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Stories from the Field: Implementing Hepatitis C Test-to-Treat Models

Rapid treatment models, or “test-to-treat” models, can accelerate hepatitis C treatment initiation. During early 2026, hepatitis C programs shared examples of facilitators and barriers at the various stages of implementing test-to-treat models.

SUMMARY: Facilitators and barriers for hepatitis C test-to-treat models		
Testing for hepatitis C virus (HCV)		
Facilitators	• Adopting a testing sequence that matches your settings and needs • Expanding access to testing • Partnering with organizations who may benefit from HCV testing	
Barriers	• Testing costs and reimbursement limitations • Delays in receiving test results	
Prescribing treatment		
Facilitators	• Implementing facilitated telehealth models • Improving availability for same-day visits • Utilizing prior lab results within health records systems for pre-treatment assessments • Offering transportation options to complete labs	
Barriers	• Provider and/or pharmacist availability • Hepatitis B virus (HBV) testing constraints	
Dispensing medications		
Facilitators	• Stocking medications via an in-house pharmacy • Delivering direct-acting antivirals (DAAs) directly to a client or a partner site • Having a dedicated staff member to handle paperwork and prior authorization (PA) issues	
Barriers	• Cost of stocking DAAs • PA requirements • Specialty pharmacy or mail-order pharmacy requirements	
Factors in supporting clients to cure		
• Empathetic & dedicated workforce	• Accessibility • Follow up	• Housing support • Funding
Key considerations for building hepatitis C test-to-treat models		
• Mix-and-match approach	• Prioritize adaptability	• Center the client

INTRODUCTION

Reducing delays between diagnosis and treatment can accelerate hepatitis C elimination in the United States. Rapid treatment models, or “test-to-treat” models, [simplify and accelerate](#) treatment initiation by streamlining the pathway to cure, allowing programs to “hit the fast-forward button” to start clients on treatment.

While there is not a current standardized definition, hepatitis C test-to-treat models typically aim to move an individual from testing to treatment as quickly as possible through an intentional and streamlined process. They often include a combination of:

- HCV RNA point-of-care (POC) testing with the Xpert® HCV test
- Streamlined pre-treatment assessments and labs
- Same-day testing, diagnosis, and prescribing
- Expedited drug dispensation
- Intentional navigation processes to link individuals to treatment
- Co-location of hepatitis C testing and treatment services

In early 2026, 25 hepatitis C programs participated in informal interviews¹ to share what is currently working well and where friction remains. Participating programs represented a diversity of regions and funding sources. Settings included federally qualified health centers (FQHCs), syringe services programs (SSPs) and harm reduction programs, emergency departments (EDs), mobile vans, and health departments.

This resource highlights the programs’ shared examples² of facilitators and barriers to testing for HCV, prescribing treatment, and dispensing medications. Additionally, it touches on key considerations for supporting clients to achieve cure and building hepatitis C test-to-treat models that are responsive to both client needs and program capacity, funding, and setting. As one participant noted, “*it’s not the treatment that’s the problem anymore – it’s the logistics*” of getting someone from testing all the way to cure.

TESTING FOR HCV

Facilitator: adopting a testing sequence that matches your settings and needs. Three testing approaches are commonly used by programs that implement test-to-treat models: [lab-based](#) testing, POC RNA testing with the [Xpert® HCV test](#), and [dried blood spot \(DBS\)](#)

¹ Participants were recruited and interviewed by the National Viral Hepatitis Roundtable (NVHR), a national network bringing partners together to advance viral hepatitis elimination in the United States.

² Italicized phrases are direct quotes from participants during their conversations with NVHR in early 2026.

testing. Some programs utilize a combination of approaches, such as doing DBS testing at an outreach site while using Xpert® HCV tests at a fixed SSP site. In general, programs with routine access to repeat clients find success with DBS and lab-based testing, as the delay in receiving results poses less of a barrier to eventual linkage to treatment. In comparison, programs with ad hoc or one-off access to clients often prefer the Xpert® HCV test to allow for same-day diagnosis, especially if they have the capacity for same-day on-site prescribing and treatment initiation.

