theme	Definition	Example Quote:
			here, a lot of places are mandated to treat first. Then by the state, they have to treat certain types of situations, like emergency rooms, they can't turn you away because you don't have insurance. They have to treat you first. Then there are other places, let's say for example, something happens, and then you go get Medicaid after this situation happens. You have to bill Medicaid to actually pay for the bill for three to six months after the actual charging of whatever it was that happened. If you go to a clinic and you're like, "Hey, I just found out all of this and now I gotta go take all of this medication," you have to take the bills to Medicaid and they'll take care of you.
	Support	Include any mention of support either from community or organizations in facilitating access to treatment	There's always going to be a stigma attached to anything because we as human beings, we don't want to deal with anything that makes us mortal. We don't want to deal with anything that we have to say, "Oh, no, that's a killer." Yes. That's just how we are. People like myself who have went through it and know about it, listen, you can think what you want to think. I've got a great support group. I've got great people in my life and stuff like that. I'm past the stigma. I think that's so important for anybody who's going through any kind of sickness. You got to have a

Theme	Sub-Theme	Definition	Example Quote:
			support. You got to have a great support group
	Stigma	Include any mention of stigma/perceptions regarding treatment. Also include potential ways to combat stigma Inc. Interferon, Pain, Timing, etc.	So they used to have the thing that had I think it's like either 7 caps or 11 caps or something like that that you had to put in different places in your liver, and you got to push the cap, and then you got to wait, and then it hurt and it'd make you throw up and stuff like that. I've got a cousin with Hep C and he had to go through that, he went all the way around. He's already back under his arm and stuff like that. That was the Pegasys interferon stuff. Then they said they got different stuff now where you don't have to use the needles and the caps anymore.
	Delays (individual)	Include any barriers related to the individual in accessing hep C treatment, inc. Hesitations, SDOH barriers, individual circumstances	People are scared to go to the hospital and find out what's wrong with them. They're afraid. If anything, they're afraid.
	Mistrust	Include any identification of mistrust related to HCV treatment, medications, systems etc.	Yes. I mean, certain people are distrustful of medication also. I know I'm the type of person. I don't like taking anything as sick as I might be. I'm distrustful of medication a little bit.
	Treatment Education	Include any mention of patient education around treatment etc	Well, first, I'm going to tell you how they did it with me, right? First, they asked me all kind of questions, what kind of medication I take, what I'm allergic to. Then they took a blood sample, and they got

Theme	Sub-Theme	Definition	Example Quote:
			different types of hepatitis C. They got different categories, and they told me where I was fit at, and then they gave me Mavyret, I think it was, for 90 days. I took it for 90 days, and I've been cured ever since.
Social Determinants of HCV Health Outcomes	Stigma (Hepatitis C)	Include mentions of stigma related to hepatitis C	I feel like the more marginalized the community like East New York, Flatbush where I am, the later it is for information - like updated information to be here, so there are people who still have their fear of the older treatment and the pain.
	Stigma (Substance Use)	Include mentions of stigma related to substance use	Yes, and the stigma would say, "Oh, not me because I just smoke crack," "I just do this" or "I do a certain type of drug and that's not associated with that," and they're ignorant to it.
	Immigration Status	Include mentions of immigration status as a barrier to accessing hepatitis C care	In New York State, most people are covered. But unfortunately, in some cases, people don't have a defined immigration status and don't have the same opportunities as those who do. Some institutions accept them and some don't, and unfortunately in certain emergency situations, there are very few options available. Those of us who are citizens have many opportunities everywhere, but unfortunately, people who aren't—they do get doors closed on them because of their status. Not everywhere, but it does happen.
	Language Barriers	Include mentions of language barriers	In any case, it's up to the individual. In my case, I requested many times to

