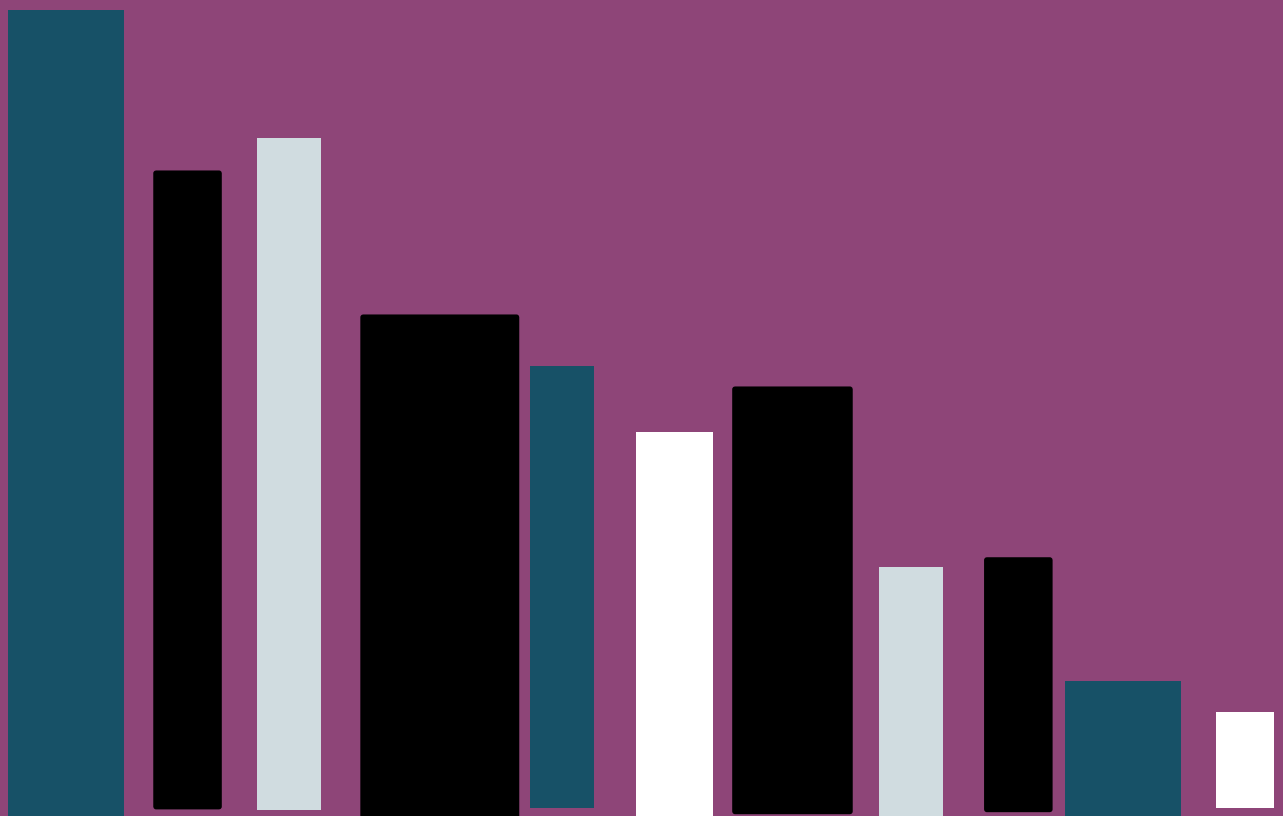


Plan to

Eliminate Viral Hepatitis

as a Major Public Health Threat
in New York City
by 2030



New York City Department of Health and Mental Hygiene

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Introduction

As of 2017, more than 300,000 people are estimated to be living with hepatitis B and/or C in New York City (NYC); without care and treatment, a quarter may progress to serious liver disease, liver cancer, or premature death.¹ Hepatitis C can be eliminated through prevention and treatment to cure infection, and health inequities among people with hepatitis B can be eliminated by supporting health care access.

The United States (U.S.) Department of Health and Human Services (HHS) released the [Viral Hepatitis National Strategic Plan: A Roadmap to Elimination in the U.S., 2021-2025](#) in January 2021. It is aligned with global approaches and goals set forth by the World Health Organization (WHO). The New York State Hepatitis C Elimination Plan was released in November 2021. NYC has developed its own plan building on national and state efforts. As a jurisdiction with a large number of viral hepatitis cases, as well as a local government, nonprofit organizations, industry, and advocates all dedicated to eliminating hepatitis B and C, NYC needed a plan that focuses strategically on NYC's specific needs and assets. Eliminating viral hepatitis in NYC is ambitious, but with effective interventions, sufficient resources, and broad stakeholder commitment, it is possible.

Starting in late 2020 and throughout 2021, the NYC Department of Health and Mental Hygiene (Health Department) convened stakeholders representing key members of the viral hepatitis community, including people affected by viral hepatitis, to participate in the development of the plan. The NYC Health Department surveyed community stakeholders and started conversations through the Hep Free NYC coalition and the Injection Drug Users Health Alliance (IDUHA). Together, the stakeholders guided the development of the Plan to Eliminate Viral Hepatitis as a Major Public Health Threat in New York City by 2030 (Viral Hepatitis Elimination [VHE] Plan), a set of strategies outlining the coordinated approach needed to reduce the number of hepatitis C infections, improve the health of people with hepatitis B and C, and reduce health inequities related to viral hepatitis infection.

Goals and Progress Indicators

The VHE Plan aligns its three central goals with HHS’s Viral Hepatitis National Strategic Plan: A Roadmap to Elimination in the U.S., 2021-2025. To monitor local strides toward these goals, the NYC Health Department developed progress indicators based on currently available NYC surveillance data. During the period of implementation — 2022 to 2030 — the NYC Health Department will assess and annually report on these indicators in stakeholder meetings to give the community an overall gauge of NYC’s progress toward the elimination goals. As discussed in the Plan Implementation section, the NYC Health Department will also report on the outcomes of specific strategies, which will signal incremental achievements. Implementing the plan will entail collaborating with the New York State Department of Health (NYSDOH) on the implementation of the New York State Hepatitis C Elimination Plan as well as with the NYC Health Department on the NYC 2020 Ending the HIV Epidemic Plan.²

¹ New York City Department of Health and Mental Hygiene. *Hepatitis A, B and C in New York City: 2019 Annual Report*. 2020.

