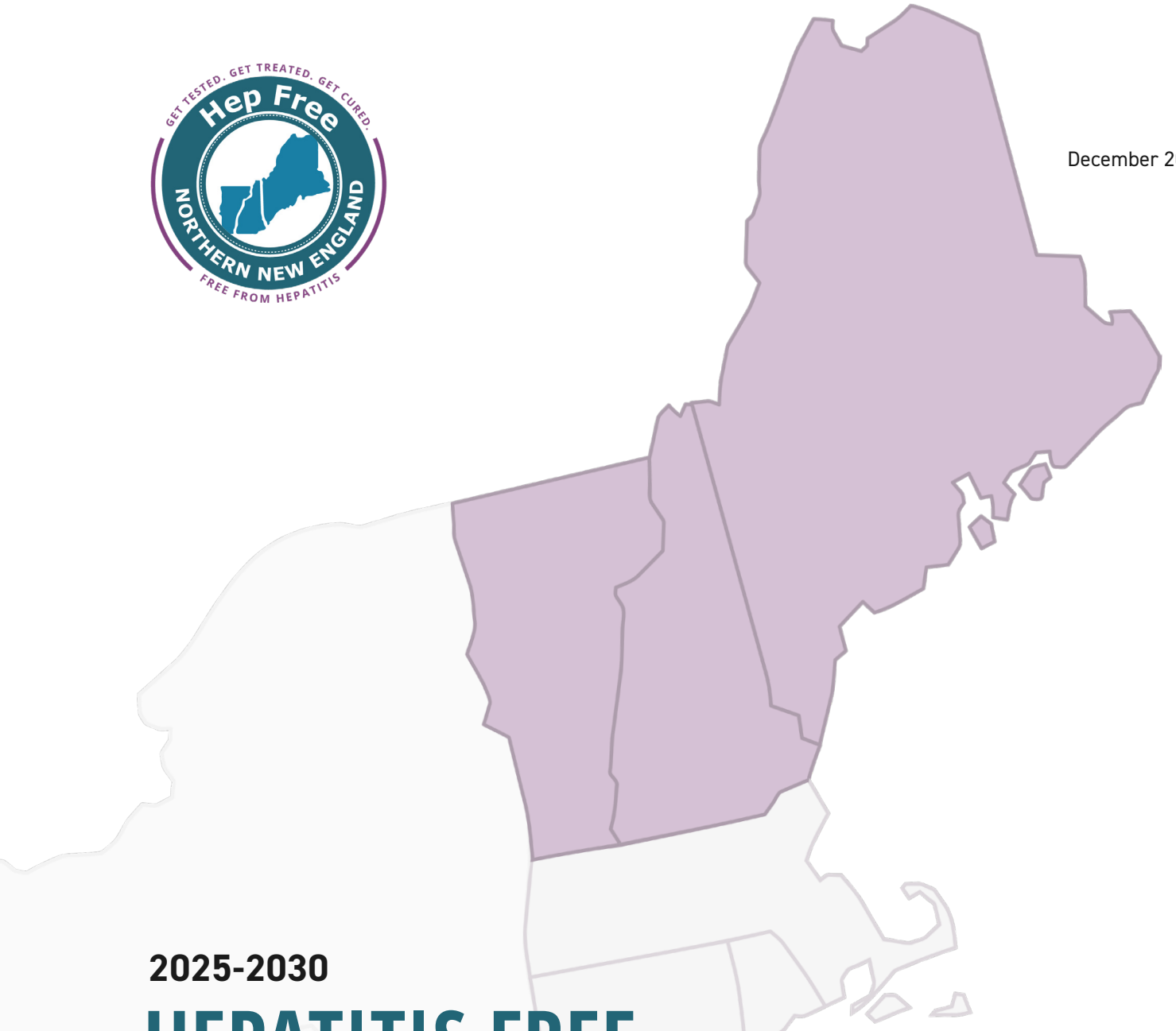
December 2024



2025-2030

HEPATITIS FREE NORTHERN NEW ENGLAND VIRAL HEPATITIS B & C ELIMINATION PLAN

A tri-state collaboration between Maine, New Hampshire, and Vermont

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This work was made possible by cooperative agreement #CDC-RFA-PS21-2103, "Integrated Viral Hepatitis Surveillance and Prevention Funding for Health Departments" award #NU51PS005173-03-01 (New Hampshire) from the Centers for Disease Control and Prevention, Division of Viral Hepatitis. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does mention of trade names, commercial practices, or organizations imply endorsement of the U.S. Government.

PURPOSE

The 2025-2030 Hep Free NNE Elimination Plan (the Plan) is a roadmap for eliminating viral hepatitis B and C in Northern New England. Developed and driven by the broader Northern New England (NNE) community, this Plan is designed to be implemented by local partners, who are the best decision-makers about their community's specific needs and resources. It is intended to be used as a guidepost to help people and organizations concerned with viral hepatitis contribute to the ultimate goal of freeing Maine, New Hampshire, and Vermont from viral hepatitis B and C.

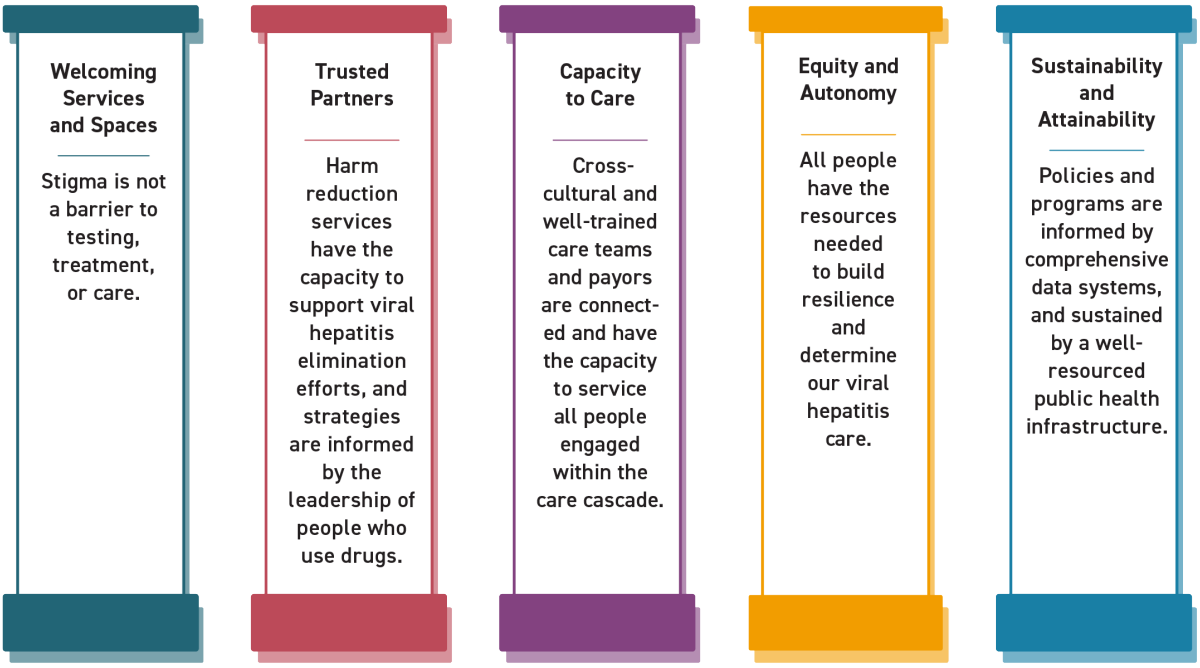
We dedicate this Plan to those across a wide range of sectors and life experiences who contributed to the development of the first-ever NNE viral hepatitis B and C elimination plan.

EXECUTIVE SUMMARY

New hepatitis B and hepatitis C infections have increased with the opioid crisis. This in turn has led to a new generation at risk of future liver cancer, cirrhosis, and premature death. Meanwhile, vaccination against hepatitis B virus continues to be underutilized for adults, and treatment initiation for hepatitis C is decreasing overall, with approximately 40% of people living with chronic hepatitis C unaware of their status. Data spanning 2013–2022 revealed that only a third of people with a documented hepatitis C diagnosis were cured over the past decade. For individuals without health insurance under the age of 40, only one in six have been cured.

The World Health Organization's global strategy to eliminate viral hepatitis aims to reduce new infections by 90% and deaths by 65% between 2016 and 2030.

