Addressing Barriers to Care and Health Equity

Session 4

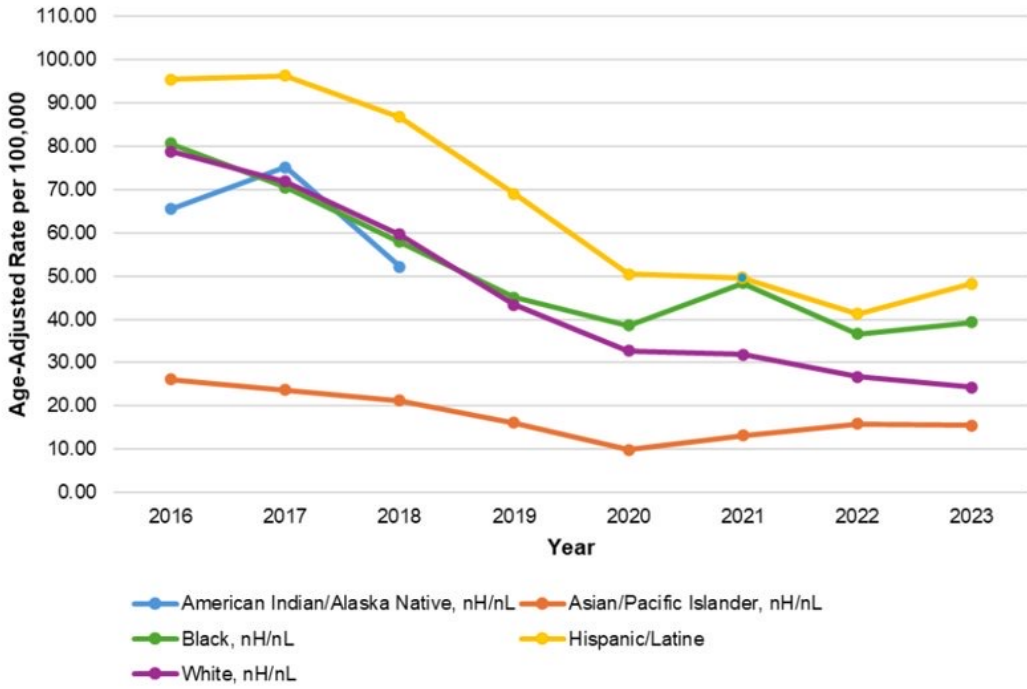
10.17.2025

Learning Objectives

1. Recognize disparities in Hepatitis C access and outcomes in Massachusetts.
2. Identify strategies to address stigma and improve engagement in care.
3. Navigate payer systems for DAA.