² New York City Department of Health and Mental Hygiene. *New York City 2020: Ending the HIV Epidemic: A Plan for America Plan*. 2021. <https://nyhiv.org/wp-content/uploads/2021/03/2021-3-29-NYC-2020-EHE-Plan-FINAL.pdf>

GOAL

1

Reduce new hepatitis C infections among people in NYC by 90% by 2030

Aggressive diagnosis and treatment of hepatitis C infections has the potential to reduce new infections. Achieving this goal depends on timely screening and rapid treatment of people in NYC newly diagnosed with hepatitis C to reduce the risk of onward transmission.

Progress Indicators	Baseline	2030 (goal)
<p>90% of participants in the NYC Health Department Viral Hepatitis Program-contracted programs will be screened³ for hepatitis C</p> <p>Data source: organizations that contract⁴ with the NYC Health Department and report screening data</p>	<p>42% (2018)</p>	<p>90%</p>
<p>80% of adults⁵ newly diagnosed with hepatitis C will be RNA negative within one year of diagnosis</p> <p>Data source: NYC surveillance data</p>	<p>29% (2018)</p>	<p>80%</p>
<p>The number of people re-infected with hepatitis C annually will be reduced</p> <p>Data source: NYC surveillance data</p>	<p>Being assessed in 2021</p>	<p>To be determined after assessing baseline</p>

³ There is currently no reliable estimate of the number of people in NYC at risk for hepatitis C or the number of people in NYC who use injection drugs. As such, the denominator for this indicator is the number of people that contracted organizations reach.

⁴ These include NYC City Council-funded facilities that host hepatitis B and C navigation programs and facilities that participate in other grant-funded projects with the Viral Hepatitis Program of the NYC Health Department, such as federally qualified health centers (FQHCs), syringe services programs (SSPs), hospitals, and health centers.

⁵ Throughout plan implementation, data will be disaggregated by demographic categories, including age, to identify and address emergent gaps in treatment rates.

GOAL

2

Reduce premature deaths among people with chronic hepatitis B and chronic hepatitis C in NYC by 65% by 2030; Improve the health of people with hepatitis B and C in NYC

The percentage of people with hepatitis C in NYC who die prematurely (age 64 or younger) of any cause is double that of in the general NYC population, and for people with hepatitis B it is 1.5 times higher.⁶ If goals related to testing and treatment are met, premature mortality and mortality related to chronic hepatitis B and C infections can be reduced by more than half.

Progress Indicators	Baseline	2030 (goal)
<p>90% of participants in the NYC Health Department Viral Hepatitis Program-contracted programs at risk for hepatitis B infection will be screened</p> <p>Data source: organizations that contract with the NYC Health Department and report screening data</p>	<p>57% (2018)</p>	<p>90%</p>
<p>80% of people in NYC reported with hepatitis B since 2018 who meet American Association for the Study of Liver Diseases (AASLD) treatment criteria will be virally suppressed</p> <p>Data source: NYC surveillance data</p>	<p>Being assessed in 2021</p>	<p>80%</p>
<p>80% of people in NYC reported with hepatitis C since 2014 will be RNA negative</p> <p>Data source: NYC surveillance data</p>	<p>62% (2019)</p>	<p>80%</p>

⁶ New York City Department of Health and Mental Hygiene. *Hepatitis A, B and C in New York City: 2019 Annual Report*. 2020.

GOAL

3

Reduce health inequities related to viral hepatitis infection among people in NYC

In NYC, Asian or Pacific Islander people have seven times the rate of death due to hepatitis B infection as compared with White people, and Latino people and Black people have 2.9 and 2.6 times the rate of death due to hepatitis C infection, respectively, as compared with White people.⁷ NYC neighborhoods with high rates of poverty have the highest overall numbers of hepatitis C infections.⁸ Equitable access to hepatitis care and treatment — including access to regular liver cancer screening, when indicated — is crucial to reducing health inequities and achieving the other goals of this elimination plan.

Progress Indicators	Baseline	2030 (goal)
<p>Mortality due to hepatitis B will be reduced by 65% for Asian or Pacific Islander people in NYC</p> <p>Data source: Surveillance and vital statistics</p>	<p>2.2 per 100,000 Asian or Pacific Islander people (2019)</p>	<p>0.8 per 100,000 Asian or Pacific Islander people</p>
<p>Mortality due to hepatitis C will be reduced by 65% for Black and Latino people in NYC</p> <p>Data source: NYC surveillance and vital statistics</p>	<p>6.4 per 100,000 Latino people; 5.7 per 100,000 Black people (2019)</p>	<p>2.2 per 100,000 Latino people; 2.0 per 100,000 Black people</p>
<p>Inequities in hepatitis B and C treatment rates across neighborhoods of residence⁹ will be reduced</p> <p>Data source: Surveillance and vital statistics</p>	<p>Being assessed in 2021</p>	<p>80% of each neighborhood’s residents diagnosed with hepatitis B and eligible for treatment will be virally suppressed; 80% of each neighborhood’s residents diagnosed with hepatitis C will be RNA negative</p>

⁷ New York City Department of Health and Mental Hygiene. *Hepatitis A, B and C in New York City: 2019 Annual Report*. 2020.

⁸ New York City Department of Health and Mental Hygiene. *Hepatitis A, B and C in New York City: 2019 Annual Report*. 2020.

⁹ We selected inequities by neighborhood tabulation area (NTA) as a unit of comparison due to the lack of individual-level data on socioeconomic status. These geographic units are comprised of U.S. Census tracts and can be used with Census and American Community Survey data. Therefore, they can be presented and further categorized with neighborhood-level poverty statistics and racial or ethnic makeup.

How to Use This Plan

NYC benefits from an extensive and dynamic public health infrastructure, with many clinical and social service providers working with people with hepatitis B and/or C, as well as community advocates leading the way toward policy changes that seek to make care more accessible, affordable, and equitable. The COVID-19 public health emergency, during which this plan came together, kept many people with hepatitis B and/or C from seeking care and hampered prevention, education, and screening efforts that rely on community gatherings. Nonemergency appointment hours were temporarily reduced and resources were concentrated on fighting COVID-19. The public health emergency also presented an opportunity to significantly expand hepatitis care via telemedicine, a delivery mechanism that will facilitate access to care for people with hepatitis B and/or C if it continues to be reimbursable in the years to come. Alongside clinical providers, many patient navigators switched to telephone-based navigation to reach community members during the public health emergency. NYC saw firsthand the resilience and creativity of the public health infrastructure as it pivoted in response to COVID-19. Working toward the elimination of viral hepatitis as a public health threat will require the same resourcefulness and energy, albeit sustained over a longer period.