Given the availability of highly effective, well-tolerated curative treatments, and proven harm reduction strategies to reduce transmission, Northern New England (NNE) has the tools to free itself from the viral hepatitis epidemic. However, preventing new diagnoses and curing those living with hepatitis C will take a coordinated approach. The Hep Free Northern New England (Hep Free NNE) tri-state collaborative set out to develop this 2025-2030 Hep Free NNE Elimination Plan (the Plan) to highlight evidence-based, localized, and actionable strategies that partners across the cascade of viral hepatitis care can take on to help eliminate hepatitis B and hepatitis C from the region. This community-led elimination plan is a product of more than 200 co-creators, as well as of hundreds of additional contributors who gave input through interviews, community discussions, and workgroups, and is built upon by five core pillars and goals:



A "cascade of care" or "care cascade" is a framework used in health care to track a patient's progression through stages of a treatment process between testing and diagnosis, and ultimately achieving the desired health outcome.[1]

"Micro-elimination is less daunting, less complex, and less costly than full-scale, country-level initiatives to eliminate [viral hepatitis] and it can build momentum by producing small victories that inspire more ambitious efforts. The micro-elimination approach encourages stakeholders who are most knowledgeable about specific populations to engage with each other, and also promotes the uptake of new models of care."[2]

The Plan highlights examples of successful micro-elimination strategies from around the United States. A "micro-elimination approach" is a concept first introduced by the European Association for the Study of the Liver's International Liver Foundation. This approach to eradicating viral hepatitis breaks down national-level goals into smaller goals for specific populations, enabling partners across NNE to implement more locally responsive strategies quicker, and using tailored methods.

By facilitating opportunities for partners to learn from one another, both across NNE and within each of the three states, the Hep Free NNE coalition embodies the collaboration, creativity, and flexibility required to achieve the Plan's goals, and to inspire participation and partnership across the care cascade.

We hope you will join us.

In good health and solidarity,
The Hep Free NNE State Co-Chairs

Kelly Bachiochi, MPH
HIV/STI/HCV Epidemiologist
Vermont Department of Health

Bronwyn Barnett, MPH
Viral Hepatitis Prevention Coordinator
New Hampshire Department of Health and Human Services

Chloe Manchester, MSc
Viral Hepatitis Epidemiologist
Maine Center for Disease Control and Prevention

[1] Socías ME, Volkow N, Wood E. Adopting the 'cascade of care' framework: an opportunity to close the implementation gap in addiction care? Addiction. 2016 Dec;111(12):2079-2081. doi: 10.1111/add.13479. Epub 2016 Jul 13. PMID: 27412876; PMCID: PMC5321168.

[2] Lazarus JV, Safreed-Harmon K, Thursz MR, Dillon JF, El-Sayed MH, Elsharkawy AM, Hatzakis A, Jadoul M, Prestileo T, Razavi H, Rockstroh JK, Wiktor SZ, Colombo M. The Micro-Elimination Approach to Eliminating Hepatitis C: Strategic and Operational Considerations. Semin Liver Dis. 2018 Aug;38(3):181-192. doi: 10.1055/s-0038-1666841. Epub 2018 Jul 9. PMID: 29986353.

CO-CREATORS

On behalf of the Hep Free NNE State co-chairs, Hep Free NNE extends its deepest appreciation for all of the individuals, organizations, and systems involved in bringing this Plan into existence.

Most importantly, we thank the hundreds of individuals with lived experience who entrusted their stories to Hep Free NNE, and whose experiences and desire for change were the cornerstone of the Plan.

Hep Free NNE Leadership

The Hep Free NNE Steering Committee provides central leadership, coordination, direct support, and oversight for viral hepatitis B and C elimination planning across New Hampshire, Maine, and Vermont. Steering Committee members served on subcommittees for planning initiatives and as ex-officio members of the broader Hep Free NNE Planning Group where the Elimination Plan's content was developed.

Alexander Potter | Principal, Caracal Consulting

Anna McConnell, MS, FNP, RN | Director of Drug User Health, Maine Access Points

Andrew Seaman, MD | Associate Professor of Medicine, Oregon Health & Science University; Medical Director of Hepatitis and HIV Services at Portland, Oregon's Central City Concern; Vermont Medical Director, Better Life Partners

Anne-Marie Toderico, PharmD | Pharmacy Director, Office of MaineCare Services

Brian Castonguay, RN | Statewide Nurse Educator/Infection Control Coordinator, Wellpath

Bronwyn Barnett, MPH | Viral Hepatitis Prevention Coordinator, New Hampshire Department of Health and Human Services

Carolina Rojas-Becerra, MPH | Viral Hepatitis and Harm Reduction Program Manager, Maine Center for Disease Control and Prevention

Carrie Lones | Viral Hepatitis Epidemiologist, New Hampshire Department of Health and Human Services

Cheryle Pacapelli, BS, CRSW | Project Director, Peer Recovery Supports Services Facilitating Organization, Harbor Care

Chloe Manchester, MSc | Viral Hepatitis Epidemiologist, Maine Center for Disease Control and Prevention

Courtney Plasden, DNP, FNP-BC | Medical Director, Office of MaineCare Services

David de Gijsel, MD, MSc, MPH | Chief Health Officer, Better Life Partners; Assistant Professor, Geisel School of Medicine and The Dartmouth Institute; Staff Physician, Section of Infectious Diseases & International Health, Dartmouth Health

Frank McGrady, PharmD | Executive Clinical Director of Pharmacy, Penobscot Community Health Care

Geoff McIntosh | Population Health Acct. Executive, AbbVie

Hannah Bowen, MPH | HIV/STI/HCV Surveillance Program Manager, New Hampshire Department of Health and Human Services

Jay Gupta, RPh, MS, MTM Specialist, C-IAYT | Director of Pharmacy & Integrative Health, Harbor Care

Kelly Bachiochi, MPH | HIV/STI/HCV Epidemiologist, Vermont Department of Health

Kinna Thakarar, DO, MPH | Physician, Infectious Diseases and Addiction Medicine, MaineHealth

Kristen Chopas | National Accounts Director, Gilead Sciences

Leona Alvarado | Tribal Health Liaison, The Houlton Band of Maliseet Indians

Laurie Williams, MSN, NP | Liver Diseases – Principal Medical Science Liaison, Gilead Sciences

Liana Perez, BSN, RN | Public Health Nurse, Disease Intervention Specialist & Behavioral Health Specialist, City of Nashua Division of Public Health & Community Services

Melissa Caminiti, MPH, BSN, RN | Partnership Director, Groups Recover Together

Mike Selick, MSW | Associate Director of Capacity Building, National Harm Reduction Coalition

Nikki Butler | Southern Maine Director of Overdose Prevention, Maine Access Points

Roxann Stubbs, ANP | Senior Medical Science Liaison, AbbVie

Tiffany Townsend, MS, FNP-C, AAHIVS | Family Nurse Practitioner, ME ECHO, Maine Medical Center/Maine Medical Partners

Community collaborators

Hep Free NNE's commitment to developing a community-centered elimination plan would not have been possible without the partnership of these community-based partners. These organizations conducted the interviews and discussion groups which afforded Hep Free NNE the opportunity to authentically center the Plan around the experiences of people directly impacted by viral hepatitis.

Maine

- Maine Family Planning
- Maine Access Points

New Hampshire

- Greater Seacoast Community Health
- H2RC
- Karlee's Home Team

Vermont

- AIDS Project of Southern Vermont
- Pride Center of Vermont
- Vermont CARES

Authors and facilitators

Through contracts with New Hampshire Department of Health and Human Services (NH DHHS) and the Vermont Department of Health (VDH), the following individuals were responsible for facilitating planning activities and synthesizing the results into the Plan.

- **Lauren Ferridge** | JSI
- **Emma Geurts** | JSI
- **Alexander Potter** | Caracal Consulting
- **Katherine Robert** | JSI
- **Jonathan Stewart** | JSI

BACKGROUND

This 2025-2030 Hep Free NNE Hepatitis Elimination Plan is the product of a four-year tri-state partnership that began in 2021. The analysis and design activities described in our methods would not have been possible without the successful underlying inception and planning work. The work in these formative stages was led by three individuals who would eventually become the Hep Free NNE State Co-Chairs. They were joined by a dedicated group of early partners - which would later be officially convened as the Hep Free NNE Steering Committee.

Inception

In 2021, in the depths of the COVID response, the Maine, New Hampshire, and Vermont health departments each grappled with a new charge from the federal government: complete a statewide Viral Hepatitis Elimination Plan, in line with the National Viral Hepatitis Elimination Strategy. The cross-sectoral mobilization required to create a community-driven, syndemic elimination plan was an extraordinary lift. In addition, each state's viral hepatitis program was staffed only by single individuals (state leads), making the task even more challenging. The solution: collaborate to build a regional plan.

Initiated by NH DHHS, the three state leads from Maine's, New Hampshire's, and Vermont's respective viral hepatitis programs began meeting to discuss the feasibility of a tri-state collaborative planning effort. While the state health departments communicate regarding infectious disease outbreaks, this was the first disease-specific collaboration for the three states. As such, variable surveillance capacity, decision-making structures, and political environments across the three states required careful planning, collaboration, and communication to set expectations.

Syndemic implies "a phenomenon in which two or more diseases or health conditions and the social contexts in which they occur coincide and exacerbate one another, resulting in worse outcomes such as increased transmission, morbidity, and mortality."

- National Association of County and City Officials

To garner support from thought leaders, decision-makers, and stakeholders within their states, state leads identified the following benefits to a regional approach:

- **Pooled resources**: Sharing resources (people, time, money, talent/skills) means all three states can more effectively and efficiently use existing resources while we work to leverage broader opportunities. Collaborating across jurisdictions also reduces duplication and increases peer learning opportunities and networks.
- **Increased visibility**: Raising the visibility of viral hepatitis as a public health priority is a necessary first step toward getting stakeholders engaged in elimination efforts.
- **Access and marketability**: Working together increases our collective power for getting the attention and support of champions and entities with regional priorities.