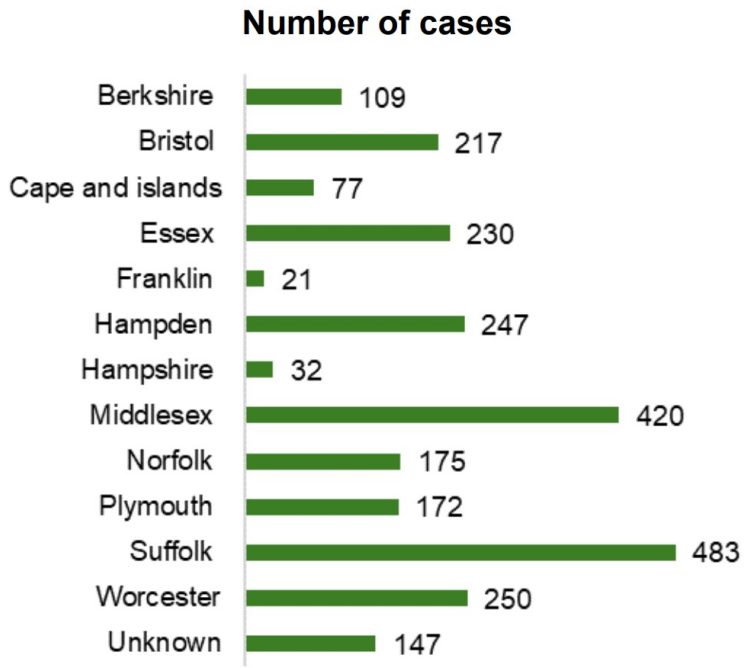
Current State of HCV in Massachusetts

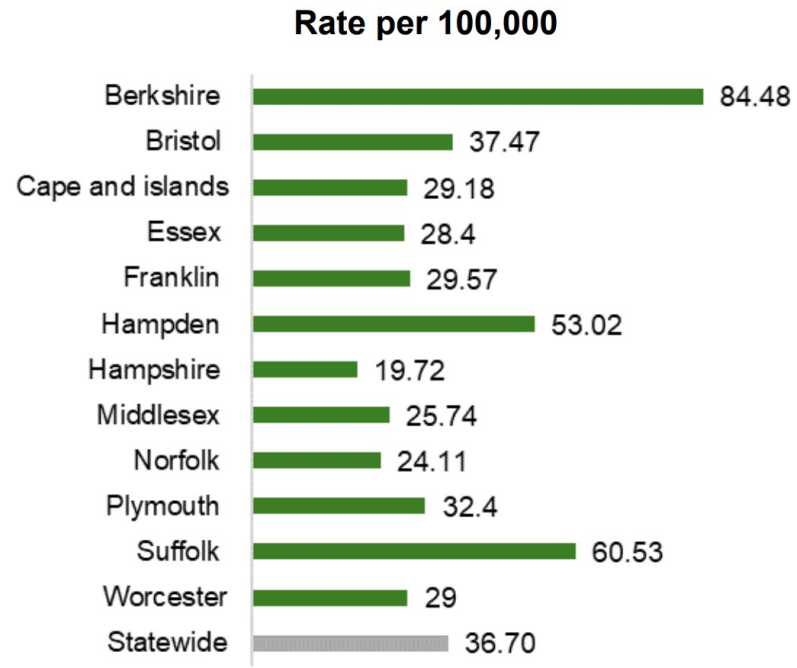
- ~60,000 people estimated to be living with chronic HCV statewide
- Highest rates among:
  - People who inject drugs
  - Individuals experiencing homelessness
  - Incarcerated populations
- Significant racial inequities: higher rates of late diagnosis and lower treatment uptake among Black and Latinx residents
- Only about 58% of those who tested positive have cleared HCV infection in MA



*Rates for the American Indian/Alaska Native population are not displayed for years 2019, 2020, 2022, and 2023 due to N <5

Current State of HCV in Massachusetts





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Why Inequities Persist

Populations facing greatest barriers in MA:

People who use drugs

Unhoused individuals

Criminal-legal system

Racial/ethnic disparities

Insurance-based disparities

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Why Inequities Persist

Structural barriers:

- **Limited phlebotomy** or lab access in community settings
- **Fragmented care**: HCV, SUD, and primary care often separate
- **Payer complexity**: MassHealth vs. managed care plans
- Inconsistent **provider comfort** treating active substance use
- Persistent **stigma** among both patients and clinicians

Progress Made

- ✅ 2019–2023: MassHealth removed fibrosis and sobriety restrictions
- ✅ DPH supports micro-elimination in correctional and community health sites
- ✅ MA HCV Elimination Plan → focus on equity, harm reduction, and community-led care

Addressing Stigma & Improving Engagement

At the system level:

- Embed harm reduction in every touchpoint
- Train all team members to reduce stigma
- Involve peers with lived experience
- Provide flexible visit structures (telehealth, walk-ins, street outreach)

At the patient level:

- Normalize treatment in primary care & OBAT settings
- Use person-first, nonjudgmental language ("people who use drugs")
- Build the relationship

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Addressing Stigma & Improving Engagement

Mistrust

Different communities have concrete, evidence-based reasons to **not** trust us.