The strategies described in this plan comprise a vision for addressing hepatitis B and C through coordinated efforts that span systems and policy changes, enhanced clinical infrastructure, training, community outreach, and stigma-free, culturally and linguistically responsive care.

While the NYC Health Department will take the lead on coordinating, implementing, and monitoring this plan, advocates, community-based organizations (CBOs), health care facilities, and individual providers are encouraged to use it to guide their own efforts toward hepatitis elimination. The plan can serve as a tool for organizations fighting for additional resources and policy changes, and as a blueprint for enhancing clinical and social service provision. The plan can also serve as a starting point for individuals and organizations to learn more about and contribute to efforts toward eliminating viral hepatitis in NYC.

Hepatitis

B

Hepatitis B

An estimated 241,000 people are believed to be living with chronic hepatitis B in NYC, approximately 46% of whom are undiagnosed.¹⁰ Despite efforts to raise awareness of the value of hepatitis B screening among providers serving communities with a high prevalence of hepatitis B and among community members themselves, many people with hepatitis B do not get screened. Part of the challenge is that current risk-based hepatitis B testing guidelines can be stigmatizing, difficult to automate in electronic health record (EHR) prompts, and unfamiliar to health care providers.¹¹ Many have therefore called for a universal adult hepatitis B testing recommendation. Furthermore, in November 2021 the Advisory Committee on Immunization Practices voted to recommend hepatitis B vaccination for adults ages 19 to 59¹² and New York State has authorized licensed pharmacists to administer the hepatitis B vaccination.¹³ Additional awareness-raising efforts for health care providers and community members are also needed.

In 2017, in NYC, the percentage of people with chronic hepatitis B who died prematurely (age 64 or younger) was 1.5 times higher than that of the general population.¹⁴ NYC neighborhoods with a high number of people with hepatitis B also tend to have a higher percentage of people who are uninsured.¹⁵ The majority of people with chronic hepatitis B in NYC have immigrated from areas of the world where hepatitis B is endemic.¹⁶ Efforts to eliminate hepatitis B are directly linked

¹⁰ New York City Department of Health and Mental Hygiene. *Hepatitis A, B and C in New York City: 2019 Annual Report*. 2020.

¹¹ Wang S, Cohen C, Tang AS, Graham CS. Hepatitis B virus elimination in the U.S.: time to dismantle barriers and implement solutions. *Current Hepatology Reports*. 2021;20:34-42.

¹² Advisory Committee on Immunization Practices. Meeting recommendations October 2021. Centers for Disease Control and Prevention. Published 2021. Accessed December 2, 2021. <https://www.cdc.gov/vaccines/acip/recommendations.html>

¹³ New York State. Legislation S.4807-A/A.6476 authorizes licensed pharmacists to administer vaccines for hepatitis A and B, HPV, measles, mumps, rubella, and varicella. Published November 2, 2021. Accessed December 2, 2021. <https://www.governor.ny.gov/news/governor-hochul-signs-legislation-authorizing-pharmacists-administer-additional-vaccines>

¹⁴ New York City Department of Health and Mental Hygiene. *Hepatitis A, B and C in New York City: 2019 Annual Report*. 2020.

¹⁵ New York City Department of Health and Mental Hygiene. *Hepatitis A, B and C in New York City: 2019 Annual Report*. 2020.

¹⁶ Nelson, NP, Easterbrook PJ, McMahon BJ. Epidemiology of hepatitis B virus infection and the impact of vaccination on disease. *Clin Liver Dis*. 2016;20(4):607-628.

to immigrant and refugee health promotion, particularly for immigrants from Asia and Africa.¹⁷ Language barriers, low health literacy, immigration status and economic hardships commonly hinder access to care for these communities in NYC.

In 2014, the NYC Health Department launched Check Hep B, a culturally and linguistically responsive patient navigation program that provides linkage to medical care and care coordination for people with hepatitis B in NYC. The program is implemented by CBOs and community health care providers, including federally qualified health centers (FQHCs) and hospitals where people at risk for hepatitis B often seek care and supportive services. Check Hep B has seen robust results, with 97% of enrolled patients linked to care and 94% of treatment-eligible enrolled patients retained in treatment, according to 2019-2020 program data. However, the program remains relatively small compared to the patient population and relies on discretionary funding requiring annual renewal by the NYC City Council. Contracted providers and advocates must expend time and resources to secure renewed funding for these critical services.

The NYC Health Department implements Hep B Moms, a telephone-based patient navigation program that links people with hepatitis B in NYC to care during pregnancy and following childbirth. According to a recent study of the intervention, Hep B Moms participants were 1.66 times as likely to see a hepatitis B care provider within six months of childbirth as nonparticipants.¹⁸ To expand access to care, the Empire Liver Foundation offers clinical training to community-based health care providers on managing uncomplicated chronic hepatitis B, though these trainings have not been as widely sought out by health care facilities as hepatitis C trainings. The Hep Free NYC coalition also disseminates information about local and national training opportunities to clinicians in its network.

¹⁷ Reducing new hepatitis B infections is not included as a goal because most new diagnoses in the U.S. come from immigration of people from parts of the world where hepatitis B is endemic and who acquired the infection perinatally. Rates of perinatal transmission (5 perinatal infections reported in 2017) and acute hepatitis B infection in adults (21 chronic infections reported in 2018) remain low in NYC, and thus were not prioritized. In addition, only 5% of adults with acute hepatitis B infection go on to develop chronic infection.