This partnership to stand up a tri-state collaborative charged with creating a regional viral hepatitis elimination plan was officially formalized with Memorandums of Agreement signed in 2022.

"We all have our unique governance structures and approaches for getting things done, but we're similar in the ways that matter, with shared values and a deep commitment to practical public health strategies that bolster the incredible work that is already happening in our local communities."

– Bronwyn Barnett, Viral Hepatitis Program Coordinator, NH DHHS

Planning

In 2022, the state leads, now titled as State Co-Chairs, assembled a nascent Steering Committee of seven members. These individuals were recruited because of their roles as deeply committed, active participants in hepatitis prevention, treatment, and care across the three states. These early members provided the foundation of some of the most important aspects of creating this plan, namely community engagement, community-driven thinking, and the championing of voices that were not yet explicitly part of meetings.

During the Steering Committee's early meetings, the group worked to articulate its own role within the broader Hep Free NNE planning efforts. The committee's role, it was determined, was to guide and oversee a viral hepatitis elimination strategic planning process that engages a diverse group of partners across NNE with a focus on prioritizing and amplifying the voices of individuals disproportionately affected by viral hepatitis and the organizations that serve them. Together, the State Co-Chairs and Steering Committee finalized the Hep Free NNE keystone items:

- **Mission**: To free Northern New England from viral hepatitis B and C
- **Vision**: Northern New England is a place where new hepatitis B and C infections are prevented, every person knows their status, and every person with viral hepatitis has high-quality health care and treatment free from stigma and discrimination.

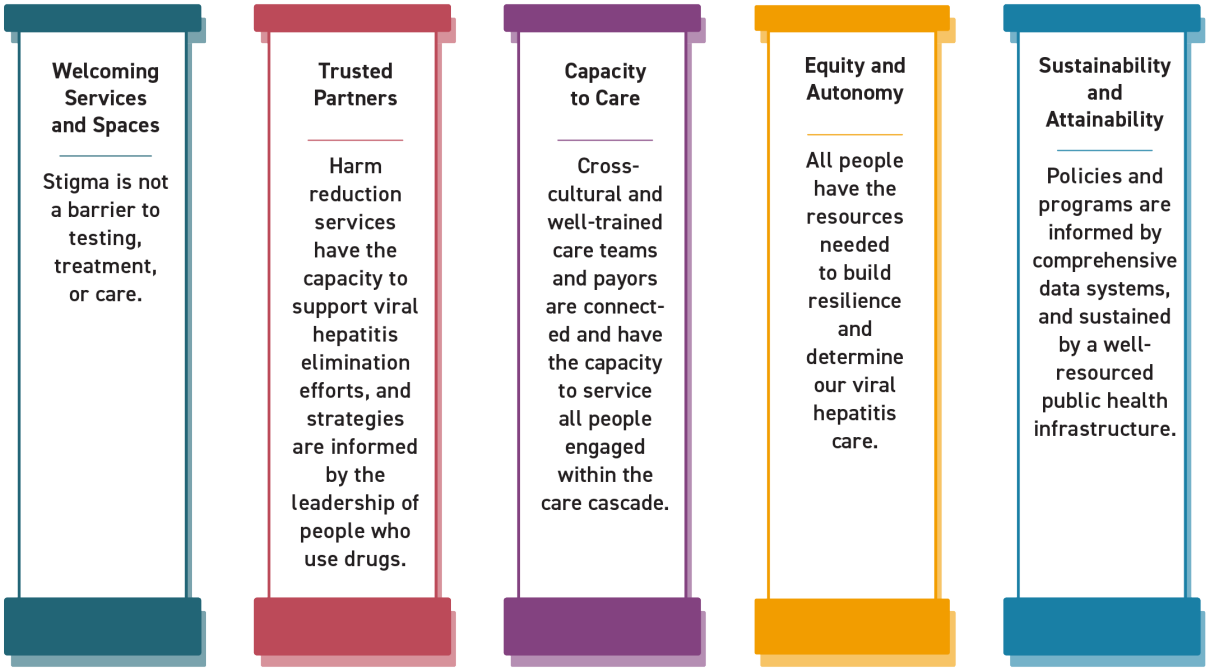
The Steering Committee also identified five core values upon which all future planning activities would be based:

1. **Non-traditional Partnerships**: The success of the plan will depend on our ability to engage non-traditional partners focused on addressing an array of factors driving health outcomes.
2. **Syndemic Approach**: A harmonized, integrated, whole-person response to transform siloed strategies into systems of care is essential for addressing the overlapping epidemics of HIV, STIs, viral hepatitis, and injection drug use.
3. **Many Voices**: Engaging and amplifying diverse voices will result in more impactful strategies to free NNE from viral hepatitis.
4. **Harm Reduction**: Hep Free NNE adheres to the principles of harm reduction (National Harm Reduction Coalition) and is committed to developing strategies that support the rights of people who use drugs.
5. **Intersectionality:** Addressing the many ways that power collides and intersects to create systems of discrimination, disadvantage, and barriers to health is a Hep Free NNE planning priority.

Guided by its mission, vision, and values, Hep Free NNE implemented a holistic, multimodal approach to gathering data and designing a Plan that retained community and individual experiences at its core. That data gathering and design process is documented in **Appendix A: Methods**.

2025-2030 HEP FREE NNE ELIMINATION PLAN

The 2025-2030 Hep Free NNE Elimination Plan is a dynamic resource that has been designed to support partners committed to eliminating viral hepatitis in Maine, New Hampshire, and Vermont. The Plan is structured around five core pillars and goals. Each pillar contains a set of objectives and activities recommended for action by the Hep Free NNE Planning Group and Steering Committee. To provide context for future measuring of progress, each set of objectives and activities is accompanied by a list of desired outcomes.



How is the Plan structured?

Organized by its five pillars, each section of the Plan includes the following:

- **Introductory statement:** Co-authored by a Hep Free NNE Steering Committee member, each introduction describes the overall intent of its pillar and offers a glimpse into what an environment free of viral hepatitis might look like.
- **Drivers for change:** Highlighted data points and quotes reflect the lived experience which grounded the objectives and activities within each pillar.
- **Pathways to elimination:** Each pillar is framed by a singular goal statement, and built out with objectives. Each objective contains a set of activities which were identified by the Hep Free NNE Planning Group and Steering Committee, and a list of desired outcomes that indicate each objectives' progress towards success.

The Plan also highlights findings from research on implementation of microelimination strategies in different settings and at different scales.

Community member quotes are included throughout this Plan in order to center the humanity that underlies this important work to eliminate viral hepatitis in Northern New England. Hep Free NNE honors the experiences of individuals who contributed to "the heart" of this Plan, and extends our endless gratitude.

The Plan is intended for use as an advocacy tool to showcase the extensive work that must be resourced to achieve this goal, as well as a planning guide for partners seeking actionable ideas on how they can contribute to this collective effort. This document is NOT a one-size-fits-all work plan for partners wanting to help eliminate viral hepatitis. It recognizes the diverse needs and approaches of different stakeholders, and aims to provide flexibility rather than dictate a single method of action.

Who should use this Plan?

As packaged, the Plan is designed to speak to the interests of a wide range of stakeholders, including:

- Any organization, coalition, clinical practice, or community-based group that supports individuals living with/at higher risk for viral hepatitis
- Policymakers involved in developing legislative, administrative, or regulatory measures that impact the viral hepatitis care cascade

Whether you're conducting outreach within communities or shaping policies at the state or local level, this Plan aims to offer guidance and inspiration for meaningful contributions to the elimination of viral hepatitis.

How does the work in the Plan happen?

The Plan documented in the following pages reflects a myriad of priorities, and requires teamwork and coordinated strategies to succeed. No single organization or system can achieve elimination alone. However, we generate collective energy towards our shared goals when partners across the care cascade can identify and align their own micro-elimination activities with a single roadmap. Consistent with the equity values underlying Hep Free NNE's work and the Plan's activities, this document was designed to reflect a range of activities that offer equitable opportunity for any implementing partner to contribute to this important work through tailoring micro-elimination strategies that reflect the needs of the individuals they serve.

This document is NOT a one-size-fits-all work plan for partners wanting to help eliminate viral hepatitis. It recognizes the diverse needs and approaches of different stakeholders, and aims to provide flexibility rather than dictate a single method of action.

So, how does an implementing partner get started?

Given the regionality of this Plan and the very different conditions in which care cascades in Maine, New Hampshire, and Vermont operate, implementation of this Plan will look unique to every partner. Regardless of where an organization sits along the collaboration spectrum, there is an opportunity to be part of this work. This is true even if it means simply focusing on implementing a single best practice within your organization. The Plan is a guidepost to help partners begin moving in a coordinated direction, and any momentum in that direction is helpful. Below, we highlight some examples of how an organization might take action to begin using the Plan as a resource to inform their work.