Programs implementing Xpert® HCV testing shared additional insights:

- It has *“absolutely sped up the process”* and *“people really liked knowing their status, both positive and negative... within that hour”* of getting tested.
- It expands where clients can access confirmatory testing, such as at an SSP, and it is *“awesome [to find] a lot of folks who just weren’t going to come”* to a traditional clinic.
- Getting clients to wait up to 60 minutes to receive their test results can be a challenge for some programs, while others view it as an opportunity to connect with clients—offering snacks, entertainment, or conversation.
- Consider whether Xpert® HCV testing will ultimately reduce the number of touchpoints required to start a client on medications. As one participant put it, *“is it worth it if in the end you still need to link [clients] to care?”*
- With capacity to run only four tests per hour, it may not be a strong fit for programs conducting time-limited testing events with higher client volume that need to run many tests simultaneously to avoid delays in providing results.
- There can be challenges gathering adequate fingerstick blood and using the machine itself, particularly at the start of implementation.
- Programs note that *“where we run into issues... is telling folks we still need to get a hepatitis B test”* via a venous blood draw after the client has given fingerstick blood for their HCV test, therefore requiring two sample collections during an encounter.
- Same-day confirmatory results may have a [limited impact](#) on treatment outcomes if same-day medications are not available to immediately initiate treatment.

Facilitator: expanding access to testing. Many participants stress the importance of making testing as available and accessible to clients as possible through mobile vans, offering walk-in appointments, providing testing at a variety of pop-up and fixed locations, or offering transportation to phlebotomy services. Others emphasized the value of having immediate availability to test partners or friends that tag along with a client, especially if they share drug use equipment or live together.

Facilitator: partnering with organizations who may benefit from HCV testing. Multiple programs report coordinating with medication assisted treatment (MAT) programs or

inpatient substance use disorder (SUD) treatment programs for HCV testing, particularly in jurisdictions where these types of programs are required to test for HCV upon entry. These partnerships allow hepatitis C programs to reach a wider audience, and clients in these settings may be “*in a better headspace*” to accept testing. The strongest outcomes are reported when hepatitis C program staff are given access to internal client records and data systems, or the partner organization is willing to actively coordinate follow up to hepatitis C program staff for treatment linkage and medication delivery. However, some programs may limit contact between clients and hepatitis C program staff, or clients may leave a program or enter incarceration unexpectedly without reliable contact information.

Barrier: testing costs and reimbursement limitations. Programs report difficulty with:

- Identifying local laboratories with the capacity and interest to conduct the validation requirements for DBS testing given that there is no currently FDA cleared HCV DBS test, along with limited avenues for DBS test reimbursement.
- Mounting or emerging costs to sustain Xpert® HCV testing after previously receiving discounted or no-cost supplies.
- State and local restrictions, such as those that require specific certifications or licensure to perform phlebotomy, restrict whether labs can be reimbursed when performed outside of a client’s medical home network, or categorize what types of services can be provided within a MAT or inpatient SUD treatment program by in-house staff versus external hepatitis C program staff.

Barrier: delays in receiving test results. In comparison to the rapidity of Xpert® HCV test results, programs using lab-based and DBS testing increasingly view delays in receiving and giving test results as a barrier to their programs’ implementation. Although some programs have routine clients and see minimal loss to follow up when waiting a week or more to provide results back to clients, others note there are “*opportunities to lose clients at every step*” of the hepatitis C care cascade when same-day diagnosis with Xpert® HCV testing is not available. Additionally, some participants identify data silos, limited informatics infrastructure, passive reporting systems, and data sharing restrictions as additional hurdles to the timely receipt and sharing of test results with clients.

PRESCRIBING TREATMENT

Facilitator: implementing facilitated telehealth models. Programs operating mobile units or “satellite services” – bringing hepatitis C services to an already existing service location like an SSP or housing program – often report using facilitated telehealth models to conduct provider and pharmacist visits. In a facilitated model, a program staff member,

often an HCV tester or hepatitis C coordinator, assists with or "facilitates" a virtual telehealth visit between the client and a provider or pharmacist who shares the diagnosis, prescribes medications, and discusses the treatment regimen. Other programs utilize fully remote telehealth models, in which a virtual care team orders labs, follows results, and prescribes DAAs without an in-person component, which can be appropriate for motivated patients. Both models can reduce staffing needs and costs.

Facilitator: improving availability for same-day visits. Like walk-in availability for testing, programs report success when they can slot clients into readily available provider visits. Particularly for facilitated telehealth models, programs suggest having a provider with a flexible schedule who can join calls with limited notice. Across settings and models, programs emphasize the value of having an on-site coordinator to troubleshoot technology and coordinate schedules, using [HIPAA-compliant](#) messaging systems, and having a provider willing to conduct a visit immediately upon receiving HCV test results.

Facilitator: utilizing prior lab results within health records systems for pre-treatment assessments. This is particularly of value for ascertaining HBV status. Programs suggest:

- Reviewing existing records within an internal health system.
- Using health information exchange networks like [Epic's Care Everywhere](#) to locate prior client records from other clinics or systems, as clients often *"have labs all over the place – you just have to know where to look."*
- In addition to determining HBV and HIV status, a coordinator or provider may also be able to use existing data to assess liver function, prior hepatitis C treatment, or other co-occurring conditions without needing to perform additional tests or labs.