Theme	Sub-Theme	Definition	Example Quote:
			change my doctor. I'm being treated at Mount Sinai, and they kept saying there were no Spanish-speaking doctors and that at the time they couldn't change mine. So even though I couldn't switch, I asked many times, until this woman retired from Mount Sinai, and then I was finally assigned a Spanish-speaking doctor.
	Cultural Barriers	Include mentions of cultural barriers to hep C care access	The doctor did say, "You got a hep C. You want to take a treatment?" Nutrition in Puerto Rico is different. You don't care, only motrin or Tylenol or something, but when I'm being here in New York, I'm being programmed. I'm taking the MAVYRET treatment. It's good. Do the work. When the doctor checks my blood, I'm good. The virus is not active. You got the virus, but it's not active. You know what I'm saying?
	Competing Priorities (Individual)	Include any mentions of competing individual priorities related to accessing hep C care (inc. Mention of Housing, substance use etc)	Yes, it's a matter of priorities. If I'm using drugs, my priority is the drug, nothing else.
	Housing Stability	Include mentions of housing stability as a barrier to hep C care	They could be homeless on the street and they have no place to keep the medication because all kinds of scenarios could happen when you're out there.
	Social Support	Individual mentions any modes of social support that facilitated hep C care	I have a friend who was co-infected and he hated it. Every day we have to go and make sure that we checked up on him. If I wasn't checking up on

Theme	Sub-Theme	Definition	Example Quote:
			him, his partner had to go check up on him, you know what I mean? We had to make a tag team just to make sure he can make it through the day, and he hated it. He just, like, it was a whole self-damaging thought process where he's like, "I'm not worth anything. Why am I going to go outside and go to Sadie's? It's like, look how stupid I was, I went and caught both of them now." You know what I mean? It's like, stuff like that goes through your head. It's like, dude, the reality of it can be difficult.
	Harm Reduction	Individual mentions any harm reduction strategies that supported hep C care	No, but I'm an ex-addict. So, it's important because then I didn't think about none of that. It's not until after I start getting high that I'm like, "Okay. Yes, I want to check my whole body. I want to check for everything. I want to check for AIDS/HIV, all of that. Just check me because I was in the streets.

Provider Codebook

Theme	Sub-theme	Definition	Example Quote
Prevention	Awareness Risk/Aquisition	Individual states awareness level (knowledge or lack of...) about HCV acquisition	We see such an influx of HIV being thrown in your face, but I think that HCV is not being thrown in your face like that. When we really think about it, [...] it's easier to transmit HCV without you even knowing it,
	Awareness Outreach	Individual states effective outreach techniques and/or examples of effective outreach (inc. Specifically related to outreach, exc. Other types of prevention strategies)	I think that, yes, these public reminders of hep C existence and options for treatment, not just in terms of ads, but I think I've had clients who found it very helpful to like go to their local park and see needle exchange sort of tabling, I guess, at different spots, I think.
	Education Hepatitis C	Individual states an example or suggestion for educating clients on hep C prevention	So, I think giving clients education and awareness, especially in challenging environments. So, not only can they protect themselves during or know what to look out for while they're there, but then when they go back to community or their next sort of phase, they can also be safe.
	Education Harm Reduction	An individual mentions anything related to education around harm reduction strategies including; syringe related transmission, intravenous drug use, support within SSPs	We distributed like 27,000 naloxone kits and 2023 and like 20,000 in 2024 and then have a train the trainer model. So there's an overdose prevention champion trainer. There should be an overdose prevention champion trainer in every shelter and that trainer is responsible for training staff in their shelter and offering training to clients and also distributing naloxone kits. Then there's a policy that whenever

Theme	Sub-theme	Definition	Example Quote
			somebody's unconscious/unable to wake in shelter, overdose response steps must be followed including naloxone administration. So that happens pretty consistently but just because our client population risk is so high, our overdose rates remain high because it's just like despite that, people are still using incredibly risky manner. Then we worked on this harm reduction initiative to bolster the prevention services that are offered before an overdose/after an overdose and that's where we're really focusing our efforts. I would actually include like a hep C navigation intervention in that because like when somebody is connected to hep C care, they're usually going to get some additional services and boost their morale, their overall wellness
	Access Harm Reduction	Individual states an example of how access to harm reduction resources can support hepatitis C prevention	So, I wanted to add to that because my population is IV drug users, and most of them know, like, they've been educated. I think it's just them having easy access to harm reduction supplies. I think a lot of them know about like going to OnPoint or going to certain places, but in the heat of the moment, if they're going to use, they need to share like they're - even if they know they're going to do it. So, my wishful thinking would be if they could just have harm reduction supplies just