Examples of Implementing Partner Activities	Benefit
Invite a Hep Free NNE Steering Committee member to present the background of Hep Free NNE and the Plan to your team and other partners from your care cascade.	• Raise awareness within your organization about the Plan and the collective efforts to eliminate viral hepatitis. Promote a sense of community and inspire action to address the epidemic. • Engage a formal or informal network of partners from within your care cascade who are similarly committed to aligning work with the Plan.
Review the Plan with your team to identify points of existing overlap, as well as opportunities to explore new strategies within the context of your organization's mission and environment.	• Build consensus around commitment to aligning existing efforts and expansion opportunities generally with the Plan. • Identify which data or evaluation measures you currently collect and can be used to set baseline and progress goals.
Consider the Plan activities designated as "Quick Starts" or "Big Wins" in the context of your organization and broader care cascade to identify ways to strengthen or build new partnerships.	• Contribute to building momentum towards the Plan's goals by initiating "Quick Win" activities. • Understand how your work is contributing to systemic or population-level improvements, and how you might continue to make incremental changes that align with those specific goals.

Pillar #1 | WELCOMING SERVICES and SPACES

Introduction co-authored by David de Gijsel, *Hep Free NNE Steering Committee Member*

Creating welcoming services and spaces is essential to reducing stigma around hepatitis B and C, ensuring that everyone feels valued in their health care journey. Normalizing conversations about these viruses in primary care and making testing routine shifts the focus from fear and judgment to understanding and support. Collaborating with harm reduction programs and health care providers to create clear, compassionate messaging helps people who use drugs feel valued as members of the health care community.

A "welcoming services and spaces" designation will identify health care sites committed to this effort, empowering patients to seek care without fear. Education, awareness campaigns, and trauma-informed care principles make clinical practices more inclusive and effective. Training health care workers to discuss hepatitis with empathy strengthens connections, leading to better testing, treatment, and health outcomes. Training includes improving the understanding of hepatitis care and guidelines, ensuring that all members of health care teams are aware of the current recommendations to offer treatment to people regardless of their substance use. The voices of people with lived experience (PWLE), both of substance use and hepatitis C, are essential in educating health care workers about the stigma experienced by people who use drugs, and can guide the creation of welcoming services and spaces.

Together, we can build a culture of openness and inclusivity, empowering individuals to take charge of their health. By bridging harm reduction organizations, health care providers, and peer support networks, we ensure everyone has access to the resources, support, and care they deserve.

DRIVERS FOR CHANGE

40% of people living with chronic hepatitis C are unaware of their status.

"People's discomfort is a barrier to testing and treatment."

" ...[B]e more open-door and inviting about it. Don't look at it as an illness, but an opportunity to prevent an illness. Approach it with prevention rather than diagnosis. It's scary for some people to be told you are positive."

"There are a lot of misconceptions about drug use, and people don't want their drug use to be known because of stigma."

WELCOMING SERVICES AND SPACES: PATHWAYS TO ELIMINATION

GOAL: Stigma is not a barrier to testing, treatment, or care.

KEY: Quick start Big win

Objective 1: Reduce stigma by normalizing conversations about hepatitis and testing for hepatitis B and C during routine primary care visits.

Activities

- Collaborate with harm reduction programs and primary care practices to develop clear messaging that can be shared and used in clinical settings, and is aimed at making people who use drugs feel welcome and valued as patients.
  - Develop a welcoming services and spaces designation that can be achieved by health care sites, and an accompanying list that is made available to the public
  - Identify providers across the care cascade who are implementing "welcoming and trauma-informed care" practices
- Provide education to primary care providers on normalizing conversations around hepatitis B and C with patients.
  - Facilitate the development of regional learning communities, as well as other opportunities for continuing professional education
- Adapt clinical practice to incorporate evidence-informed guidelines for screening and vaccination into routine care.
  - Include education around approaching routine screening conversations in a non-stigmatizing manner
- Develop and disseminate public awareness campaigns, including:
  - Communication campaigns in waiting rooms, pharmacies and other health care locations to increase awareness and generate more visibility and discussion around viral hepatitis testing and treatment
  - Radio broadcasts showcasing people's lived experiences with hepatitis B and C as a means of educating via storytelling
  - General educational brochures that can be widely distributed
  - Social media, SMS, and email campaigns
- Program electronic medical record systems to require reflex testing.
- Equip all electronic medical record systems with an automatic notification for universal hepatitis B and C screening.
- Include a discussion script for health care providers who offer testing.
- Promote universal screening across all practices.

The use of electronic prompts for clinicians is reported to increase by threefold the likelihood of clinicians ordering tests for patients recommended for Hepatitis C virus (HCV) screening.[3]

[3] Tsay CJ, Lim JK. Assessing the Effectiveness of Strategies in US Birth Cohort Screening for Hepatitis C Infection. J Clin Transl Hepatol. 2020 Mar 28;8(1):25-41. doi: 10.14218/JCTH.2019.00059. Epub 2020 Mar 24. PMID: 32274343; PMCID: PMC7132023.

WELCOMING SERVICES AND SPACES: PATHWAYS TO ELIMINATION

GOAL: Stigma is not a barrier to testing, treatment, or care.

Objective 1: Reduce stigma by normalizing conversations about hepatitis and testing for hepatitis B and C during routine primary care visits.

Desired outcomes

- Programs across Maine, New Hampshire, and Vermont receive a Welcoming Services and Spaces designation.
- Care providers receive Continuing Education related to viral hepatitis.
- Patients are screened for hepatitis during primary care visits, per CDC guidelines.
- Patients are vaccinated for hepatitis A and B, per CDC guidelines.
- A public awareness campaign is implemented.
- Electronic medical record systems are programmed with automatic hepatitis screening prompts.

Objective 2: Increase awareness among health care workers and patients of the high cure rates and low reinfection rates of viral hepatitis among people who use drugs.

Activities

- Increase health care worker training around the effectiveness of treatment.
  - Provide evidence of low reinfection rates
- Increase general public awareness of high cure rates.
- Support skills of harm reduction program staff to assess patient readiness to seek testing and treatment.

Desired outcomes

- Health care workers receive training in the effectiveness of viral hepatitis treatment.
- Harm reduction staff are trained on strategies for assessing and supporting people who use drugs in making choices for testing and treatment.
- No one is denied viral hepatitis care.

A meta-analysis of 41 observational studies showed reinfection rates were lowest among people who inject drugs as compared to other higher risk groups, such as those in prison settings and MSM. Micro-elimination efforts among target populations offer important information that can challenge assumptions (for example, that people who inject drugs have high reinfection rates) and bring to the surface challenges for closer inspection.[4]

[4] Munari SC, Traeger MW, Menon V, Latham NH, Manoharan L, Luhmann N, Baggaley R, MacDonald V, Verster A, Siegfried N, Conway B, Klein M, Bruneau J, Stoové MA, Hellard ME, Doyle JS. Determining reinfection rates by hepatitis C testing interval among key populations: A systematic review and meta-analysis. Liver Int. 2023 Dec;43(12):2625-2644. doi: 10.1111/liv.15705. Epub 2023 Oct 10. PMID: 37817387.

WELCOMING SERVICES AND SPACES: PATHWAYS TO ELIMINATION

GOAL: Stigma is not a barrier to testing, treatment, or care.

Objective 3: Build the capacity of peer support workers, health advocates, and CHWs to make judgment-free connections and build productive relationships between communities and local health care resources.

Activities

- Support multi-pronged and regionally specific relationship building between community harm reduction organizations, substance use treatment settings, housing programs, and local health care resources.
- Educate primary care professionals on the importance of peer advocacy and CHWs.
- Provide funding for peer and patient navigation programs at syringe service programs, community health centers, and other relevant community organizations.
- Fund an organization to provide training, mentoring, and technical assistance to navigators across all of the programs.

Desired outcomes

- Organizations are funded to strengthen the peer navigator workforce.
- Mechanisms are in place to support strong relationships between organizations that provide harm reduction, SUD treatment, housing and health care services.
- Facilitating organizations for peer navigator staff are operationalized.

Objective 4: Increase the use of trauma-informed care principles through health care worker training and education, and the redesign of testing and treatment practices and programs.

Activities

- Provide more continuing professional education opportunities, and leverage resources for the development and support of cross-state learning communities.
  - Increase the capacity of health care practices to implement trauma-informed care approaches

Desired outcomes

- Health care professionals receive training in trauma-informed care principles and practices.
- Health care systems deliver care using trauma-informed approaches.

[4] Munari SC, Traeger MW, Menon V, Latham NH, Manoharan L, Luhmann N, Baggaley R, MacDonald V, Verster A, Siegfried N, Conway B, Klein M, Bruneau J, Stoové MA, Hellard ME, Doyle JS. Determining reinfection rates by hepatitis C testing interval among key populations: A systematic review and meta-analysis. Liver Int. 2023 Dec;43(12):2625-2644. doi: 10.1111/liv.15705. Epub 2023 Oct 10. PMID: 37817387.

