

Policy Considerations for Local Health Departments Implementing Hepatitis C Test-to-Treat Models



Introduction

We have the tools to prevent, detect, and cure hepatitis C, yet many individuals remain undiagnosed or do not complete treatment, in part due to fragmented care pathways that require multiple steps, visits, and referrals. Low-barrier “test-to-treat” models aim to reduce these gaps by streamlining the continuum from antibody screening and RNA testing to linkage to care and treatment initiation. As providers and coordinators of local health services, **local health departments (LHDs) play a critical role in implementing these approaches, and their organizational policies shape how quickly and effectively individuals move through the testing-to-treatment process.**

The Role of Organizational Policy in Hepatitis C Testing and Treatment

Organizational policies play a central role in shaping how hepatitis C services are delivered at LHDs. For the purposes of this brief, organizational policy refers to internal rules, protocols, and standing orders that guide how LHDs allocate resources, implement programs, and deliver services. These policies determine who can provide testing and treatment, where and when services are offered, and how patients move along the testing to treatment continuum.

Because these decisions are often within local control, organizational policy is a powerful lever for improving access and reducing delays. At the same time, organizational policy choices are shaped by federal and state policy and guidance, resources, and data systems. Policies can either restrict service delivery or enable more flexible, low-barrier approaches that expand access to care.

The Testing-to-Treatment Continuum



Antibody testing conducted via **rapid, point-of-care test** or blood draw indicates if patient has ever been exposed to HCV.



HCV RNA testing—which indicates whether the patient has an active infection—is typically conducted via **blood draw**. A point-of-care test that provides results in an hour using a fingerstick blood sample is now available in some LHDs.



Individuals with confirmed infection are linked to care. Additional **lab work** (e.g., AST, ALT, HBsAg, etc.) is required but test-and-treat guidance allows providers to initiate treatment while waiting for results. In some states and under some plans, **insurance prior authorization** may be required.



Direct-acting antivirals can cure >95% of cases in 8–12 weeks with limited side effects.

Methods

To better understand how organizational policies influence the accessibility and timeliness of hepatitis C testing and treatment, the National Association of County and City Health Officials (NACCHO) engaged an existing advisory group of LHD STI, HIV, and hepatitis staff in December 2025. In March 2026, NACCHO convened a listening session with 40 health department representatives from 17 states to further explore these themes and identify common challenges and emerging practices. The listening session was open to all interested LHD hepatitis staff and participants were recruited via NACCHO's existing LHD networks. NACCHO then conducted further follow-up with 11 organizations to examine specific policies and service delivery approaches in greater detail.

Terminology

Standing orders: Written authorizations approved by a licensed clinician (e.g., Medical Director) that allow designated staff to carry out specific clinical actions without obtaining an individual patient-specific order each time.

Protocols: Standardized step-by-step procedures that guide how services are delivered. Protocols help ensure consistency, quality, and safety across staff and settings. In some settings, this could also be called a standard operating procedure.

For LHDs without licensed clinicians on staff, implementing standing orders and other clinical protocols may require partnerships with local healthcare providers.

Policy Factors that Affect Hepatitis C Testing and Treatment at LHDs

Through these engagement efforts, NACCHO identified key areas where organizational policies most directly influence access to and timeliness of HCV testing and treatment.

Testing

Who Can Conduct Testing

Organizational policies shape who can conduct different types of HCV testing, including required training, supervision, and competency standards. These requirements often vary by specimen type (e.g., venipuncture, fingerstick, dried blood spot) and must align with federal and state regulations.

LHDs are increasingly expanding testing capacity by training and authorizing non-clinical staff—including outreach workers, case managers, and peer workers with lived experience—to conduct point-of-care tests and, in some cases, collect blood samples. For example, Washington County Health and Human Services (OR) has a standing order allowing community health workers to conduct HCV testing in the field following training in phlebotomy, rapid testing platforms, and prevention education.

Local Example: Expanding Testing Capacity Through Community Health Workers

Leveraging staff with lived experience to lead outreach, testing, and education efforts has been critical to Washington County Health and Human Services' approach. Community Health Workers bring first-hand knowledge of challenges such as trauma, housing instability, and substance use, enabling them to build trust and deliver services that are responsive to community needs.