¹⁸ Schwartz J, Bocour A, Tang L, et al. Telephone patient navigation increases follow-up hepatitis B care in the postpartum period for immigrants living in New York City. *J Immigrant and Minority Health*. 2021;23(6):1179-1186. doi:10.1007/s10903-021-01240-5

Efforts to support people with hepatitis B and link them to care, ultimately improving health outcomes and reducing premature mortality, must include expanded patient navigation and care coordination services. Additional efforts are needed to ensure that high-quality hepatitis B care is widely available in primary care settings,¹⁹ accessible to people who are uninsured and underinsured, and delivered in a stigma-free, culturally and linguistically responsive manner. Additional funding is needed to support these initiatives, as current resources are not sufficient to implement all the strategies in the following pages.

¹⁹ Nguyen VH, Le AK, Trinh HN, et al. Poor adherence to guidelines for treatment of chronic hepatitis B virus infection at primary care and referral practices. *Clin Gastroenterol Hepatol*. 2019;17(5):957-967.

1

Hepatitis B Awareness, Education, and Prevention Strategies

To increase availability of hepatitis B awareness, education, and prevention:	
1.1	Implement a clinical provider public health detailing campaign to disseminate updated, streamlined guidelines ²⁰ for hepatitis B screening, management, treatment, and adult vaccination for health care providers serving communities with a high prevalence of hepatitis B.
1.2	Provide in-depth training on hepatitis B epidemiology, screening, and the latest management and treatment options to more primary care providers serving communities with a high prevalence of hepatitis B.

To increase accessibility of hepatitis B awareness, education, and prevention:	
1.3	Identify and partner with more CBOs and faith-based organizations (FBOs) serving communities with a high prevalence of hepatitis B to disseminate culturally and linguistically responsive messaging emphasizing hepatitis B screening and vaccination as part of routine health care; as part of these efforts, widely promote anti-stigma initiatives such as the #justB storytelling campaign. ²¹
1.4	Expand no- or low-cost adult hepatitis B vaccination for people who are uninsured or underinsured. Focus vaccination efforts on adults with comorbidities such as HIV and hepatitis C that can make it more difficult to clear acute hepatitis B infection. Offer testing co-located with vaccination across a wide variety of health care facilities.

²⁰ For example, the Hepatitis B Primary Care Workgroup’s *Hepatitis B Management: Guidance for the Primary Care Provider*. <https://www.hepatitisb.uw.edu/page/primary-care-workgroup/guidance>

²¹ Hepatitis B Foundation. #justB: real people sharing their hepatitis B stories. Updated 2021. Accessed October 21, 2021. <https://www.hepb.org/research-and-programs/patient-story-telling-project>

To increase acceptability of hepatitis B awareness, education, and prevention:

1.5	Develop additional culturally and linguistically responsive educational materials tailored to communities with a high prevalence of hepatitis B, including videos, infographics, audio materials for radio or podcasts, and social media messaging. As part of these outreach efforts, include contact information for places the public can ask anonymous questions and obtain confidential referrals to testing and related services (for example, 311, nyc.gov/health/hepb , and the Hep B Foundation).
1.6	Develop additional trainings and materials for clinical providers that communicate the importance of delivering trauma-informed, stigma-free, culturally and linguistically appropriate hepatitis B care.
1.7	Integrate culturally and linguistically responsive, stigma-free hepatitis B care in job descriptions and performance assessments for individuals serving communities with a high prevalence of hepatitis B and provide training accordingly.

To increase quality of hepatitis B awareness, education, and prevention:

1.8	Hire people with lived experience of hepatitis B to participate in the development of educational materials for community members and health care providers. Feature messaging that addresses the personal, cultural, and stigma-based hesitations and motivations of people living with hepatitis B to engage in screening, vaccination, ongoing monitoring, or treatment.
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2 Hepatitis B Testing and Linkage to Care Strategies

To increase availability of hepatitis B testing and linkage to care:

2.1	Support health care facilities serving communities with a high prevalence of hepatitis B to build screening capacity and increase screening rates among both patients and their contacts (such as household members, sex partners, or people with whom they share needles and drug use equipment).
2.2	Join national stakeholder groups advocating for a universal, one-time adult hepatitis B screening recommendation, to be covered by insurers without cost sharing.

2.3	Advocate for aligned hepatitis B screening and treatment guidelines across agencies and stakeholders (Centers for Disease Control and Prevention, U.S. Preventive Services Taskforce, AASLD) to increase clarity for providers.
2.4	Expand culturally and linguistically responsive patient navigation and care coordination services, particularly in communities with low engagement in hepatitis B care.

To increase accessibility of hepatitis B testing and linkage to care:

2.5	Support increased funding for patient navigation programs (such as Check Hep B) for people with hepatitis B.
2.6	Advocate for Medicaid and other health insurance reimbursement for patient navigation and care coordination services for people with hepatitis B.

To increase acceptability of hepatitis B testing and linkage to care:

2.7	Design, pilot, and implement an approach to patient navigation and screening that addresses a broad array of health needs, including those related to HIV, sexually transmitted infections (STIs), viral hepatitis, sexual health, mental health, and substance use. Align this approach with patient navigation specifically for people with hepatitis B to focus on communities where each is most needed and could be most effective.
2.8	Offer hepatitis B testing at community venues, especially those located in or serving communities with high hepatitis B prevalence or vulnerability in congregate settings (such as shelters), at faith-based and cultural activities, in pharmacies, and alongside other types of testing (for example, COVID-19, HIV, glucose, and blood pressure) to normalize hepatitis B screening as a part of routine health care, especially those located in or serving communities with high hepatitis B prevalence.

To increase quality of hepatitis B testing and linkage to care:

2.9	Collect and disseminate qualitative data on the experiences of people with hepatitis B engaging in health care, to better understand common barriers to screening and linkage to care and to inform program planning and advocacy.
2.10	Expand professional development opportunities for patient navigators and care coordinators (and similar positions) for people with hepatitis B by providing more training on navigating insurance and medication access, motivational interviewing, cultural responsiveness, and other areas.

3

Hepatitis B Care and Treatment Strategies

To increase availability of hepatitis B care and treatment:	
3.1	Widely promote the availability of no- or low-cost hepatitis B care and treatment options in different languages and in community venues to address concerns about prohibitive costs among people with hepatitis B, including those who are uninsured or underinsured.
3.2	Support health care facilities serving communities with a high prevalence of hepatitis B to build hepatitis B management and treatment capacity, such as algorithms to identify patients who need screening, monitoring, or treatment via EHR alerts and other clinical workflow changes.