Pillar #2 | TRUSTED PARTNERS

Introduction co-authored by Mike Selick and Lauren McGinley, *Hep Free NNE Steering Committee Members*

Eliminating viral hepatitis requires trusted partnerships, inclusive care, and sustainable harm reduction practices that reach all communities. Guided by voices with lived experience, harm reduction services can reshape health care by integrating hepatitis education, testing, and support across the care continuum. Empowering peer leaders and fostering collaborative outreach creates accessible, trauma-informed programs that reduce barriers to care. Partnerships with community organizations, faith leaders, and local advocates give everyone a stake in this journey to wellness. Diverse funding and innovative reimbursement models will secure long-term support, making harm reduction services resilient. With education, evidence-based practices, and compassionate partnerships, we can build a future grounded in trust, inclusivity, and a shared vision, where viral hepatitis is eliminated.

DRIVERS FOR CHANGE

"I only use the AIDS Project and Habit Opco. We need to expand syringe service programs and get more outreach and navigators with lived experience."

"...[Health centers need to better understand how to provide care to] minority groups...[it causes people to not] trust doctors."

"There should be peer-to-peer support, and having more people who are positive speak out about their experiences and educate about the pros and cons of waiting versus going for treatment."

TRUSTED PARTNERS: PATHWAYS TO ELIMINATION

GOAL: Harm reduction services have the capacity to support viral hepatitis elimination efforts, and strategies are informed by the leadership of people who use drugs.

KEY:  Quick start  Big win

Objective 1: Increase the number of people with lived experience planning, leading, and participating in outreach and peer programming efforts to integrate viral hepatitis education and testing into high-quality, established programs.

Activities

- Develop a free, confidential, and easily accessible support group to prevent burnout and sustain collaborative partnerships with people engaged in peer support work.
- Provide multiple channels to gather and act on feedback from people with lived experience regarding how to better meet people where they are to decrease barriers to participation, planning, leadership, and outreach.
- Collaborate with faith-based and other community leaders to provide space to share personal experiences and offer peer support.

Desired outcomes

- Programs have a documented plan to engage people with lived experience in their planning work, based on evidence-supported strategies.
- Program implementation and improvements are responsive to the input of people with lived experience.
- Peer support opportunities meet service area demand.

Objective 2: Increase and diversify funding for harm reduction programs.

Activities

- Conduct long-term financial planning to prevent over-dependence on opioid settlement funds.
  - Use data and evidence of the effectiveness of harm-reduction programs to encourage increased financial support.
- Establish mechanisms to distribute surplus resources from organizations receiving grants for viral hepatitis activities and services.
- Support diversified funding streams for harm reduction programs.

Desired outcomes

- A long-term financial sustainability plan for harm reduction services is completed.
- Increase the number of braided funding or other supplemental funding applications.
- Increased proportion of program funding from braided sources.

TRUSTED PARTNERS: PATHWAYS TO ELIMINATION

GOAL: Harm reduction services have the capacity to support viral hepatitis elimination efforts, and strategies are informed by the leadership of people who use drugs.

Objective 3: Expand the ability of harm reduction programs to provide viral hepatitis supports and services across the full care cascade.

Activities

- Offer confirmatory testing in harm reduction settings.
- Ensure harm reduction programs can dispense medication.
- Provide training opportunities for harm reduction program staff on evidence and communication strategies for supporting people who use drugs in seeking testing and treatment.
- Expand harm reduction program staff capacity to provide care navigation and coordination assistance.

Desired outcomes

- All harm reduction program clients are offered confirmatory testing.
- All harm reduction programs can offer their clients the ability to safely store medication.
- All harm reduction programs will have staff with training and capacity for providing viral hepatitis care navigation services.

The proximity of syringe service programs are directly linked to lower rates of new and reinfections of HCV among people who inject drugs.[5]

Objective 4: Make it easier to seek care from harm reduction services and recovery-focused community organizations by fostering collaboration between treatment programs that offer welcoming and trauma-informed care.

Activities

- Increase awareness of harm reduction initiatives through media campaigns and/or other avenues.
- Create and distribute a list of health care systems/sites that are harm reduction-friendly.
- Incorporate whole-person care into harm reduction and recovery settings.
- Develop communities of practice focused on partnership and shared services between different types of harm reduction and substance use and behavioral health programs.

[5] Romo E, Rudolph AE, Stopka TJ, Wang B, Jesdale BM, Friedmann PD. HCV serostatus and injection sharing practices among those who obtain syringes from pharmacies and directly and indirectly from syringe services programs in rural New England. Addict Sci Clin Pract. 2023 Jan 3;18(1):2. doi: 10.1186/s13722-022-00358-7. PMID: 36597153; PMCID: PMC9809047.

TRUSTED PARTNERS: PATHWAYS TO ELIMINATION

GOAL: Harm reduction services have the capacity to support viral hepatitis elimination efforts, and strategies are informed by the leadership of people who use drugs.

Objective 4 *(continued)*: Make it easier to seek care from harm reduction services and recovery-focused community organizations by fostering collaboration between treatment programs that offer welcoming and trauma-informed care.

Desired outcomes

- All harm reduction programs are aware of the harm reduction-friendly health care systems/sites in their community.
- Collaborative partnerships are established between harm reduction and SUD and Behavioral Health programs.
- Regional communities of practice are operationalized with active participation of harm reduction, treatment, and recovery organizations.

A common myth is that people who inject drugs and are cured of hepatitis C are at high risk of reinfection. However, data suggest that reinfection is rare for people who inject drugs and clear HCV with therapy, even if they continue to inject drugs.[6]

Objective 5: Make harm reduction programming more financially sustainable through insurance coverage and other innovative reimbursement models.

Activities

- Offer confirmatory testing in harm reduction settings.
- Ensure harm reduction programs can dispense medication.
- Provide training opportunities for harm reduction program staff on evidence, and communication strategies for supporting people who use drugs in seeking testing and treatment.
- Expand harm reduction program staff capacity to provide care navigation and coordination assistance.

Desired outcomes

- Harm reduction programs are consulted in the development of a Roadmap to Reimbursement.
- A Roadmap to Reimbursement is distributed and utilized by harm reduction programs.
- Harm reduction programs are reimbursed by a diverse pool of payors.

[6] HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; Key Populations: Identification and Management of HCV in People Who Inject Drugs. www.HCVGuidelines.org. American Association for the Study of Liver Disease and the Infectious Diseases Society of America.

Pillar #3 | CAPACITY TO CARE

Introduction co-authored by Frank McGrady, *Hep Free NNE Steering Committee Member*

Building a health care system capable of supporting everyone affected by viral hepatitis requires culturally responsive, well-trained, and connected care teams. When health care workers reflect the communities they serve, patients feel respected and are more likely to complete treatment. Prioritizing recruitment and retention of diverse workers, including those with lived experience, ensures hepatitis care is empathetic and effective.

Expanding technical and culturally relevant training empowers both clinical and nonclinical staff to provide meaningful support across cultural and linguistic lines. Smoother care transitions, expanded telehealth, and support tailored for specific populations, like justice-involved individuals, ensure no one falls through the cracks.

To sustain this level of care, reimbursement models must recognize and support comprehensive hepatitis services, allowing organizations to deliver compassionate, high-quality care. By creating a health care environment where each patient feels valued, we pave the way for universal access to treatment, equitable outcomes, and stronger community health.

DRIVERS FOR CHANGE

"If there were more places for people to get tested, like at the harm reduction program or pop-up clinics like the flu shots. It takes so long to get into a doctor around here, every couple of months it feels like we have to find a new PCP."

"It can be hard to get labs done without transportation. I tend to get my labs drawn at the pharmacy – would be good to offer screening and treatment through there. There should be more places to access information."

CAPACITY TO CARE: PATHWAYS TO ELIMINATION

GOAL: Cross-cultural and well-trained care teams and payors are connected and have the capacity to serve all people engaged with the care cascade.

KEY: Quick start Big win

Objective 1: Prioritize recruitment and retention of viral hepatitis health care workers who most closely reflect the communities they serve.

Activities

- Ensure training programs and career pathways within the care cascade are available to people with lived experience.
- Promote recruitment of linguistically and culturally diverse staff in clinic- and community-based health care and Medications for Opioid Use Disorder (MOUD)/SUD treatment sites.

Desired outcomes

- People with lived experience are active members of care teams.
- Diverse care teams receive adequate support and training during onboarding and beyond.
- Care teams collectively represent the linguistic and cultural diversity of the communities they serve.

Objective 2: Expand technical training for clinical and nonclinical staff to deliver culturally appropriate viral hepatitis services that support individuals towards completion of treatment and eventual clearance.

Activities

- Conduct a needs assessment to identify current training needs and opportunities to improve access to culturally appropriate training.
- Create a catalog of existing training resources that includes national, state, and locally relevant content.
- Develop culturally appropriate training materials and train-the-trainer models that have been informed by individuals with relevant lived or professional experience, and tested by the intended audience.
- Create technical assistance centers to expand access to culturally relevant training.

Desired outcomes

- Training needs are identified.
- Existing national, state, and local training content is cataloged.
- Culturally appropriate training content is delivered.
- Individuals receive culturally appropriate viral hepatitis services.

CAPACITY TO CARE: PATHWAYS TO ELIMINATION

GOAL: Cross-cultural and well-trained care teams and payors are connected and have the capacity to serve all people engaged with the care cascade.

Objective 3: Make the patient's transition between and across systems smoother to improve the likelihood of completion of treatment and eventual clearance.