What are some examples of those reasons?

The Tuskegee Syphilis Study

Starting in 1932, 600 African American men from Macon County, Alabama were enlisted to partake in a scientific experiment on syphilis. The "Tuskegee Study of Untreated Syphilis in the Negro Male," was conducted by the United States Public Health Service (USPHS) and involved blood tests, x-rays, spinal taps and autopsies of the subjects.

It wasn't until a whistleblower, Peter Buxtun, leaked information about the study to the *New York Times* and the paper published it on the front page on November 16th, 1972, that the Tuskegee study finally ended. By this time only 74 of the test subjects were still alive. 128 patients had died of syphilis or its complications, 40 of their wives had been infected, and 19 of their children had acquired congenital syphilis.

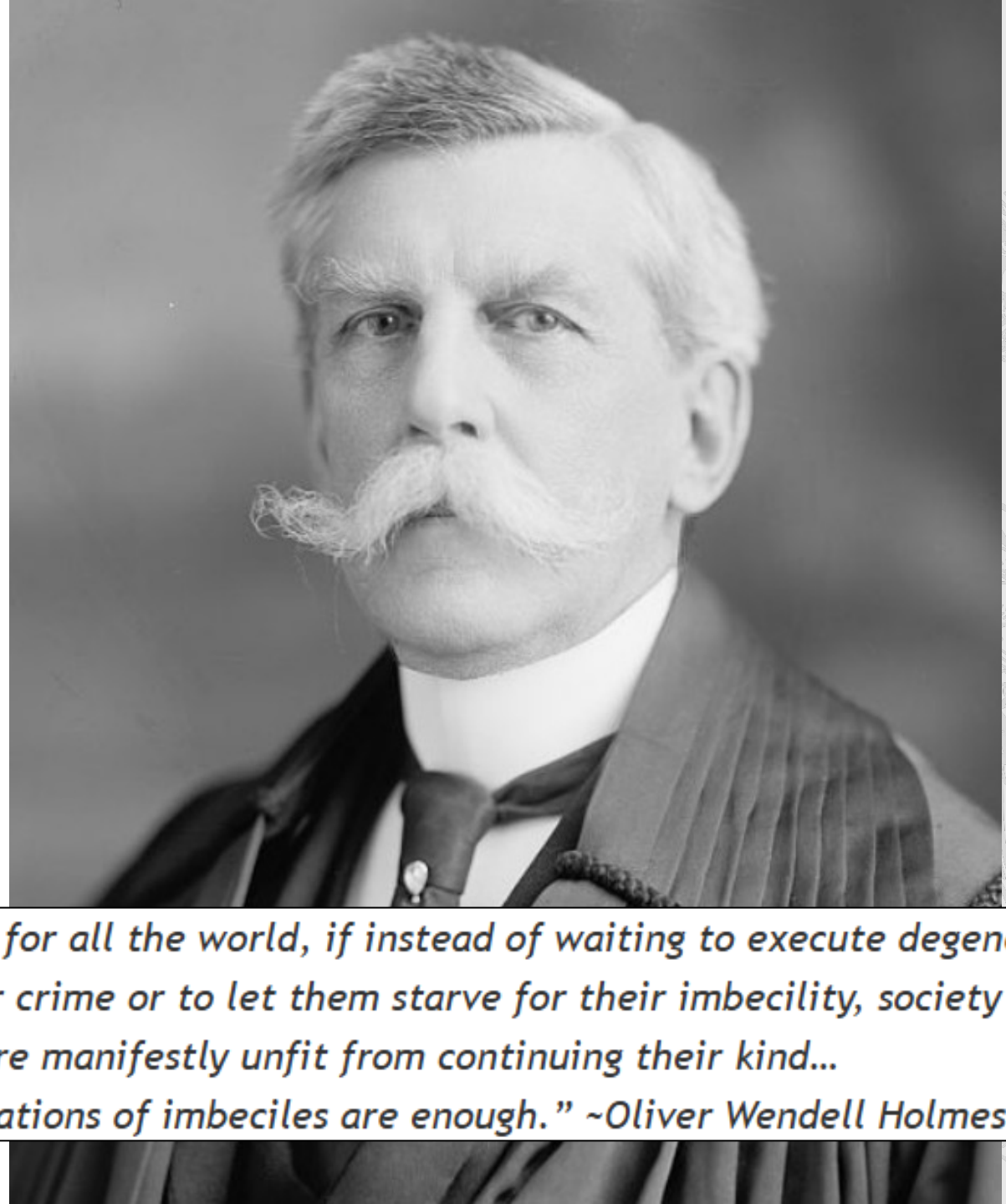
- *PCN was tx for syphilis starting in the early 1940s and considered first line treatment by the late 1940s*

