




your guide

to Integrating HCV Services into Opioid Treatment Programs


Promising and Emerging Best Practices

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disclaimer



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At the time of this publication, Elinore F. McCance-Katz, MD, PhD served as the Assistant Secretary of Mental Health and Substance Use. Captain Chideha Ohuoha, MD, MPH served as the CSAT Director, and Humberto Carvalho, MPH served as the CSAT Project Officer.



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1. **Providence, Rhode Island:** [CODAC Behavioral Healthcare](#), founded in 1971, is a nonprofit outpatient treatment provider for OUD, with seven community-based locations in Rhode Island. Special thanks to Dr. Lynn Taylor and Sophie Sprech-Walsh.
2. **Buffalo, New York:** [Drug Abuse Research and Treatment \(DART\)](#), also founded in 1971, administered by the nonprofit Community Action Organization of Western New York (NY), provides OUD treatment in the Western NY community. Special thanks to Dr. Andrew Talal, Dr. Weissman, Cynthia Smith, RN, and Kenneth Bossert.
3. **San Francisco, California:** The [End Hep C SF](#) initiative is a multi-sector consortium established in 2016 that partners with the three participating agencies below (among others) to reduce the public health threat of HCV in San Francisco. Special thanks to Katie Burke.
 - a. BAART Turk, administered by BayMark Health Services, offers an outpatient Medication for Addiction Treatment (MAT) program for OUD in San Francisco within a comprehensive behavioral and primary health treatment setting.
 - b. The Opiate Treatment Outpatient Program (OTOP) at Zuckerberg San Francisco General Hospital offers MAT for individuals with OUD.
 - c. The San Francisco AIDS Foundation's Syringe Access Services program provides street-based syringe



access and disposal services to people who inject and runs a multi-service Harm Reduction Center. Senior HCV Coordinator and Harm Reduction Specialist Pauli Gray participated in the discussion.

4. **Alexandria, Virginia:** The [Alexandria Community Services Board \(CSB\)](#) [OTP](#) is administered by the city's CSB, the public agency that administers behavioral health and developmental disability services in the community. Special thanks to Susan Tatum.
5. **Des Moines, Iowa:** [UCS Healthcare](#) is an Iowa-based nonprofit incorporated in 1997 that provides MAT in five locations across the state. Special thanks to David Chapin and Misty Angrick.

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1. Athens Clinic DM & ADR, Inc. – Athens, Georgia (Ali McCorkle)
2. Center for Behavioral Health – North Charleston, South Carolina (Chrissie Martin)
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introduction to the guide

Section One

Intent of Guide and Audience

The intent of this guide is to build the capacity of Opioid Treatment Programs (OTPs), with an emphasis on publicly funded OTPs, to integrate Hepatitis C Virus (HCV) prevention and treatment services into their programs to enhance patient care and address gaps in the HCV cascade of care. The cascade of care is a way to organize specific actions and assess how a linkage model moves patients through a sequence from prevention to testing to treatment to cure.¹

The guide is intended to be a tool accessible to a wide range of OTPs and those individuals or entities invested in opioid use disorder (OUD) and HCV integration.

While the primary audience for this guide is publicly funded OTP staff (including administrators, physicians and physician assistants, nurse practitioners, nurses, case managers, counselors, patient navigators and peer support specialists), the guide may also be useful for community and healthcare coalitions, nonprofit organizations, community-based organizations, other substance use disorder (SUD) and HCV treatment providers, community health providers and policymakers.

Overview of Guide

This comprehensive guide is divided into sections to provide a thorough overview for OTPs looking to better understand how they can integrate HCV and OUD services and plan to implement organizational changes around policies, procedures, staffing and workflow.

Section Two provides helpful background information about the opioid epidemic in the United States (U.S.) and its impact on HCV incidence, testing guidelines, treatment and the role of OTPs in addressing HCV. **Section Three** shares information about integrated-care models and promising practices underway in the U.S., as well as what different integrated service requirements may look like, ranging from meeting minimal requirements to making service enhancements to moving toward integrated care. **Section Four** focuses on the steps of implementation and key activities associated with each step. **Section Five** provides information about financing and sustaining integrated OUD/HCV services and the challenges and opportunities facing OTPs that engage in this work. **Section Six** provides a basic glossary and list of acronyms.



Promising practices and core components of integrated-care models in OTPs continue to emerge. This guide includes links to useful tools and external resources that support current and evolving practices. As significant new information becomes available, addendums or revisions to the guide will be published.