Theme	Sub-theme	Definition	Example Quote
			available, like at a pharmacy or at their methadone clinic.
Diagnosis and Linkage to Care	Testing Strategies	Individual states a specific hep C testing strategy utilized at their organization	I mean, at START, we have an opt-out policy. Clients that are admitted get a list of tests that we provide, and they can say, well, I'm not ready to do this right now, but it is done. All of our hepatitis C tests are reflexed so that we know if a patient is antibody positive, we'll know if there's a viral load or not, and then they will be referred to my department for treatment.
	Testing	Individual provides any mentions of testing policy and/or procedure	No, I don't think [providers are aware of testing requirements and eligibility criteria for hep C testing]. The providers I work with, they do, but a lot of them don't. Like we will see. We'll get an alert, for example, that a patient was in the ER and the ED, and it's a patient who's there because they overdosed. So, it's a patient who uses drugs, so they should be tested and then they won't be tested
	Loss to Follow Up	Individual states any type of loss to follow up after initial contact with patient.	We try to give them some teaching materials. We really try to look for clinics or places that have - what's it called - walk-ins. We give them a referral packet, whether they are able to keep the forms that we give them, and the hand outs, that's a completely different thing. We try to let them know. We give them stuff to contact us if they want to make an appointment, but a lot can happen between here and there.

Theme	Sub-theme	Definition	Example Quote
	Linkage Network	Individual states an example of collaboration with different systems/CBOs/DOH to support patient through care continuum	Like I said, at my site, we see HIV and hep C clients, and I manage specifically the HIV program, but yes, keep in touch with someone from the Department of Health who want to know this patient is in jail, are they missing their treatment? We don't have that program or that sort of tracking for hepatitis C clients. What we do sort of have is we're building a relationship - or we have a relationship with them, Bellevue Neurology Clinic and other hospitals. They'll ask us, this patient was here with us, they're going to go to Rikers, they're hepatitis C positive, would you be able to start treatment? Yes, there was that connection that was made, right? So, also, we are starting treatment with these clients, and they're being discharged, and we're making appointments for them to go to whatever hospital, whatever clinic of their choosing, not necessarily in the New York City Health Hospital system.
	Partnerships	Individual states specific type of partnership (i.e. with CBOs, Elected officials, pharmacy reps etc.) ***can double code with linkage network***	So, I have [pharma reps] incentivize our patient in-services, our patient education session. So, we can either give the patient car fare or food so that they'll be able to stay for a meeting or something
	Structural Barriers	Barriers within the structure, policies, or operational	When we're talking about how to eliminate hepatitis C and what clients are left, all the

Theme	Sub-theme	Definition	Example Quote
		systems of an organization or larger system that lead to delays in linkage to care	clients that are left are the ones that haven't received care for all these other reasons that's not their actual - not the actual disease and how do we meet them where they're at. The current healthcare system is not working for that.
	Internal Workflow	Individual mentions clinic or organizational workflow related to hep C	I can give an example. We present at an inpatient center and we've received their - I got an email with a person that was positive for Hep C, with the viral load, the whole thing. I got this email on Friday, they have an appointment tomorrow, and I'm going there so the person can have a telemed appointment with the provider. We're very hands-on and very like, "Let's do this," like linkage and that person will probably have meds. Meds will be ordered tomorrow, but they may not get them until the next day. We use delivery pharmacy and bing, bang, boom
HCV Care and Treatment Access and Support	Access	Individual mentions access to treatment (either in the positive or negative i.e. facilitators and barriers to treatment access)	I love that she said that because automatically, I'm like, yes, because I'm thinking about me being at OnPoint, which is a - we have syringe exchange, and we have the OPC, so people could go use in that building, so all the doctors, like we have fellows come in, and then we have our regular doctors. So, all the doctors that I work with are just, they're pretty cool. Like they're pretty in touch with the people that we serve. I didn't take a moment to step outside of that. So, I'm actually glad that you