Activities

- Promote the use of clinical decision support tools and quality improvement projects within systems to facilitate linkage to care across settings.
- Implement closed-loop referral platforms.
- Build the capacity of care navigators and peer recovery specialists to support transitions across the care cascade.

Desired outcomes

- Systems are implementing quality improvement activities to facilitate linkage to care and complete treatment.
- Individuals moving through the care cascade are not lost to follow-up.

Objective 4: Expand care teams to include those who work with at-risk populations, peer navigators, and other community-based staff who typically work outside of traditional health care settings.

Activities

- Develop tools to help care teams assess and monitor team composition to ensure membership reflects the needs of the population being served.
- Develop resources to help organizations across the care cascade build teams focused specifically on supporting the specialized needs of individuals with justice system involvement.
- Develop partnerships that support individuals maintaining stability upon re-entry to the community from correctional settings.

Desired outcomes

- Care team composition reflects the needs of the population they serve.
- Partnerships exist to support successful community reentry and completion of treatment for justice-involved individuals.

CAPACITY TO CARE: PATHWAYS TO ELIMINATION

GOAL: Cross-cultural and well-trained care teams and payors are connected and have the capacity to serve all people engaged with the care cascade.

Objective 5: Increase telehealth access for viral hepatitis education and treatment, focusing especially on access for rural populations and people who do not typically engage with traditional health care settings.

Activities

- Develop resources that support organizations across the care cascade to assess and implement telehealth services.
- Expand networks that allow primary care clinicians to connect with subspecialists for remote case consultation.
- Identify resources to mitigate cost and reimbursement barriers to implementing telehealth.

Desired outcomes

- Organizations across the care cascade offer telehealth services.
- Primary care providers have access to remote case consultation from subspecialists.

The American Association for the Study of Liver Diseases group highlights how Project ECHO can progressively simplify management of HCV care and treatment by integrating it into routine primary care. Project ECHO, a tele-mentoring model, links liver-disease specialists with primary care physicians (PCPs) in a "knowledge network" to discuss management of more complex cases.[7]

Community-based collaborative care teams have proven effective in working in rural areas. Public health nurses and case managers communicate with populations about referrals, lab tests, and direct-acting antiviral treatment.

Objective 6: Improve and enhance access generally for viral hepatitis care through broader reimbursement strategies.

Activities

- Conduct a scan to document public and private payors' reimbursement guidelines and state regulations across the viral hepatitis care cascade.
- Conduct a scan to document how providers are being reimbursed for viral hepatitis services across the care cascade, and other reimbursement barriers.
- Develop a toolkit that can broadly guide service providers in seeking and implementing new reimbursement models.
- Develop policy recommendations for payors and lawmakers on ways to improve service providers' access to reimbursement for viral hepatitis services.

Desired outcomes

- Providers have access to information about ways to remove reimbursement barriers to providing viral hepatitis care.
- Payers and lawmakers are informed on ways to improve policy around payment for viral hepatitis services.

[7] Feld JJ, Ward JW. Key Elements on the Pathway to HCV Elimination: Lessons Learned From the AASLD HCV Special Interest Group 2020. Hepatol Commun. 2021 May 3;5(6):911-922. doi: 10.1002/hep4.1731. PMID: 34141979; PMCID: PMC8183173.

Pillar #4 | EQUITY and AUTONOMY

Introduction co-authored by Anna McConnell, *Hep Free NNE Steering Committee Member*

We must work together to transform our current systems of care and ensure that every person has the resources they need to understand and navigate their health; this is especially important for those at higher risk. Empowering people to have a voice in their viral hepatitis care is essential to building equitable, resilient communities. Designing care models that center the lived experiences of people who use drugs and address the social determinants of health will result in care that is both accessible and effective.

Removing barriers related to cost, distance, and time is critical. Direct engagement with those affected by viral hepatitis helps us tailor strategies to meet their needs. Working at the intersection of multiple systems (housing, mental health, and systems of incarceration) supports a holistic approach, addressing viral hepatitis alongside other health and social challenges.

Inclusive task forces, innovative outreach, and accessible educational materials in diverse languages are necessary to amplify community voices and raise awareness. Sharing educational materials in familiar clinical and community settings will create the pathways for informed, shared decision-making, as well as meaningful engagement with care. Together, we can create a supportive environment where everyone has the ability to get the care they deserve.

DRIVERS FOR CHANGE

For patients without health insurance under the age of 40, only 1 in 6 has been cured.

"I got tested when I was in prison. They were going to treat me, but my stint wasn't long enough. I actually thought of finding a way to do more time so. . .I could get treatment."

"...[T]esting and vaccine clinics happen[ing] at community centers. More education and access to info. More queer doctors, and free testing would help."

EQUITY AND AUTONOMY: PATHWAYS TO ELIMINATION

GOAL: All people have the resources we need to build resilience and determine our viral hepatitis care.

KEY: Quick start Big win

Objective 1: Increase the use of easy-to-access resources for those who may be at higher risk for viral hepatitis or who may have more trouble getting care.

Activities

- Disseminate educational resources in clinical and community-based settings, including SSPs, where individuals with higher risk for viral hepatitis frequently and comfortably spend time.
- Engage with dissemination partners to identify new and creative channels to deliver care resources to intended audiences.
- Expand outreach and service delivery models that remove cost, distance, and time barriers to accessing treatment and other care resources.

Desired outcomes

- Educational resources are widely available in settings where individuals with higher risk for viral hepatitis spend time.
- Low-barrier care is available to those at higher risk for viral hepatitis.

Decentralizing care and providing care services where higher-risk individuals are more readily found has been shown to increase screening and treatment initiation. "Opt-out" systems that automatically link individuals experiencing homelessness to care early in the cascade have proven to be a promising protective factor.[8]

Objective 2: Design and improve viral hepatitis care around the experiences of people who use drugs and social drivers of health data.

Activities

- Implement strategies, such as structured, motivational interviews, to incorporate input from people who use drugs and incarcerated individuals to inform and improve viral hepatitis care.
- Implement procedures for regularly and systematically gathering and acting on data from social drivers of health screening tools.
- Formalize quality assurance strategies to ensure new activities, materials, and services are grounded by the goals of improving equity and reducing disparities.

Desired outcomes

- Systems have the knowledge and skill to sensitively engage people who use drugs and incarcerated individuals for quality improvement processes.
- Viral hepatitis care is informed and improved by the experiences of people who use drugs and other social drivers of health data.

[8] Seaman A, King CA, Kaser T, Geduldig A, Ronan W, Cook R, Chan B, Levander XA, Priest KC, Korthuis PT. A hepatitis C elimination model in healthcare for the homeless organization: A novel reflexive laboratory algorithm and equity assessment. Int J Drug Policy. 2021 Oct;96:103359. doi: 10.1016/j.drugpo.2021.103359. Epub 2021 Jul 27. PMID: 34325969; PMCID: PMC8720290.

EQUITY AND AUTONOMY: PATHWAYS TO ELIMINATION

GOAL: All people have the resources we need to build resilience and determine our viral hepatitis care.

Objective 3: Provide information, knowledge, and support needed for everyone to make informed decisions about viral hepatitis care.

Activities

- Develop patient educational materials that provide clear and accurate information on current prevention, screening, testing, and treatment recommendations.
- Make educational materials available in multiple languages pertaining to local communities and delivered through virtual and in-person modalities that align with diverse styles of learning and communication.
- Develop social marketing campaigns that highlight the experiences of people who have completed HCV treatment.

Desired outcomes

- Individuals can access viral hepatitis educational materials and other information in their preferred language, literacy level, and modality.
- Individuals can incorporate the experiences of people who have completed HCV treatment into their decision-making.

Objective 4: Integrate viral hepatitis care in strategic plans focused on housing, substance use, mental health, and incarceration.

Activities

- Form multi-sectoral state-level task forces:
  - Which are inclusive of people experiencing housing insecurity, substance use or mental health challenges, or involvement with the justice system
  - To identify, inform, and act on opportunities for a holistic approach to addressing viral hepatitis and other associated health and social conditions
  - That emphasize two-way communication to keep the public informed on the progress of these plans
- Pursue funding opportunities that support integrated planning across sectors.
- Include terms in requests for proposals, contracts, and other funding mechanisms that require vendors to provide information and resources as appropriate for viral hepatitis awareness, education, screening, referral, or treatment.
- Develop state-specific recommendations for how government agencies can incorporate viral hepatitis considerations into relevant planning and programming efforts.

Desired outcomes

- Multi-sectoral partnerships pursue funding for plans that integrate viral hepatitis considerations.
- Viral hepatitis considerations are incorporated into plans that address housing stability, substance use, mental health, and carceral health.
- Government agencies promote syndemic solutions through administrative and contractual procedures.

Pillar #5 | SUSTAINABILITY and ATTAINABILITY

Introduction co-authored by Anne-Marie Toderico, *Hep Free NNE Steering Committee Member*

A sustainable public health infrastructure is key to eliminating viral hepatitis. By leveraging data systems and creating collaborative partnerships, we will build a coordinated care cascade that effectively serves those at risk. Our progress over time will be measured by the achievement of our clear incremental goals.