How This Guide Was Developed

The Addiction Technology Transfer Center (ATTC) Network Coordinating Office (NCO), funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), is working to ensure that OTP staff have tools and resources available to help them integrate their response to the dual epidemic of OUD and infectious disease. OTPs can be leveraged to deliver evidence-based HCV screening, testing, treatment and/or referrals, and service coordination with HCV-treatment specialists, which is critical to improving the integration of OUD and infectious disease care.

The development of this guide has been informed by the convening of two HCV thought-leader summits (each of which included more than 20 experts in HCV or OUD treatment), an environmental scan to organize and briefly summarize existing resources on the topic and visits to six geographically and demographically diverse OTP sites in the United States where some level of OUD and HCV treatment integration was underway.

background

Section Two

Impact of Opioid Epidemic and Transmission of HCV through Injection Drug Use

The opioid epidemic has resulted in significant increases in HCV among people who inject drugs (PWID). At the time of the development of this guide, HCV prevalence among PWID is estimated at 40% globally, with injection drug use (IDU) accounting for 23% of new infections.² HCV can be transmitted perinatally and through specific types of healthcare exposure, but new cases of acute HCV are highly correlated with IDU. PWID are significantly more likely to contract HCV if they are sharing preparation space and equipment or sharing or reusing syringes.

What is HCV?

HCV is transmitted through blood and causes liver inflammation, which can lead to serious liver disease.

Effective harm-reduction strategies include syringe service programs (SSPs), which provide access to sterile needles, syringes and drug-preparation equipment. A 2017 study showed that 80% of young people living with HCV lived more than 10 miles from an SSP.³ The lack of SSPs is largely related to stigma and unsubstantiated perceptions that this practice promotes

drug use. As CDC notes, SSPs promote a point of entry into treatment; PWID who use SSPs are five times more likely to enter OUD treatment.⁴

Intersection of HCV and OUD

HCV is highly infectious, and minute amounts of infected blood can survive on both equipment and surfaces for up to six weeks. Key to harm reduction and prevention of HCV for PWID is using new and sterile equipment and not sharing preparation space, equipment or syringes.

HCV may also impact other organ systems, referred to as the “extrahepatic impact,” which may manifest through brain and mood changes as well as exacerbate existing diseases, such as diabetes, kidney disease and arthritis. Unlike Hepatitis A and B, there is no vaccine for HCV. See Table 1 (page 12) for distinctions among Hepatitis A, B and C.

80% of acute infections result in chronic HCV, which may result in liver damage, liver failure, liver cancer and even death. Early detection and treatment that leads to a sustained virologic response (SVR), defined as achieving and sustaining a virus-