To increase accessibility of hepatitis B care and treatment:	
3.3	Advocate for the elimination of Medicaid and other health insurance prior authorization requirements to increase ease of access to treatment and medications for hepatitis B, including removing barriers for pharmacies to carry commonly prescribed types and brands of hepatitis B medications.
3.4	Advocate for Medicaid, Medicaid Managed Care Plans, and private insurance plans to require insurers to fully cover hepatitis B screening, treatment, lab work, routine ultrasound/liver cancer screening, and other related costs, without cost sharing.
3.5	Advocate to expand the NYSDOH AIDS Drug Assistance Program (ADAP) to include all hepatitis B treatment options for people with HIV and co-infected with hepatitis and to raise the income level for eligibility and simplify the application process.
3.6	Advocate to create a New York State Patient Assistance Program for hepatitis B, similar to HepCAP for hepatitis C, which would provide a medical and treatment evaluation as well as ongoing treatment monitoring for people with hepatitis B who are uninsured.
3.7	Advocate for Medicaid, Medicaid Managed Care Plans, and private insurance plans to work to make hepatitis B treatment and ongoing monitoring via telemedicine available and reimbursable beyond the COVID-19 public health emergency.

To increase acceptability of hepatitis B care and treatment:

3.8	Develop a culturally and linguistically responsive, stigma-free hepatitis B care pledge for providers and facilities to sign onto. Involve people with lived experience of hepatitis B in developing the pledge, and publicly recognize facilities and providers that sign it.
3.9	Provide training and develop resources on diversity, equity, and inclusion to staff at health care facilities and social service providers serving communities with a high prevalence of hepatitis B to help address stigma and systemic racism in hepatitis B service delivery.

4

Hepatitis B Surveillance Data Strategies

To increase availability of hepatitis B surveillance data:

4.1	Increase the number of facilities that report hepatitis B screening rates to the NYC Health Department.
4.2	Amend the NYC Health Code to require laboratories to report the tests commonly used to monitor hepatitis B (for example, negative HBeAg).

To increase quality of hepatitis B surveillance data:

4.3	Integrate hepatitis B surveillance to better identify people with hepatitis B who are out of care and to enable outreach for referrals to treatment.
4.4	Identify algorithms for determining treatment-eligible people with hepatitis B using hepatitis B surveillance data.
4.5	Establish and implement electronic case reporting from EHR systems to the NYC Health Department to obtain demographic (such as country of birth, race or ethnicity) and clinical (such as fibrosis or pregnancy) information to enable better analysis of care outcomes and identification of related inequities, and to ensure timely and complete identification of pregnant patients with hepatitis B by the NYC Health Department Perinatal Hepatitis B Prevention Program.
4.6	Conduct serosurvey to update the estimated number of people with undiagnosed hepatitis B in NYC.

Hepatitis

C

Hepatitis C

An estimated 91,000 people are believed to be living with chronic hepatitis C in NYC, approximately 40% of whom are undiagnosed.²² Hepatitis C can be cured; direct acting antiviral (DAA) drugs have produced hepatitis C cure rates higher than 90% among Medicare beneficiaries,²³ and are easier to tolerate than previously available medication regimens, given their shorter course of treatment (8-12 weeks). However, many people with hepatitis C in NYC do not know that they are infected and/or do not engage in treatment, so cure rates are suboptimal.

Although the annual number of newly reported chronic hepatitis C cases in NYC has declined steadily in recent years, many people remain infected and undiagnosed in large part due to inadequate access to health care services, including hepatitis C screening. People who are diagnosed with hepatitis C experience stark inequities and poorer health outcomes than the general NYC population. The percentage of people with chronic hepatitis C in NYC who die prematurely (age 64 or younger) is twice as high as that of the general population.²⁴ NYC neighborhoods with high rates of poverty and a large proportion of Black and/or Latino residents historically have the highest overall numbers of hepatitis C infections of neighborhoods citywide.²⁵ In NYC, people who use drugs and/or who have a history of involvement with the criminal justice system are more likely to have acquired hepatitis C than the general population,^{26,27} and are much less likely to have

²² New York City Department of Health and Mental Hygiene. *Hepatitis A, B and C in New York City: 2019 Annual Report*. 2020.

²³ Kalidindi Y, Jung J, Feldman R, Riley T III. Association of direct-acting antiviral treatment with mortality among Medicare beneficiaries with hepatitis C. *JAMA Netw Open*. 2020;3(7):e2011055. doi:10.1001/jamanetworkopen.2020.11055

²⁴ New York City Department of Health and Mental Hygiene. *Hepatitis A, B and C in New York City: 2019 Annual Report*. 2020.

²⁵ New York City Department of Health and Mental Hygiene. *Hepatitis A, B and C in New York City: 2019 Annual Report*. 2020.

²⁶ Jordan AE, Des Jarlais DC, Arasteh K, McKnight C, Nash D, Perlman DC. Incidence and prevalence of hepatitis C virus infection among persons who inject drugs in New York City: 2006-2013. *Drug Alcohol Depend*. 2015;152:194-200. doi:10.1016/j.drugalcdep.2015.03.039

²⁷ Varan AK, Mercer DW, Stein MS, Spaulding AC. Hepatitis C seroprevalence among prison inmates since 2001: still high but declining. *Public Health Rep*. 2014;129:187-95.

access to adequate hepatitis C treatment services.²⁸ People who use drugs are much more likely to live in poverty and have much higher rates of housing instability and food insecurity as compared to the general population of NYC. Hepatitis C elimination efforts should be linked to other programs addressing these social determinants of health (for example, NYC Department of Homeless Services initiatives).

Hepatitis C care must be integrated into health promotion initiatives for people who use drugs. Because of its association with injection drug use, hepatitis C is a highly stigmatized condition; more efforts are needed to destigmatize the condition in health care settings and among individual providers, who often do not treat people who actively use drugs for hepatitis C despite data showing similar hepatitis C treatment adherence and cure rates among this population and people who are not actively using drugs.²⁹ Furthermore, few opioid treatment programs (OTPs) offer hepatitis C treatment, a missed opportunity to provide access to treatment to people who use drugs where they already receive care. Most OTPs refer out for hepatitis C treatment because of low reimbursement rates and the many administrative hurdles involved in setting up insurance reimbursement and billing. All substance use programs regulated by the NYS Office of Addiction Services and Supports (OASAS) offer hepatitis C testing, but most are not licensed clinics where treatment can take place. Furthermore, prevalence of chronic hepatitis C infection is very high among clients of inpatient detoxification and rehabilitation programs, as well as shelters.^{30,31} Innovative strategies to bring hepatitis C treatment into these settings through reimbursable telemedicine are urgently needed.