Cooperation across health systems, including data-sharing policies and improved communication, streamlines access to vaccinations, screenings, and treatment. Training diverse community partners, especially those serving vulnerable populations, ensures people at risk for viral hepatitis receive effective, low-barrier care in all settings.

The buy-in of policymakers and legislators is essential for this work. Their support of better surveillance and standardized reporting will allow the data to reveal essential insights into treatment outcomes and disparities. Embedding long-term funding in state budgets and creating resource-sharing mechanisms empower communities to build adaptable and resilient care systems.

Together, we can transform viral hepatitis care, fostering collaboration and innovation that prioritizes health for all. Our collective efforts pave the way for a future where viral hepatitis is eliminated, ensuring a healthier tomorrow for everyone.

DRIVERS FOR CHANGE

"They do the best they can, but we always need more for more people. We could use [counselors] that can help people make a plan for the future and execute it."

"The services and things only work as well as you put energy into them, but sometimes it feels like you're trying to make things work while the people you're working with have no clue what's going on."

SUSTAINABILITY AND ATTAINABILITY: PATHWAYS TO ELIMINATION

GOAL: Policies and programs are informed by comprehensive data systems and sustained by a well-resourced public health infrastructure.

KEY: Quick start Big win

Objective 1: Leverage existing systems, capabilities, routines, and partnerships to improve information sharing and coordination of services across the care cascade.

Activities

- Develop goals for collaborative efforts that create early momentum and have increasing levels of complexity over time.
- Establish opportunities for partners across the care cascade to learn about successful practices and workflows that might be replicated.
- Promote use of data-sharing policies and agreements to improve care coordination, case monitoring, and access to care.
- Support systems of care in building capacity to track measurable outcomes in screening, vaccination, linkage to treatment, and treatment success.

Desired outcomes

- Collaborations have written documentation of their shared goals and expectations for participation.
- Peer-learning opportunities are accessible to partners across the care cascade.
- Partners within the care cascade have documented data-sharing agreements.
- Systems can monitor and accurately report measurable outcomes across the viral hepatitis care cascade.

Objective 2: Increase training and technical assistance on new and best practices for testing, care, and support across diverse health and community care systems.

Activities

- Support systems of care in establishing mechanisms that remove treatment adherence barriers and alleviate burden on primary care offices.
- Promote novel options that support individuals in receiving initial screening and completing the viral hepatitis care cascade.
- Prioritize capacity-building specific to meeting the needs of individuals with viral hepatitis living in correctional settings, and those same individuals as they transition back into a community setting.
- Offer low-barrier viral hepatitis training opportunities specifically designed for community partners (harm reduction programs, recovery community organizations, shelters).

Desired outcomes

- Care cascades include services that promote treatment adherence outside of the primary care setting.
- Providers utilize novel strategies to engage individuals across the care cascade.
- Care teams across systems have enhanced knowledge to support individuals re-entering the community from correctional settings.
- Community partners have access to viral hepatitis training opportunities.

SUSTAINABILITY AND ATTAINABILITY: PATHWAYS TO ELIMINATION

GOAL: Policies and programs are informed by comprehensive data systems and sustained by a well-resourced public health infrastructure.

Objective 3: Improve ways to report laboratory test results and gauge outbreaks, trends, and disparities to support better viral hepatitis surveillance.

Activities

- Make all hepatitis C results reportable to the state - including + ab, + and - RNA antibody tests.
- Establish a prevalence measure for each state.
- Upgrade surveillance systems to track cases of clearance, cure, and reinfections.

Desired outcomes

- State surveillance systems can track all hepatitis C cases through the care cascade.
- State surveillance programs have access to data that assesses viral hepatitis disparities.

In 2014 the Department of Veterans Affairs (the VA) began an effort to cure a defined population in a specific setting - the 170,000 veterans with chronic HCV in VA care. By early 2019, they had treated 116,000 vets. This demonstrates how a focused effort can help an existing system adapt. The VA relied on a strong existing HCV surveillance system and the ability to implement rapid clinical redesign.[9]

Objective 4: Improve advocacy and collaboration for funding, policies, and other resources that are needed to make progress toward the elimination of viral hepatitis.

Activities

- Identify "gold-standard" measures New Hampshire, Maine, and Vermont can each use to illustrate progress towards viral hepatitis elimination.
- Identify gaps in systems to report on "gold-standard" measures, and identify incremental steps towards addressing those gaps.
- Create standard surveillance reports for stakeholders to share with policy- and decision-makers.
- Develop an awareness campaign that informs policy- and decision-makers about the viral hepatitis epidemic, and necessary policy and funding solutions.
- Incorporate long-term funding into the state budget(s) for public health staff and community organizations working across the viral hepatitis care cascade.
- Build mechanisms that allow partners to share grant and funding opportunities within and across New Hampshire, Maine, and Vermont.

Desired outcomes

- "Gold standard" measures are documented to guide progress towards the elimination of viral hepatitis.
- State budgets include adequate funding to support viral hepatitis elimination activities.

[9] Gonzalez R, Park A, Yakovchenko V, Rogal S, Chartier M, Morgan TR, Ross D. HCV Elimination in the US Department of Veterans Affairs. Clin Liver Dis (Hoboken). 2021 Aug 18;18(1):1-6. doi: 10.1002/cld.1150. PMID: 34484696; PMCID: PMC8405054.

APPENDIX A: METHODS

Building upon the State Co-Chairs' and Steering Committee's early inception and planning efforts, the Hep Free NNE initiative embarked on its next phases of work to 1) analyze the environmental landscape in which elimination strategies will take place, and 2) design a community-driven, iterative framework by which to interweave the findings of the analysis activities with the practical, experience-based perspective of individuals participating in the actual planning activities.

Analysis

Hep Free NNE's analysis phase, completed during 2023, encompassed a mixed-methods approach to ensure the elimination plan was grounded by community voices and supported by quantitative data.
Analysis activities included:

- Develop an epidemiologic profile
- Facilitate opportunities for people with lived experience using drugs, having viral hepatitis, or engaging with the care cascade to guide the planning work
- Host a kick-off summit, inclusive of an interactive, participatory session to affirm and refine a set of draft goals for the elimination plan

In 2023, NH DHHS contracted with JSI, who partnered with Caracal Consulting (a VDH contractor) to guide implementation of these activities.

Epidemiologic profile

The epidemiologic profile developed for NNE examined the population demographics of Maine, New Hampshire, and Vermont, means by which viral hepatitis is reported in each state, key indicators for hepatitis A, and indicators for both acute and chronic hepatitis B and C.

A primary challenge to completing the profile was the variability in completeness of hepatitis B and C data in the region; this variability arose from varying state laws, resources, and infrastructure. Nevertheless, the data yielded some key findings about hepatitis A, B, and C virus transmission across northern New England:

- Injection drug use and non-injection drug use are leading risk factors for transmission across all hepatitis viruses.
- Housing stability, recency of incarceration, and unlicensed tattoos are leading additional risk factors (hepatitis A and B, Maine and New Hampshire only).
- The largest proportion of cases reported for both hepatitis B and C have been for those aged 30-39.

The full epidemiologic profile and findings from the work to engage people with lived experience in communities are summarized together in the 2023 Northern New England Situational Analysis report.

Engaging communities across levels

Parallel to the epidemiologic profile, Hep Free NNE invested significant resources towards ensuring the experiences of community members and practitioners across the care cascade were forefront to the subsequent planning phase. This took the form of a multipronged approach that captured first-hand experiences of individuals, organizations, and loose "systems" of stakeholders working to address issues related to viral hepatitis.

INDIVIDUALS: Partnerships with community collaborators

The Hep Free NNE Steering Committee partnered with seven community-based organizations to coordinate qualitative input from individuals with lived experience using drugs, having viral hepatitis, or engaging with the care cascade. Over the course of three months, partners engaged more than 150 individuals receiving services from their respective organizations or via community outreach in conducting brief interviews.

ORGANIZATIONS: Key informant interviews and group discussions

Team members from JSI and Caracal Consulting conducted hour-long key informant interviews with 45 representatives of primary and community health centers; infectious disease, syringe service program, and harm reduction specialists; substance use prevention, treatment and recovery providers; HIV/AIDS service organizations; as well as state and local public health, tribal health, pharmaceutical industry, and advocacy organizations. Those interviewed helped inform the situational analysis and emerging themes. Additionally, State Co-Chairs participated in 10 group discussions embedded within existing meetings or trainings hosted by coalitions or associations focused on a broad range of issues directly related or adjacent to viral hepatitis, including rural health and health equity, community health workers (CHWs), family planning, and corrections. These interviews and discussion groups provided important perspectives about hepatitis awareness, prevention, testing, and treatment barriers and opportunities.