Supported by standing orders and training protocols, Community Health Workers provide prevention education, hepatitis C care navigation, point-of-care testing, and phlebotomy, expanding the health department's capacity to deliver hepatitis C services in community settings.

Where, When, and How Testing is Conducted

Organizational policies also determine where, when, and how HCV testing is offered. Standing orders and protocols can enable testing in community-based and non-traditional settings by authorizing staff and outlining processes for RNA testing and linkage to care.

Testing protocols further define **who** is offered testing and at what frequency. Some LHDs conduct routine testing (e.g., at intake or at regular intervals) for individuals accessing substance use–related services, while others offer universal testing in sexual health clinics and other clinical settings. In some cases, eligibility for free testing is restricted based on organizational policy, though these decisions are often driven by limited funding and the need to prioritize available resources.

Finally, policies shape **how** testing is delivered in practice, including whether testing is offered universally or based on risk criteria, and whether testing is opt-in or opt-out. Several LHDs reported using integrated testing protocols in which patients seeking or identified as needing HIV, STI, or hepatitis C services are routinely offered testing for all three unless they decline. These approaches allow LHDs to more effectively address **syndemic diseases and conditions** and provide more holistic care.

Syndemic: *this term refers to multiple epidemics that co-occur within a population as a result of shared social and contextual factors, resulting in worse health outcomes.¹*

Testing Sequence and Specimen Collection

Organizational policies shape testing workflows, including how rapid antibody testing is paired with RNA testing. Many LHDs have reflex testing protocols through standing orders that allow staff to automatically initiate a venous blood draw for RNA testing following a reactive antibody test, reducing delays between screening and diagnosis.

Less commonly, some LHDs use concurrent specimen collection approaches, in which a sample for RNA testing is collected during the same visit while awaiting the antibody test result. This approach can eliminate the need for a follow-up visit if the antibody test is reactive. **Several LHDs noted that even a short wait time (e.g., ~20 minutes for a rapid test result) can present a barrier, underscoring the importance of completing as many steps as possible within a single encounter.**

Local Examples: How Policies Shape Eligibility for Free HCV Testing

Health departments (HDs) shared that policies often dictate who is eligible for free testing. For example:

- HD 1: HCV testing is offered free of charge to anyone, in accordance with local protocols.
- HD 2: HCV testing is offered free of charge to individuals with a history of injection drug use. State policy governing the use of state-funded testing supplies allows up to 10% of tests to be used for individuals without this history.
- HD 3: HCV testing is offered free of charge to individuals with identified risk factors. Under state policy, tests must be used to identify new infections and cannot be used for monitoring individuals with a prior hepatitis C diagnosis.

Even when same-visit specimen collection is available, barriers may arise, including patient readiness, venous access challenges, and limited supplies. One health department has implemented an alternative pathway in which staff can provide a clinician-authorized laboratory requisition form for a venous specimen, allowing individuals to complete RNA testing at a commercial lab at a later time or in a setting better suited to specimen collection. While this approach may limit access to results for the LHD and delay follow-up, it can provide a practical alternative when same-visit specimen collection is not feasible.

Procurement and Funding Policies Related to Testing Supplies

Procurement and funding policies shape what testing supplies and technologies LHDs can access, in what quantities, and how they can be used. In some jurisdictions, state-funded testing supplies or laboratory services come with requirements that influence local testing practices.

These policies can directly affect who is eligible for testing, where testing is offered, and how tests can be used in practice, including restrictions tied to the use of state-funded supplies (see *Local Examples: How Policies Shape Eligibility for Free HCV Testing*).

At the same time, LHDs emphasized that available funding—separate from formal policy—is often the primary driver of what testing approaches are feasible. **In particular, the cost of point-of-care RNA testing was frequently cited as prohibitive, limiting adoption of more streamlined testing models.**

How Funding Shapes Policy and Practice

While this brief focuses on how organizational policy shapes access to and uptake of hepatitis C services, engagement with LHDs throughout this project underscored that funding and resource availability play a central role in determining which policies and protocols can be implemented in practice.