https://www.mcgill.ca/oss/article/history/40-years-human-experimentation-america-tuskegee-study

The Eugenics Movement

In 1927, in a decision known as *Buck v. Bell*, the US Supreme Court decided, by a vote of 8 to 1, to uphold a state's right to forcibly sterilize a person "unfit to procreate."

One of the associate supreme court justices at the time was Oliver Wendell Holmes. He was on the Supreme Court from 1902 – 1932.



"It is better for all the world, if instead of waiting to execute degenerate offspring for crime or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind...
Three generations of imbeciles are enough." ~Oliver Wendell Holmes

The Guatemala Project, c1946

Berta was a female patient in the psychiatric hospital. Her age and the illness that brought her to the hospital are unknown. In February 1948, Berta was injected in her left arm with syphilis. A month later, she developed scabies (an itchy skin infection caused by a mite). Several weeks later, [lead investigator Dr. John] Cutler noted that she had also developed red bumps where he had injected her arm, lesions on her arms and legs, and her skin was beginning to waste away from her body. Berta was not treated for syphilis until three months after her injection. Soon after, on August 23, Dr. Cutler wrote that Berta appeared as if she was going to die, but he did not specify why. That same day he put gonorrheal pus from another male subject into both of Berta's eyes, as well as in her urethra and rectum. He also re-infected her with syphilis. Several days later, Berta's eyes were filled with pus from the gonorrhea, and she was bleeding from her urethra. On August 27, Berta died.[3]

First, Do No Harm: The US Sexually Transmitted Disease Experiments in Guatemala

Michael A Rodriguez [1,✉], Robert García [1]