SYSTEMS: Discovery committees

The Hep Free NNE Steering Committee convened Discovery Committees in the spring of 2023, each led by a member of the Steering Committee. These small workgroups convened to engage communities of stakeholders working on complex, high-priority issues related to viral hepatitis elimination. Discovery committees for this phase of work were organized around these drivers of viral hepatitis elimination:

- Medicaid partnerships
- Perinatal hepatitis C care
- Hepatitis C care in correctional settings and reentry

Discovery committee members conducted individual and small group interviews with 34 stakeholders from across the region. Presented at the Kick-off Summit, the input from these stakeholders illuminated the unique experiences of providers and individuals across these three domains, and offered vital input for the Plan. The analysis activities produced the following high-level needs:

- Increased capacity across the viral hepatitis care cascade
- Improved education and awareness for communities and providers to reduce stigma around viral hepatitis
- Improved accessibility of viral hepatitis testing and treatment

These identified needs served as the foundation for the elimination plan. Based on these needs, the Hep Free NNE Steering Committee drafted an initial set of pillars and goal statements that would be refined and affirmed during the Hep Free NNE Kick-off Summit.

Hep Free NNE Kick-off Summit

In late 2023, the Hep Free NNE Steering Committee hosted a virtual summit to officially launch Hep Free NNE and its planning efforts. This virtual gathering welcomed more than 150 partners across Maine, New Hampshire, and Vermont. The Summit showcased:

- Situational analysis of the region's hepatitis screening, treatment, and care with special attention to the voices of people with lived experience
- Discovery Committees findings on topics such as Medicaid prior authorizations and viral hepatitis in corrections systems
- Epidemiologic picture of viral hepatitis across the three states
- Panel on harm reduction with people with lived experience
- Participatory sessions for all attendees to provide input on the pillars and goals

Design

The design phase for the Plan took place between December 2023 and December 2024. Facilitated by JSI, a large, multi-sectoral Planning Group convened to develop lists of objectives and activities for each of the five pillars, assess each activity through the criteria of feasibility, urgency, impact, and equity, and then participate in conversations around implementation strategies.

Iterative collaboration

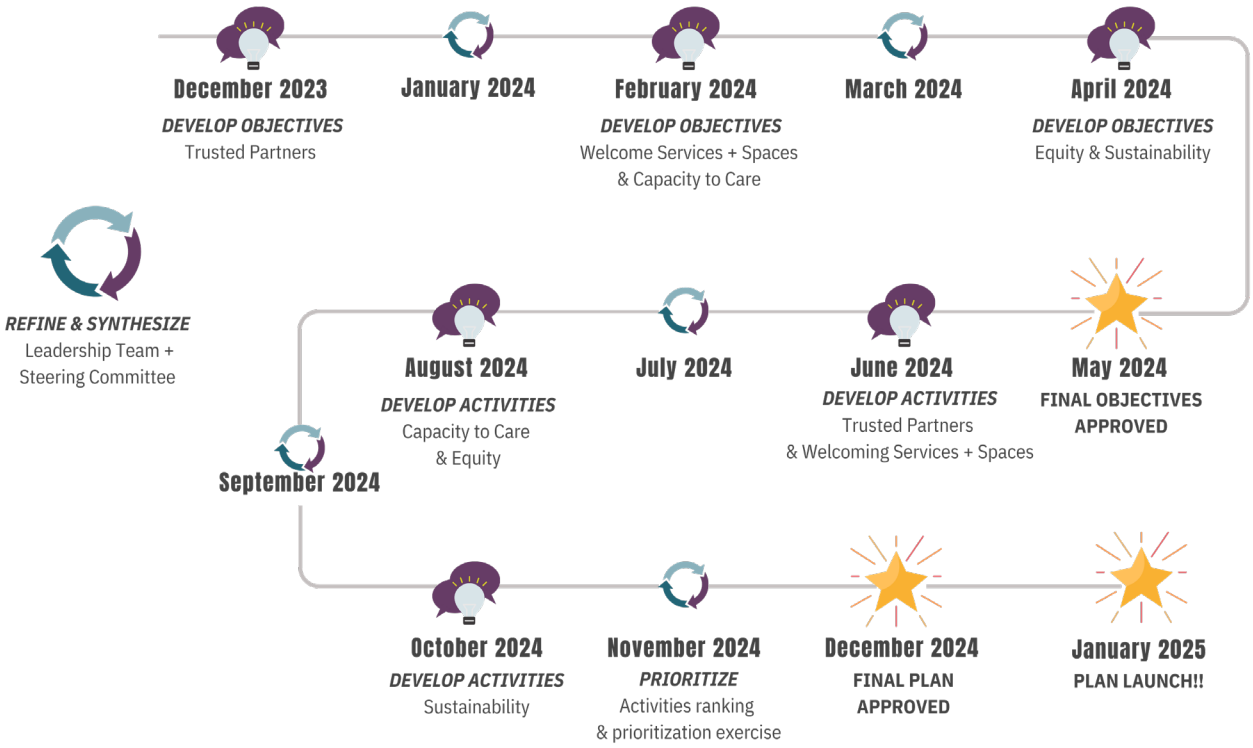
Recruitment for a cross-sector Planning Group initiated following the Kick-off Summit, with a goal of bringing in wide participation in a manageable format for the community expertise sought. The large group of more than 40 individuals represented a multitude of perspectives, including:

- People with lived experience lived experience of using drugs and engaging in harm reduction strategies
- People who lived/are living with hepatitis, as well as their families and caregivers
- Syringe service programs
- Harm reduction programs
- Substance use disorder (SUD) treatment programs
- Mental health services
- Organizations serving people with higher risk
- Faith-based organizations
- The pharmaceutical industry
- Commercial pharmacies
- Correctional facilities
- Medical/professional societies
- Maternal and child health programs
- Advocacy organizations
- Federally Qualified Health Centers (FQHCs) and rural health centers
- Hospitals and EMS
- Medicaid
- Managed care organizations

The Planning Group convened virtually six times over a 10-month period. During these meetings, the Planning Group organized its work around the five pillars created by the Steering Committee.

Generally applying the Institute of Cultural Affairs' focused conversation framework to the process, JSI facilitators utilized a variety of facilitation techniques to engage participants across the spectrum of learning and communication styles. The formats by which real-time input was captured ranged from highly-interactive Miro boards, to simple online polls, and basic verbal conversation. This approach provided structure to the planning conversation, allowed the work to follow a logical progression, and also ensured fully inclusive participation by each Planning Group member in the manner preferred.

Anchored by a shared definition of consensus as the absence of strong objection, the Planning Group and Steering Committees worked together to give their best thinking to this process and produced the heart of what is seen in these pages. This consent-based decision-making framework combined speed and inclusiveness, encouraged "good enough" solutions, and helped avoid a hyper-focus on perfection.



As illustrated in the figure above, the Planning Group and Steering Committee worked in tandem and iteratively. The Planning Group met to tackle the creation of objectives for each goal statement. In the intervening month the Steering Committee would review and fine-tune the goal statements. The next Planning Group meeting would take on the next objectives, until all pillars were complete, and activities for each objective became the focus of the brainstorming and ranking process of each meeting.

As activities were finalized by the Planning Group and Steering Committee, the Leadership Team drafted desired outcomes for each objective within the pillars. Targets incorporated in this plan are purposefully generalized and only indicative of a desired direction for change. This approach encourages implementing partners to make progress within the context of their own environment.

Hep Free NNE operationalized consent as "the absence of objections" after adequately defining a problem or decision.

Identifying "Quick starts" and "Big wins"

The final step in developing this Plan was for the Planning Group and Steering Committee to designate the plan's activities as either a "quick start" or a "big win". The designations were intended to reflect the advice and expertise of the Planning Group and Steering Committee, and offer insight to partners interested in aligning their work with the Plan. The Planning Group and Steering Committee selected four criteria by which each activity was considered, and assigned points value (table below).

Implementation considerations	**Feasibility** → What financial and human resources are needed to complete the activity?
	Urgency → Process-wise, how important is it for this activity to move forward early in the plan's implementation?
Impact considerations	**Impact** → How wide of an impact will this activity have?
	Equity → Does this activity embody Hep Free NNE's core value of promoting health equity and reducing disparities?

SURVEY TOOL

To capture Planning Group and Steering Committee's priorities, JSI programmed and distributed an online survey via Alchemer. The survey took approximately 30 minutes to complete, and consisted of four questions for each of the five pillars. Respondents were asked to allocate 100 points across each pillar's activities for the four criteria, based on their agreement with the following statements:

- **Feasibility:** Resources and political will exist to implement this activity
- **Urgency:** Progress on other activities is contingent upon this activity starting
- **Impact:** This activity contributes to progress across multiple objective/goal areas
- **Equity:** This activity improves health equity and reduces disparities

Responders were able to allocate points to as many or as few activities as they wanted. Each set of pillar questions was followed by an open-ended question to capture additional comments.

ANALYSIS

Utilizing a points allocation (also referred to as constant sum) method allowed survey data to be presented in a way that showed magnitude of preference and general breadth of preference across respondents. Activities with higher average point allocations indicate consistently high preference by individuals, whereas activities with higher overall point allocations might indicate preference by a greater number of individuals.

JSI conducted basic descriptive analysis to calculate the total sum and average point allocations for each activity. For each criteria, an activity was deemed "high" if both the total sum AND average point allocation was in the top 25th percentile for all activities. Activities scoring "high" per the feasibility and urgency criteria were designated as a "Quick Start". Similarly, activities that scored "high" per the impact and equity criteria, were designated as a "Big Win". These designations are visually cued throughout the Plan.