Theme	Sub-theme	Definition	Example Quote
			said that because it's true that our people don't get the support and treatment that they need. They are seeing providers who aren't used to treating in a harm reduction manner.
	Strategies	Individual identifies specific types of treatment strategies (i.e. via telehealth, mobile clinics etc)	I go there once a week, and I'll try to be with the clients who have tested positive. I have access to their EMR. I provide education, and then I'm flexible to the patient. As long as I know that the patient's wanting to get treatment, I can go on different days. We give phones as incentives. So, if they're able to use a phone, then they can do telehealth from wherever they like. We can courier the meds from our pharmacy directly to where they are. Then same thing in the inpatient facilities. Clients that have very heavy drug use, when they're not in an inpatient facility, a lot of times their life and their structure is difficult to maintain appointments and to have that traditional structure. So, we try to make it happen when they're inpatient, we have them see a provider, have them start treatment. We bring them the meds to the inpatient facility, have the nurses dispense it, and then follow them to where they go next. Either via telehealth or have them come to the clinic, or if they go to long-term care treatment program, we're able to continue with there as well.

Theme	Sub-theme	Definition	Example Quote
	Barriers to cure	Patient identifies specific barriers to cure	I think just to add something else, I think one of the things that we are seeing now, and I think this is one of the gaps that need to be filled, is that our clients that are elderly, 65 years and older that are on Medicare, I'm noticing that we're getting a lot of denial for their medication. These are the Baby Boomers. This is the category of clients where that has the highest propensity to lose their liver or whatever the case may be. Why are we still being denied for these kind of patient, particularly Medicare patient? With our Medicaid clients, it's one, two, and they're treated. These are the clients that had hepatitis C for longer period. They're probably going to get to the point where they have cirrhosis or something. These are the clients that need the treatment more than anybody else, and they're being denied.
	Support	Individual identifies specific support for clients from initiation to completion of treatment	So, when someone I know is confirmed a viral load, then we do like a little intake into the program and I always say, "Listen, I'm your new best friend from the beginning to the finish of your treatment." That starts to establish like more of a personal relationship. So, I'm like, "You can call me for anything." Including like I've even met them other places to get them their meds or to get them even like just clean syringes and stuff as well.

Theme	Sub-theme	Definition	Example Quote
	Delays (Individual)	Individual mentions reasons for an individual patient to delay hepatitis C treatment.	I think that in my community of Jackson Heights, we see a lot of new migrants who are coming in, who are discovering a lot of these infections now that they have the opportunity to immerse themselves into nursing healthcare, and a lot of them are now realizing that they're either positive in one infection or another, and it's either misinformation, lack of healthcare in their home countries.
	Delays (Structural)	Individual states structural issues that can cause delays in hcv treatment for individual clients (i.e. within initiation of linkage, referrals, etc.)	[...] in some ways I feel there is a disconnect. I have clients that get incarcerated or hep C positive that we would've started treatment on, but they go into the prison system, and they're just left there.
	Insurance	Mentions of insurance (i.e. barriers, coverage, perceptions of coverage)	Payment is a barrier because if they have a copay, they have to pay their copay before the visit. So, at the time of registration, they have to pay their copay. So, if they cannot afford their copay, we can take them to the finance office, but then they wouldn't be seen because they need to have that clearance first [Or they can be seen without signing their copay if they sign the document that says they'll be responsible for it if insurance doesn't cover it or if they don't qualify for financial assistance, which is very scary for them. So, they choose not to sign those documents. Some of them do, but most of them don't, and I