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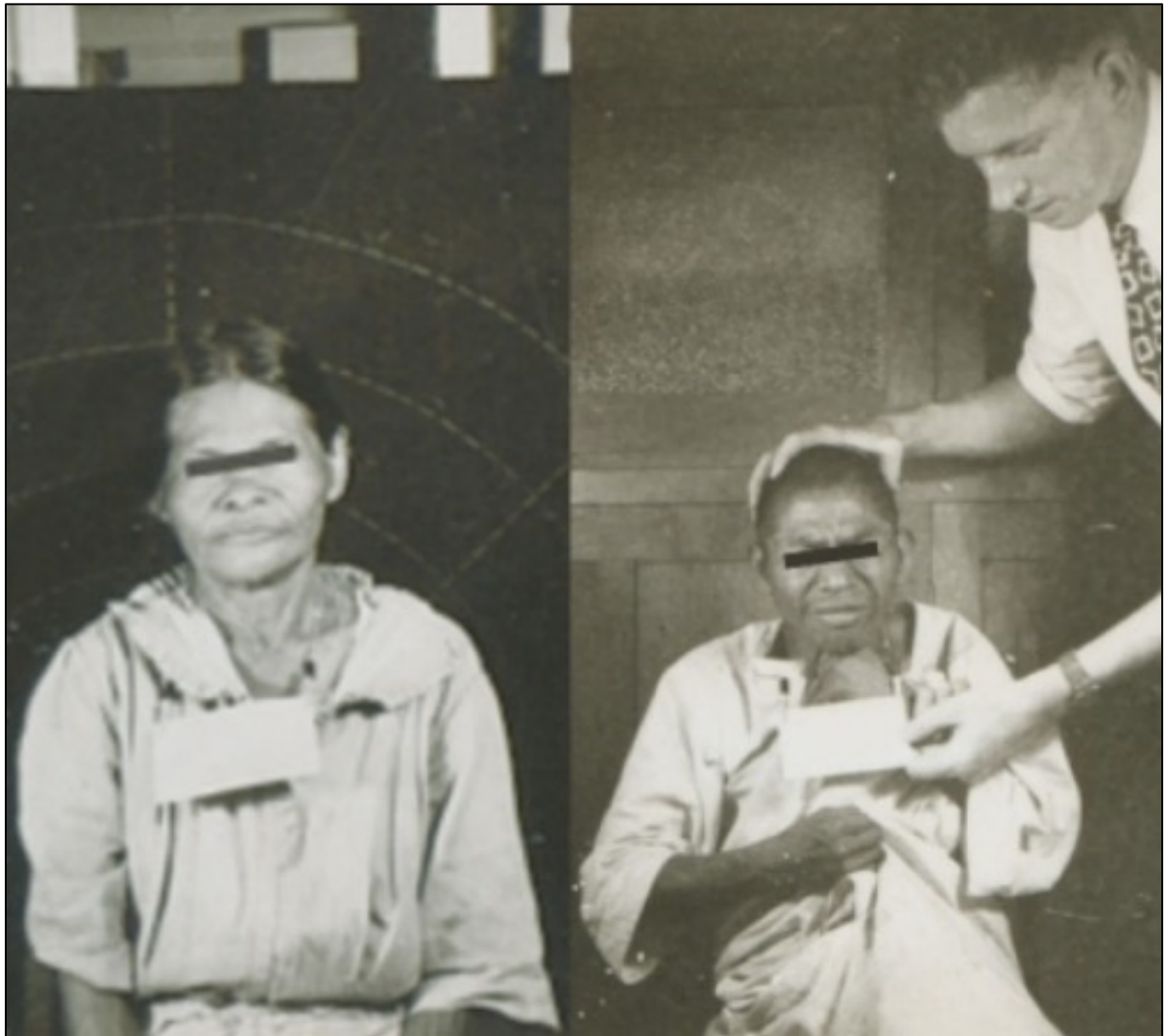
PMCID: PMC3828982 NIHMSID: NIHMS594075 PMID: 24134370



Addressing Stigma & Improving Engagement

Mistrust

Different communities have concrete, evidence-based reasons to **not** trust us.

- But generational and vicarious trauma doesn't look like someone saying: "The Tuskegee trial has made my family and I mistrust people in authority and the medical field."
- In my opinion it looks like patients not trusting us and being reticent to build relationships with us.
- In my opinion, it looks like: "medical nonadherence," frequently feeling not listened to even when we feel we've listened for hours, challenging our advice, vaccination hesitancy, trust in results of lab tests, experiencing more side effects from medications, being "frequent fliers," "lost to f/u," the people that "they just won't take care of themselves."
- Our response to this should not be frustration or dismissal but remembering why this mistrust exists and trying to build relationships despite it. Having thick skin and being persistently kind is a form of resistance to bigotry.

Addressing Stigma & Improving Engagement

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Building the relationship to promote engagement in care:

What we say and how we say it matters.

Specific diction I find effective:

- "I'd like to talk about things we could do to help prevent you from getting HIV, hepatitis and other infections if that is something you want to do."
- "Even though we haven't spent much time together I can tell you are X (intelligent, thoughtful, hard-working, careful, someone who worries about your health, someone who worries about the health of people in your life). It was great to get to know you today."
- "I'd love to see you about every 3 months if you are OK with (/think you have time for) that? We can even just check in over the phone if you think that would be better for you?"