²⁸ Hochstatter KR, Stockman LJ, Holzmacher R, et al. The continuum of hepatitis C care for criminal justice involved adults in the DAA era: a retrospective cohort study demonstrating limited treatment uptake and inconsistent linkage to community-based care. *Health Justice*. 2017;5:10.

²⁹ Norton BL, Litwin AH. A call to action: HCV treatment of people who inject drugs in the United States. *Clin Infect Dis*. 2020;70(11):2366-2368.

³⁰ Beiser ME, Smith K, Ingemi M, Mulligan E, Baggett TP. Hepatitis C treatment outcomes among homeless-experienced individuals at a community health centre in Boston. *International Journal of Drug Policy*. 2019;72:129-137.

³¹ Jordan AE, Des Jarlais DC, Arasteh K, McKnight C, Nash D, Perlman DC. Incidence and prevalence of hepatitis C virus infection among persons who inject drugs in New York City: 2006-2013. *Drug Alcohol Depend*. 2015;152:194-200. doi:10.1016/j.drugalcdep.2015.03.039

In 2014, the NYC Health Department launched Check Hep C, a culturally and linguistically responsive peer and patient navigation program that provides linkage to medical care and care coordination for people with hepatitis C in NYC. The program is implemented by syringe service programs (SSPs) and community-based clinical care facilities, including FQHCs and hospitals where people at risk for hepatitis C often seek care and social services. Between 2014 and 2020, Check Hep C served 4253 participants, 89% of whom were linked to care. Among those linked to care, 58% were treated for hepatitis C. For those not linked to care, many participants are lost to follow-up because they are unstably housed, do not have consistent phone access, lack insurance and the ability to pay out-of-pocket costs, and/or live with comorbid conditions and unaddressed mental health issues.³² Like Check Hep B, the program relies on unstable discretionary funding requiring annual renewal by the NYC City Council. Contracted providers and advocates must expend time and resources every year to secure renewed funding for these critical services.

Since 2017, the NYC Health Department's Clinical Practice Facilitation program has partnered with acute care hospitals, community-based health centers, and other clinical settings in NYC where people at risk for hepatitis C and people with HIV/hepatitis C co-infection seek care, to increase these facilities' clinical capacity to screen for and treat hepatitis C. The program employs a tailored mix of capacity building interventions grounded in a data-to-care approach to facilitate practice changes. Through this and other efforts, the hepatitis C treatment rate among people with HIV/hepatitis C co-infection in NYC has risen to 76%, and elimination of hepatitis C among this population is within reach.³³

³² Additionally, due to the COVID-19 public health emergency, some treatment providers were obligated to pause treatment initiation in 2020 and are working on re-engaging patients to begin treatment.

³³ New York City Department of Health and Mental Hygiene. *Hepatitis A, B and C in New York City: 2019 Annual Report*. 2020.

Since late 2018, the NYC Health Department has partnered with NYC Health + Hospitals (H + H)'s Correctional Health Services (CHS), which provides health care in the City's jails, to coordinate Corrections Navigation, a program that provides navigation to care for people released from Rikers Island while mid-treatment for hepatitis C and people screened at Rikers Island who have not yet initiated hepatitis C treatment. Despite significant challenges maintaining contact with a justice-involved patient population, particularly during the COVID-19 public health emergency, the NYC Health Department has collected data showing a 70% linkage to care rate and 37% treatment initiation rate among patients who were successfully contacted by phone. To expand access to care, the Empire Liver Foundation offers clinical training to community-based health care providers on screening for and treating chronic hepatitis C overall and specifically in pregnant people and in people who use drugs. Hep Free NYC also disseminates information about local and national training opportunities to clinicians in its network. Other initiatives work to increase hepatitis C screening, linkage to care, and treatment, such as NYS DOH's Hepatitis C and Drug User Health Center of Excellence of the Clinical Education Initiative.

A robust community of advocates works in NYC at the intersection of hepatitis C, HIV, and drug user health, fighting for resources, access, and stigma-free, trauma-informed care. There are opportunities to build upon this collective energy and knowledge to make significant strides toward hepatitis C elimination. As with hepatitis B, additional funding is needed to enact many of the strategies outlined in the following pages.

5

Hepatitis C Awareness, Education, and Prevention Strategies

To increase availability of hepatitis C awareness, education, and prevention:	
5.1	Implement a clinical provider public health detailing campaign to disseminate updated guidelines for hepatitis C screening and treatment for health care providers, particularly providers serving groups targeted for micro-elimination projects (for example, people with HIV/hepatitis C co-infection, people in substance use treatment programs).
5.2	Engage more primary care providers and addiction medicine providers to attend in-depth training on trauma-informed, stigma-free, and harm reduction-oriented hepatitis C care.

To increase accessibility of hepatitis C awareness, education, and prevention:	
5.3	Identify and partner with more venues serving communities with a high prevalence of hepatitis C, including community health centers, correctional facilities, OTPs, SSPs, HIV clinics, rehabilitation and detoxification facilities, sex workers' rights spaces, LGBTQ+ spaces, CBOs, FBOs, and shelters, to disseminate culturally and linguistically responsive messaging emphasizing hepatitis C screening and treatment as part of routine health care.
5.4	Support greater availability of and access to sterile injection equipment, overdose prevention services, and harm reduction programs targeting communities vulnerable to hepatitis C infection.
5.5	Employ more peer educators to raise awareness about hepatitis C prevention and the availability of a cure in their respective communities.