LHDs consistently identified inadequate funding as the primary barrier to implementing low-barrier, test-to-treat models for hepatitis C. Resource constraints act not only as a direct barrier, but also indirectly by shaping the policies LHDs adopt. For example, policies that restrict eligibility for free testing are often developed to prioritize limited testing supplies. Similarly, LHDs reported that the cost of testing equipment and supplies is a key barrier to adopting policies that support concurrent specimen collection or point-of-care RNA testing.

Ensuring adequate investment in local public health is critical to scaling up hepatitis C testing and treatment and would enable LHDs to adopt and sustain policies and protocols that more effectively move individuals along the testing-to-treatment continuum.

Treatment

Linkage and Treatment Protocols

Organizational policies and protocols influence how individuals are connected to treatment and the models through which care is delivered. **Establishing clear policies and protocols is often essential to launching and sustaining hepatitis C treatment services, particularly in non-traditional or low-barrier settings.** For LHDs that do not provide treatment directly, strong referral protocols are critical to ensuring successful linkage to care. These may include warm handoffs, case management or navigation services, and coordination between providers.

LHDs are also exploring more accessible treatment models to address persistent barriers related to provider access and patient engagement. Some programs use telehealth-based treatment, non-prescriber initiated patient orders, and care coordination workflows to reduce delays between testing, laboratory evaluation, provider visits, and treatment initiation.

Some LHDs and partners are exploring lower-barrier prescribing approaches, including initiating treatment with minimal upfront laboratory requirements. Enabled by the safety and efficacy of direct-acting antivirals, these models prioritize rapid treatment initiation while completing additional clinical assessment as needed. **Several LHDs reported that their ability to rapidly initiate treatment was supported by updating treatment protocols to align with test-and-treat guidance** developed by the American Association for the Study of Liver Diseases/Infectious Diseases Society of America.² These guidelines allow providers to draw baseline labs (e.g., AST, ALT, platelets, HBsAg) and initiate treatment during the same visit rather than waiting for results.

Across the Continuum

LHDs also identified policy factors that shape access to and delivery of hepatitis C services across the continuum from testing to treatment:

Incentives

Incentives can increase uptake of hepatitis C testing and treatment, particularly among populations facing structural barriers or competing priorities.³ Several LHDs reported that offering small incentives for testing, returning for results, or initiating and completing treatment can improve engagement across the care continuum.

Organizational policies may determine whether incentives can be offered, including allowable uses of funds and restrictions on type or value. However, even when permitted, the availability of funding often determines whether incentive-based strategies can be implemented or sustained.

Data Access and Sharing

Data access and sharing practices influence the efficiency and effectiveness of hepatitis C service delivery. Organizational policies and state regulations may determine whether LHDs can access prior test results, including HCV RNA and baseline laboratory tests. LHDs shared that, despite test-and-treat guidance that encourages providers to initiate treatment while waiting on hepatitis B virus (HBV) test results, many are still hesitant to do so, given concerns about HBV reactivation during hepatitis C treatment. Consequently, access to HBV test results increases provider confidence with same-day treatment initiation following an HCV RNA result.

In settings with limited data sharing, providers may need to repeat testing, contributing to delays and inefficiencies. Conversely, timely access to integrated data systems can support more streamlined treatment initiation.

Local Example: Supporting Telehealth-Based Hepatitis C Treatment Through LHD Partnerships

Johns Hopkins University partners with 10 LHDs and community-based organizations in Maryland to support telehealth-based hepatitis C treatment. Through this model, clients accessing LHD services can connect virtually with a provider, receive support navigating laboratory testing and insurance, and initiate treatment via telehealth.

The program also utilizes non-prescriber initiated patient orders, which allow nurses to place laboratory orders in real time when patients first engage with services. This approach allows initial laboratory testing and care coordination to occur before direct provider involvement, reducing delays and supporting more efficient progression along the testing-to-treatment continuum.