Navigating the Payer System

- **MassHealth:**
  - Covers all DAAs **without sobriety** or fibrosis restrictions
  - **Smart PA** (Prior Authorization) bypasses PA if first line DAA, no prior treatment, no history of decompensated cirrhosis, and no drugs that will lower DAA efficacy
- **Commercial & Managed Care Plans:**
  - Some require specialist signature or pre-approval
  - Variability in lab requirements and pharmacy distribution

Navigating the Payer System

- Partner with specialty pharmacy teams early
- Keep prior authorization templates and coverage checklists accessible
- Document clinical justification (e.g., ongoing transmission risk)
- Leverage peer navigators & interdisciplinary care team for follow-up and medication pickup

Navigating the Payer System

E. Patient Clinical Information

Please refer to plan-specific criteria for details related to required information.

Diagnosis: ☐ B18.2 Hepatitis C (chronic) ☐ Other: _____

HCV Genotype: ☐ 1 ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Stage of Hepatic Fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4
If F4: ☐ Compensated ☐ Decompensated

Check all methods of assessment that apply and include result:

Method	Result
☐ Liver biopsy	See above
☐ Transient elastography (FibroScan)	_____ kPa
☐ Shear wave elastography	_____ kPa
☐ MRE	_____ kPa
☐ FibroSure (FibroTest)	_____
☐ Echosens Fibrometer	_____
☐ Fibrospect	_____
☐ APRI	_____
☐ Fib-4	_____
☐ Hepascore	_____
☐ Other: _____	_____

Does the patient have HIV coinfection? ☐ Yes ☐ No ☐ Unknown

Is the patient status post liver transplant? ☐ Yes ☐ No

Confirm the patient's GFR range: ☐ 0–14 ☐ 15–29 ☐ 30 or greater *(Please specify.)* _____

HCV RNA levels:
Baseline (most recent): _____ IU/mL Date of lab work: _____
Week 8 of treatment (if continuation request): _____ IU/mL Date of lab work: _____

Previous Treatments

Has the patient been previously treated for Hepatitis C and failed treatment? ☐ Yes ☐ No

Adverse Reaction? ☐ Yes ☐ No

Drug Name	Date of treatment (MM/YY)	Response to treatment
		☐ Relapsed ☐ Partial response ☐ Null response (<2 log reduction in HCV RNA at Week 12) ☐ Did not complete

- Create note templates based off standard Prior Authorization template

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Key Takeaways

1. **Achieving 90% infection reduction and 80% cure by 2030** requires direct attention to inequities in HCV screening and treatment.
2. **Access to screening and treatment remains limited** for many Black and Latinx communities, reflecting ongoing structural and systemic barriers.
3. **MassHealth's removal of fibrosis and sobriety restrictions** has improved access to DAA therapy and represents meaningful statewide progress.
4. **Different communities have evidence-based reasons for mistrust;** building authentic, consistent relationships is key to improving engagement in care.
5. **Use Smart PA pathways, standardized templates, and pharmacy partnerships** to streamline DAA access and reduce payer-related delays.

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Thank you !

Session Number	Topic
Session 1 – 9/5/25	Intro to ECHO Model and HCV: Epidemiology, Screening, and Diagnosis
Session 2 – 9/19/25	Staging of Liver Disease and HCV
Session 3 – 10/3/25	Initiating Treatment
Session 4 – 10/17/25	Addressing Barriers to Care and Health Equity
Session 5 – 10/31/25	**Monitoring During and After Treatment**
Session 6 – 11/7/25	Management of co-occurring conditions (HIV, HBV, SUDs)
Session 7 – 11/21/25	How to incorporate HCV treatment in your practice

Submit Cases using this Qualtrics link:

https://umassmed.co1.qualtrics.com/jfe/form/SV_0f8rrTTCXBKW7nn

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