To increase acceptability of hepatitis C awareness, education, and prevention:

5.6	Develop additional culturally and linguistically responsive educational materials tailored to communities with a high prevalence of hepatitis C, including videos, infographics, audio materials for radio or podcasts, and social media messaging. In particular, develop outreach campaigns specific to people who inject drugs (PWID), young people, transgender people, and sex workers. As part of these outreach efforts, include contact information for places where the public can ask anonymous questions and obtain confidential referrals to testing and related services (such as 311, nyc.gov/health/hepc , and the American Liver Foundation).
5.7	Develop additional trainings and materials for clinical providers that communicate the importance of delivering trauma-informed, stigma-free and harm reduction-oriented hepatitis C care. Ensure that clinical provider trainings include education about reinfection and cirrhosis follow-up care and address the need for urgency in initiation of hepatitis C care.
5.8	Integrate provision of culturally and linguistically responsive, stigma-free hepatitis C care into job descriptions and performance assessments of clinical and social service providers who serve communities with a high prevalence of hepatitis C and provide training accordingly.

To increase quality of hepatitis C awareness, education, and prevention:

5.9	Hire people with or cured of hepatitis C, and/or who have lived experience of injection drug use, to participate in the development of educational materials for community members and health care providers featuring messaging that addresses the personal, cultural, and stigma-based hesitations and motivations of people with hepatitis C to engage in screening and treatment.
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6 Hepatitis C Testing and Linkage to Care Strategies

To increase availability of hepatitis C testing and linkage to care:

6.1	Expand availability of point-of-care hepatitis C tests and dried blood spot (DBS) hepatitis C RNA (confirmatory) testing in community settings, especially at OTPs, SSPs, shelters, pharmacies, and primary care facilities.
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6.2	Support health care facilities serving communities with a high prevalence of hepatitis C to build universal screening capacity, address barriers to implementing reflex RNA testing, encourage re-screening of cured individuals with ongoing risk and facilitate rapid treatment starts. Track time from diagnosis to treatment initiation and use those data to identify and address bottlenecks.
6.3	Expand culturally and linguistically responsive peer and patient navigation and care coordination services, particularly in communities with low engagement in hepatitis C care.
6.4	Join national stakeholder groups in advocating for alternative hepatitis C testing technologies, such as the point-of-care RNA test.

To increase accessibility of hepatitis C testing and linkage to care:

6.5	Support increased funding for patient navigation programs (such as Check Hep C) for people with hepatitis C.
6.6	Advocate for Medicaid and other health insurance reimbursement for patient navigation and care coordination services for people with hepatitis C.
6.7	Advocate for Medicaid, Medicaid Managed Care Plans, and private insurance plans to eliminate all remaining hepatitis C treatment prior authorization requirements to facilitate rapid linkage to care and one-visit diagnosis and treatment starts, including for PWID and regardless of reinfection risk, and to ensure that all insurance providers comply and do not impose barriers to care, such as prohibiting treatment for hepatitis C reinfection.

To increase acceptability of hepatitis C testing and linkage to care:

6.8	Design, pilot, and implement an approach to patient navigation and screening that addresses a broad array of health needs, including those related to HIV, sexually transmitted infections (STIs), viral hepatitis, sexual health, mental health, and substance use. Align this approach with patient navigation specifically for people with hepatitis C to focus on communities where each is most needed and could be most effective.
6.9	Implement hepatitis C screening in mobile health units operating in NYC neighborhoods with high prevalence of hepatitis C. Hire peer navigators to conduct outreach, testing and linkage to care from these mobile units.

6.10	Work with H + H to expand the pilot Corrections Navigation program to all city jails and re-entry programs to provide hepatitis C screening, linkage to care and continuity of care for people newly released from correctional facilities.
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To increase quality of hepatitis C testing and linkage to care:	
6.11	Collect and report on qualitative data on the experiences of people with hepatitis C engaging in health care, to better understand common barriers to screening and linkage to care and to inform program planning and advocacy.
6.12	Expand professional development opportunities for patient navigators and care coordinators (and similar positions) for people with hepatitis C by providing more training on navigating insurance and medication access, motivational interviewing, cultural responsiveness, and other areas. Offer opportunities for patient navigators to train in phlebotomy.
6.13	Develop and disseminate to health care facilities a protocol for following up at regular intervals with patients cured of hepatitis C who are at ongoing risk of exposure to hepatitis C to help prevent reinfection and navigate patients to needed social services.

7 Hepatitis C Treatment Strategies

To increase availability of hepatitis C treatment:	
7.1	Create a centralized, citywide telemedicine program to serve participants of inpatient drug treatment programs, SSPs, OTPs, shelters, and other settings where traditional referrals may be insufficient.
7.2	Support health care facilities serving communities with a high prevalence of hepatitis C to build hepatitis C treatment capacity, by implementing changes to EHR systems, integrating order sets, and making other clinical workflow changes to improve treatment and cure rates.

To increase accessibility of hepatitis C treatment:

7.3	Advocate to eliminate all prior authorization requirements in order to increase ease of access to treatment and medications for hepatitis C, including removing barriers for pharmacies to carry commonly prescribed types and brands of hepatitis C medications and medications to treat opioid use disorders. Also, support all efforts to increase ease of access to all medications to treat opioid use disorder.
7.4	Advocate for Medicaid, Medicaid Managed Care Plans, and private insurance plans to limit out-of-pocket expenses that pose a barrier to access to HCV treatment by requiring insurers to fully cover hepatitis C screening, treatment, lab work, routine ultrasound/liver cancer screening, and other related costs.
7.5	Advocate to expand eligibility of the NYSDOH AIDS Drug Assistance Program (ADAP), which provides medications for people with HIV who are co-infected with hepatitis C, by raising the income level for eligibility and simplifying the program application process.
7.6	Advocate to expand the New York State Hep C Patient Assistance Program (HepCAP) by adding additional sites in NYC and by raising the income level for eligibility and simplifying the program application process.
7.7	Advocate for Medicaid, Medicaid Managed Care Plans, and private insurance plans to make hepatitis C treatment and ongoing monitoring via telemedicine available and reimbursable beyond the COVID-19 public health emergency.
7.8	Advocate for hepatitis C treatment in OTPs, so that they are reimbursed at equal levels as in Article 28 health care facilities.
7.9	Support access to hepatitis C treatment by providing for transportation, meals, other basic needs, and unrestricted benefits (in other words, incentives that are not gift cards to specific vendors) to incentivize ongoing engagement in treatment.
7.10	Allow patients to store hepatitis C medications at facilities where patients are receiving hepatitis C care or drug treatment services and return to take them daily, as needed.
7.11	Schedule hepatitis C treatment appointments at more flexible hours and provide walk-in appointments.