Facilitator: offering transportation options to complete labs. If a client still needs their blood drawn to complete pre-treatment assessments after a hepatitis C diagnosis, participants note the value of providing free transportation to a phlebotomy provider, as well as return transportation following the lab visit. Additionally, a rural program using telehealth highlighted success in using mobile phlebotomy services to send a phlebotomist directly to a client's location or home.

Barrier: provider and/or pharmacist availability. Even when they can use telehealth, bill for services, and limit providers' "on call" time, multiple programs still highlight the difficulty of matching staffing to client volume. This appears to be most crucial for those offering services outside of a clinical setting, where it *"[takes] a little bit of creative planning to make sure"* that staff have enough billable work to do while remaining available for walk-in clients or adjusting for clients who show up early, late, or not at all for their appointment. With limited budgets, staff is often the *"limiting aspect"* for services, especially the more resource-intensive roles such as providers and pharmacists.

Barrier: HBV testing constraints. As of summer 2026, POC HBV testing is not available in the United States, although it is available and implemented in other countries. The need to perform phlebotomy to determine HBV status after running an Xpert® HCV test with fingerstick blood is continually noted by programs as a significant barrier to rapid hepatitis C treatment initiation. While many programs are willing to initiate hepatitis C treatment while awaiting HBV test results in accordance with [clinical guidance](#), others report barriers to even initiating HBV testing, resulting in hepatitis C treatment initiation delays. Barriers include difficult venous access among clients who inject drugs, specialized equipment and staff training needed to conduct phlebotomy, and client reticence to have blood drawn for a second sample collection after providing fingerstick blood for the Xpert® HCV test.

DISPENSING MEDICATIONS

Facilitator: stocking medications via an in-house pharmacy. Programs that successfully implement same-day treatment initiation report that *"getting [the in-house pharmacy] to stock the meds was probably the biggest piece of the puzzle that [needs] to fall in place to make the same day start process actually work,"* as it enables treatment initiation to occur at the same location as testing. Having strong partnership and open communication with the pharmacists is hugely beneficial, as pharmacists manage stock, get paperwork moving rapidly to dispense DAAs as soon as a prescription is submitted, and coordinate options for dispensing. In some programs, pharmacists manage the entire hepatitis C care continuum, centralizing testing, counseling, prescribing, and dispensing at one location.

Facilitator: delivering DAAs directly to a client or a partner site. Some jurisdictions allow pharmacists to “sign out” DAAs to a hepatitis C program staff member. Staff may bring a client’s DAAs to a satellite site or on a mobile van, or transfer them to a designated and known individual working at a site the client frequents, such as an SSP or MAT program. A program using this latter model noted that identifying and working with *“a trusted community contact is kind of the secret sauce”* for ensuring that their clients follow through on starting and continuing their DAAs, especially if releases of information (ROI) or data sharing agreements can be signed ahead of time to allow the hepatitis C program to share relevant client health information with the partner site staff.

Facilitator: having a dedicated staff member to handle paperwork and PA issues. Particularly in states in which Medicaid has maintained PA requirements, programs tout the benefit of having a dedicated staff member to handle paperwork, especially if hepatitis C is *“the focus of everything”* that staff member does, instead of *“an afterthought or an add-on”* to their role.

The individual may also help with patient assistant programs (PAPs), insurance enrollment, and other documentation. Some individuals go a step further, developing standardized processes, templates, or electronic health record (EHR) actions for the information commonly requested in PA forms.

Barrier: cost of stocking DAAs. Despite reductions in price over time, DAAs can still be prohibitively expensive for hepatitis C programs to stock at an in-house pharmacy. Issues can include:

- Reticence from leadership to stock DAAs, or to stock multiple boxes resulting in the potential inability to meet same-day demand.
- Limits on same-day dispensing to clients waiting for PA approvals, PAP coverage, or additional lab results, since dispensing a 30-day supply of DAAs to a client who is later denied approval results in unexpected and significant costs.
- Denial of reimbursement for already-dispensed in-house DAAs to a client whose payor requires dispensing through a specialty pharmacy.

Barrier: PA requirements. Programs in jurisdictions with Medicaid PA requirements for hepatitis C treatment report limited ability to dispense DAAs for same-day starts. Programs report that PA requirements increase paperwork burden, introduce the potential for treatment denials, and reduce program willingness to stock and dispense DAAs for same-day treatment initiation. Removing PA requirements is seen as *“the key to making [test-to-treat] work smoothly”* not just for Medicaid clients, but for those with Medicare, commercial, or private insurance as well, as these programs often impose even more onerous PA requirements than Medicaid.