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			understand why. You can have copays, and also it is very disheartening. So, they have their copays, and it just keeps adding up, and then it can go into collections.
Social Determinants of HCV Health Outcomes	Stigma (Hepatitis C)	Individual mentions any type of stigma specifically related to hepatitis C (can include, perceptions about interferon or treatment)	think everybody. In one form or another, whether it's openly or internally, I believe that some providers may have that, or the clients may pick up on some body language, even if it's not directly spoken, or they just may think that they're going to be stigmatized or that they're not going to get the treatment. I definitely believe that it still exists. That's why it shouldn't just be the people providing the services, but it should be ongoing training for everyone. Just like there was always a stigma with HIV, I think that there definitely exists one with Hep C as well, and it can be cured, so there's even more of a push for awareness.
	Stigma (Substance Use)	Individual mentions stigma related to substance use (can include, perceptions of individuals who use illicit substances, association of substance use and hep C etc.)	I've had clients that went to a gastro for treatment and were told, "Nope, the medication is too expensive. You don't have enough 'sober time.' This, that, the other." Or they don't want to do the paperwork. There's no prior authorizations, but they feel that the person's not going to stick with it or whatever. That's what I've heard from a lot of people. Then just feeling like, "Oh, I'm dirty or whatever, whatever," because they have Hep C. I think it used to be like

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			how it was when HIV became more prevalent and things like that. A lot of people will compare it to that. Also, they think that the treatment is interferon, can never get past that.
	Immigration Status	Individual mentions any barriers to care related to a client's immigration status	I think that started since the new administration went into office. Since January, we started to see a decrease of onsite visits, and we were doing a lot of Zoom calls. We were connecting with clients because they didn't feel safe even though we tried to incentivize the visits when they would go to the office.
	Cultural Barriers	Individual mentions any type of barrier related to cultural practices/norms	there's this taboo with medical care in Latin American countries that is seen as a sign of weakness.
	Competing Priorities (Individual)	Individual mentions any type of competing priorities for individuals that hinder hep C care (i.e. other chronic illness, substance use, financial needs)	So, a lot of times, these are individuals who are already facing many challenges, competing priorities that probably inhibit them from even thinking about hep C for the most part.
	Competing Priorities (Structural)	Individual mentions any barriers to care on a structural level due to patient SDOH (i.e. incarceration, unhoused etc.)	there's a push to sort of continue with the legacy of sort of the - continue the system, maintain the system of sort of these isolated correctional facilities. I think that sort of message definitely filters this way down to the more local sectors of government. I think especially for the population of, like ours, which is already

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			corrections, isolated, it's kind of sequestered off of New York City. I think the fact that our clients are struggling with hep C, and they experience many of these gaps that we're all talking about, kind of really complicate things in terms of priorities of providing different care for people, clients that are in correctional facilities
	Housing Stability	Individual mentions any SDOH barriers related to stable housing	I think consistency of where they're going to reside or where they're in transitional housing plays a big part of follow through with medication.
	Contact Information	Individual mentions barriers to patient care/linkage based on phone access or lack thereof.	Then some of these clients come in, they get medicated once a month at 7:00 AM, and I'm not able to talk to them, they don't have a phone.
	Food Security	Individual mentions barriers related to food security	I think housing and food is one of those barriers also. Some of these medications, especially Mavyret, requires patient to have food for them to take it. So, if a patient is unable to provide the necessities, they're not going to take their medicines because one of the things that we do is prior to a patient starting medication, we sit the patient down and talk about the medication, what are the side effects, what are the requirements? So, if a patient doesn't have food, and they're on Mavyret, and I'm not biased against Mavyret or anything, but it's a higher pill burden, and it requires food.

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Data, Surveillance and Metrics	Structural Capacity	Individual mentions structural capacity related to tracking clients across the care continuum	I think in carceral settings, it's absolutely critical that that's a priority. So, I think funding and with funding, not to get political at all, I think that's societal will and political will that we're very fortunate it worked for the city because the jail is also part of the city. But, the health service and department of corrections are separate and that's something that the city funds and pays for. So, that's a priority in our jurisdiction.
	Surveillance	Individual mentions surveillance data related to hep C (i.e. tracking number of new infections, cases etc.)	The research shows that for the first year a patient is positive for hep C, 100 persons can be infected by that one person. So, if we have 17 persons out there, and we are unable to finish treatment, unable to know what their status is after treatment, we're losing the battle.