To increase acceptability of hepatitis C treatment:

7.12	Develop a culturally and linguistically responsive, stigma-free hepatitis C care pledge for providers and facilities to sign onto. Involve people with lived experience of hepatitis C in developing the pledge and publicly recognize facilities and providers that sign it.
7.13	Expand efforts to aid facilities serving populations with a high prevalence of hepatitis C (for example, FQHCs, SSPs, OTPs, alternatives to incarceration programs, inpatient drug treatment programs) to have the capacity to treat on-site, such as through co-located mobile units, patient navigation/care coordination staffing, and telemedicine. Specifically, support OTPs in addressing the staffing and administrative barriers to providing and billing for hepatitis C treatment. This may include supporting the development of 340B applications and facilitating collaborations with community health centers wishing to treat hepatitis C in OTPs.
7.14	Provide training and develop resources on diversity, equity, and inclusion to staff at health care facilities and social service providers serving communities with a high prevalence of hepatitis C to help address stigma and systemic racism in hepatitis C service delivery.

To increase quality of hepatitis C treatment:

7.15	Use hepatitis C surveillance and other data systems to develop and implement micro-elimination projects in people with comorbidities, such as people treated at STI clinics or dialysis centers, using lessons learned from interventions for people with HIV/hepatitis C co-infection.
7.16	Use hepatitis C surveillance and other data systems to develop and implement micro-elimination projects at specific health care facilities that serve people with hepatitis C and are willing to take on comprehensive quality improvement initiatives. This should include funding to the facilities to incentivize treatment for PWID.
7.17	Expand and publicize successful micro-elimination projects to other facilities and populations.

8

Hepatitis C Surveillance Data Strategies

To increase availability of hepatitis C surveillance data:	
8.1	Increase the number of facilities that report hepatitis C screening rates to the NYC Health Department.
8.2	Amend the NYC Health Code to require laboratories to report negative hepatitis C antibody results to enable the NYC Health Department to develop and share citywide and facility-specific screening rates and identify acute infections.

To increase quality of hepatitis C surveillance data:	
8.3	Integrate hepatitis C surveillance and other data systems to better identify and contact people with hepatitis C who are out of care, to expedite referrals to treatment.
8.4	Use rapid response surveillance data to guide testing and linkage to care efforts in areas of NYC that emerge as neighborhoods with above-average hepatitis C case rates.
8.5	Establish and implement electronic case reporting from EHR systems to the NYC Health Department to obtain demographic (such as race or ethnicity) and clinical (such as fibrosis) information to ascertain disease phase and severity and to identify inequities in care and treatment.
8.6	Conduct a serosurvey to update the estimated number of undiagnosed people with hepatitis C in NYC.

Plan Implementation

The NYC Health Department and Hep Free NYC community partners will create annual workplans detailing the strategies to be implemented the following year, and specific steps for implementation. For example, opportunities to design and carry out activities to eliminate hepatitis C among people with HIV and people who are justice-involved, in collaboration with the implementation of the NYC 2020 Ending the HIV Epidemic Plan. The NYC Health Department will regularly assess and report on VHE Plan progress indicators at Hep Free NYC coalition meetings and other stakeholder forums.

The NYC Health Department will also monitor progress indicators to identify the need to make course corrections along the way. The outputs (for example, the number of health care facilities, providers, and community members reached through a given strategy) and outcomes (for example, expanded availability of services, amended policies) measured in any given year will depend on the strategies that are actually being implemented, which in turn depends on the availability of resources to do so. The NYC Health Department will include VHE Plan indicators measuring the implementation of the strategies in annual workplans.

The 2022 workplan will prioritize and operationalize the following strategies for implementation in 2023.

For Hepatitis B:

1.4	Expand no- or low-cost, adult hepatitis B vaccination for people who are uninsured or underinsured. Focus vaccination efforts on adults with comorbidities such as HIV and hepatitis C that can make it more difficult to clear acute hepatitis B infection. Offer testing co-located with vaccination, across a wide variety of health care facilities.
2.8	Offer hepatitis B testing at community venues, especially those located in or serving communities with high hepatitis B prevalence or vulnerability in congregate settings (such as shelters), at faith-based and cultural activities, in pharmacies, and alongside other types of testing (such as COVID-19, HIV, glucose, and blood pressure) to normalize hepatitis B screening as a part of routine health care, especially those located in or serving communities with high hepatitis B prevalence.
3.4	Advocate for Medicaid, Medicaid Managed Care Plans, and private insurance plans to require insurers to fully cover hepatitis B screening, treatment, lab work, routine ultrasound/liver cancer screening, and other related costs, without cost sharing.
3.5	Advocate to expand the NYSDOH AIDS Drug Assistance Program (ADAP) to include all hepatitis B treatment options for people with HIV and co-infected with hepatitis and to raise the income level for eligibility and simplify the application process.
4.2	Amend the NYC Health Code to require laboratories to report the tests commonly used to monitor hepatitis B (for example, negative HBeAg).

For Hepatitis C:

5.7	Develop additional trainings and materials for clinical providers that communicate the importance of delivering trauma-informed, stigma-free, and harm reduction-oriented hepatitis C care. Ensure that clinical provider trainings include education about reinfection and cirrhosis follow-up care, and address the need for urgency in initiation of hepatitis C care.
6.5	Support increased funding for patient navigation programs (such as Check Hep C) for people with hepatitis C.
7.7	Advocate for Medicaid, Medicaid Managed Care Plans, and private insurance plans to make hepatitis C treatment and ongoing monitoring via telemedicine available and reimbursable beyond the COVID-19 public health emergency.
7.13	Expand efforts to aid facilities serving populations with a high prevalence of hepatitis C (such as FQHCs, SSPs, OTPs, alternatives to incarceration programs, and inpatient drug treatment programs) to have the capacity to treat on-site, such as through co-located mobile units, patient navigation/care coordination staffing, and telemedicine. Specifically, support OTPs in addressing the staffing and administrative barriers to providing and billing for hepatitis C treatment. This may include supporting the development of 340B applications and facilitating collaborations with community health centers wishing to treat hepatitis C in OTPs.
8.2	Amend the NYC Health Code to require laboratories to report negative hepatitis C antibody results to enable the NYC Health Department to develop and share citywide and facility-specific screening rates and identify acute infections.

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