Barrier: specialty pharmacy or mail-order pharmacy requirements. Certain payers may require DAAs, as a specialty drug, to be dispensed through their identified specialty pharmacy. This can raise issues such as:

- Requiring DAAs to be mail-ordered which can delay treatment initiation during the mailing process and introduce logistical challenges for clients experiencing unstable housing.
- Eliminating the ability to utilize an in-house pharmacy’s stocked DAAs.
- Adding procedural hoops such as phone calls with clients or additional forms.
- Necessitating travel to the specialty pharmacy for medication pick-up, which can be especially challenging when transportation options are limited, time-consuming, costly, or unavailable to the client.

SUPPORTING CLIENTS TO CURE

Several common themes emerged around supporting clients to achieve cure.

THEME	EXAMPLES FROM PROGRAMS
Empathetic & dedicated workforce	<i>"The bottom line is people,"</i> and programs emphasize the value of a hepatitis C coordinator who provides <i>"empathetic and persistent"</i> support. <i>"Having a dedicated staff member to focus solely on hep C – labs and meds and pharmacy approvals and coordination and all of that – is astronomical for the success of the program,"</i> as the greatest roadblocks to hepatitis C cure for many clients are <i>"all of the things that don't have to do with medicine."</i>
Accessibility	Texting and instant messaging are low-barrier mechanisms for communication, such as sending reminders for visits or refills, and can encourage <i>"a friendship and an accountability"</i> between clients and staff. Partnering with sites frequented by clients expands reach, as trusted staff at these sites may be in more routine contact with clients, particularly those without a consistent phone or address. Co-locating hepatitis C services with other social or clinical services can also <i>"give people more reasons to come back"</i> for appointments and refills.
Follow up	Programs say <i>"the biggest barrier is when we just can't get a hold of people"</i> once they initiate treatment, noting that they often struggle to ensure that clients complete their treatment. A workaround for programs embedded in larger clinical systems is to implement EHR alerts that notify a hepatitis C coordinator when a client encounters another part of their system, providing an opportunity to schedule an appointment, draw labs, or meet the client in-person.
Housing support	Although not an inherent barrier, unstable housing can introduce challenges. Often, <i>"hep C treatment is the easiest part"</i> of supporting a client who may be dealing with <i>"life and everything in between."</i>
Funding	Inconsistent and limited funding strains programs' ability to expand and enhance services, train and maintain staff, and purchase and implement new tools such as Xpert® HCV testing. This reality constrains programs and limits their impact on clients – despite <i>"now [having] a state where we CAN cure everybody,"</i> programs struggle <i>"to GET to cure everybody."</i>

KEY CONSIDERATIONS FOR HEPATITIS C TEST-TO-TREAT MODELS

Many participants note the value of building and implementing hepatitis C test-to-treat models within the full context of their setting, client population, and available services. A few key considerations arose repeatedly across participants and programs:

1. **Mix-and-match approach** – instead of building out a perfect, simplified, one-size-fits-all model, consider viewing your model as a “mix-and-match” approach with a variety of tools, services, and supports that are matched to a client’s specific needs and wants. This enhances flexibility to add new items into the mix – such as Xpert® HCV testing or in-house medication availability – without needing to rework existing workflows or restructure already-successful programs. Programs should also carefully consider their own capacity, setting, funding, and staffing – with such a diverse set of tools available for hepatitis C services, try to pick the ones that can work well for YOUR program, not just the ones that may work best for others.
2. **Prioritize adaptability**– programs can spend months (or even years) perfecting a workflow, only for it to be upended by new tools, changes in funding, or updated clinical guidance. Consider ways to simplify processes, enhance flexibility, and improve adaptability to be ready for both anticipated and unexpected changes.
3. **Center the client** – instead of asking whether a client is “ready” for hepatitis C services, consider how you can prepare to meet that client where they are and support them where they want to go. Clients face ongoing stigmatization and other barriers in their day-to-day life, and programs have an opportunity to intentionally “get out of [their] own reality and accept” a client’s own needs and priorities.

As more programs move towards rapid hepatitis C treatment initiation and continue to implement and enhance test-to-treat models, the portfolio of examples will expand.

Despite diverse settings, funding, jurisdictions, and staffing capacity, the programs interviewed for this effort continually and routinely emphasized a few common lessons learned from their work: the value of trusted and capable staff, the need for sustained and flexible funding, and the importance of being able to adapt their services to take advantage of emerging technologies, client feedback, and new partnerships.

Want to learn more about one of these examples or share your own great work? Get in contact with NVHR at info@nvhr.org

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Italicized phrases in this document are direct quotes from participants.

If you would like to learn more about a particular strategy, NVHR may be able to facilitate an introduction to a program utilizing that strategy. Please reach out to info@nvhr.org if you interested in more information or an introduction.

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