Factors that Enable Rapid Hepatitis C Treatment Initiation

LHDs implementing rapid and same-day hepatitis C treatment models emphasized that organizational policies alone are often insufficient. Successful implementation also depends on broader clinical, operational, and infrastructure factors, including:

- ✓ **Provider buy-in** and comfort with initiating treatment before all laboratory results are available, reducing delays between diagnosis and treatment initiation.
- ✓ **Access to public health and healthcare data** systems, including prior laboratory results (particularly for hepatitis B testing), allowing providers to avoid duplicative testing and more confidently initiate treatment.
- ✓ **FDA approval of the medication MAVYRET⁴ for acute**, in addition to chronic, hepatitis C, expanding opportunities to initiate treatment without first confirming chronic infection.
- ✓ **Elimination of prior authorization requirements** within state Medicaid programs, reducing administrative delays and enabling more immediate treatment initiation.
- ✓ **Partnerships with specialty, partner, or in-house pharmacies**, helping ensure timely medication access. Public Health – Seattle & King County emphasized that having an on-site pharmacy was critical to enabling same-day starts, although pharmacy partners may initially be hesitant to stock high-cost hepatitis C medications.

Considerations

Considerations for Local Health Departments

LHDs seeking to strengthen low-barrier, rapid hepatitis C testing and treatment models may consider developing or refining the following organizational policies and protocols:

- **Expand standing orders and related policies** to broaden who can conduct hepatitis C testing and the settings in which testing can occur.
- **Streamline testing processes** through policies such as reflex testing and concurrent specimen collection to reduce delays between screening and RNA testing.
- **Develop protocols that support integrated hepatitis, HIV, and STI service delivery**, including opt-out, integrated testing approaches and coordinated referral pathways.
- **Strengthen linkage to care** by establishing clear referral protocols, including warm handoffs between providers, to reduce loss to follow-up.
- **Support rapid treatment initiation** through partnerships and protocols, including telehealth-based and other low-barrier treatment models.
- **Improve data access and sharing** through data-sharing agreements and investments in data systems to reduce duplicative testing and support continuity of care.
- **Incorporate incentives**, where allowable and feasible, to increase uptake of testing and treatment and support treatment completion.

Implementation Considerations

Many LHDs are already implementing innovative approaches with limited resources and fragmented systems. Through NACCHO's engagement with LHDs, several factors emerged that can affect whether low-barrier hepatitis C testing and treatment models can be implemented and sustained in practice:

- **Workforce and operational capacity:** Staffing, point-of-care testing supplies, laboratory services, and supportive services (e.g., navigation, transportation, incentives) can affect the ability of LHDs to facilitate uptake of and engagement in care.
- **Modernized data systems and interoperability:** Improved access to surveillance, laboratory, and clinical data can support rapid treatment initiation and improve coordination across providers and systems.
- **Supportive policy and regulatory environments:** Federal and state policies, regulations, and clinical guidelines can support local implementation by shaping who can provide services, which diagnostic and treatment models can be used, who is eligible for treatment, and insurance coverage for hepatitis C care.

Conclusion

Organizational policies play an important role in shaping how hepatitis C services are delivered, including who can provide testing and treatment, where services are offered, and how quickly individuals move from screening to care. As demonstrated throughout this brief, policies such as standing orders and streamlined testing and treatment protocols can support more accessible and efficient hepatitis C testing and treatment.

At the same time, the impact of these policies is shaped by broader resource and infrastructure constraints. LHDs consistently emphasized that funding availability, staffing capacity, and access to testing and treatment supplies influence what is feasible in practice and how policies are implemented. Advancing hepatitis C prevention and elimination efforts will therefore require not only policy innovation but also sustained investment in the systems and resources needed to implement these approaches at scale.

Further Reading

To learn more about opportunities to expand access to hepatitis C testing and treatment, including through test-to-treat models, check out the following resources:

- The American Association for the Study of Liver Diseases and the Infectious Diseases Society of America's [Test-and-Treat Guidance](#) supports more rapid treatment initiation, reflecting growing evidence that eligible patients can safely start therapy without waiting for all baseline laboratory results.
- National Viral Hepatitis Roundtable [resource](#) highlights opportunities to enhance the accessibility, availability, and affordability of HCV test-to-treat models.
- NASTAD [resource](#) explores opportunities to expand access to hepatitis services through pharmacies.

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Citations

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