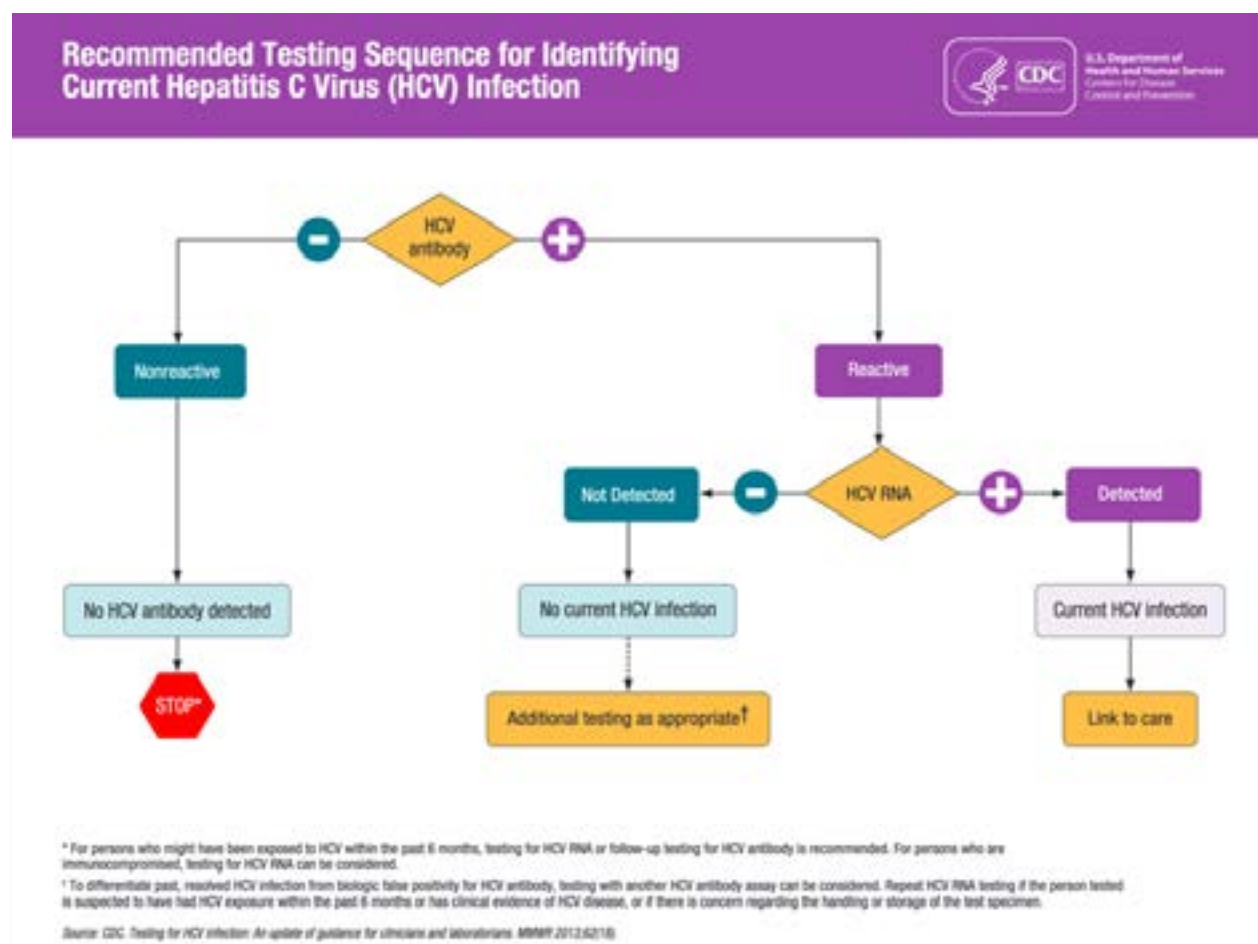
negative state for six months or longer after completing treatment for a virus, is important for preventing progression of liver disease. People with HCV may initially be asymptomatic and live for decades without feeling sick. This further emphasizes the need to screen early and continually for HCV.

Testing for HCV

Rapid initial testing has been available for HCV since 2007. The FDA's web page (see "Resources" section) has an updated list of

approved HCV-testing approaches. Testing includes an initial screen and the Hepatitis C Antibody Test, with a follow-up test for a reactive (positive) result to diagnose current HCV infection (Figure 1). A critical distinction of HCV testing and results is that an individual may have a positive HCV antibody test but a negative or undetectable viral load, due to factors such as previously treating and curing HCV, false positives due to the presence of other antibodies, and/or resolved HCV infection.⁵ SAMHSA and CDC both emphasize that "antibody and viral load do *not* give information about severity of liver disease."⁶

Figure 1: Recommended Testing Sequence⁶



Centers for Disease Control and Prevention (CDC) and U.S. Preventive Services Task Force (USPSTF) recommend testing for the following populations (Figure 2)⁷:

Figure 2: Testing Recommendations from CDC and USPSTF



- One-time testing for all adults 18 years and older
- All pregnant people during every pregnancy
- All persons with risk factors, with testing continued regularly for those with ongoing risk
- Incarcerated persons
- People who use intranasal drugs
- People who get an unregulated tattoo



“
*I'm so grateful
and excited –
I want to take
care of myself now.*

— OUD patient treated for HCV

”



Treatment for HCV

Since 2011, significant improvements have been made in FDA-approved, direct-acting antiviral (DAA) oral therapies, which have fewer reported side effects than interferon and provide SVR in more 90% of those treated.⁸ SAMHSA emphasizes that recent FDA-approved medications for those age three and older can treat multiple types/strains of HCV (pangenotypic) with shortened treatment time (most people with HCV can be treated within 8-12 weeks), fewer pills, fewer side effects and significantly better options for individuals who have been harder to treat in the past (cirrhosis, HIV/HBV co-infection, kidney disease, prior treatment failure).⁹ For a more thorough overview of HCV-treatment approaches and guidelines, visit the

American Association for the Study of Liver Diseases (AASLD). The AASLD's HCV guidelines¹⁰ outline that, while the primary goal of treatment is to eradicate HCV infection, secondary goals include improving inflammation/scarring; slowing down the progression of liver disease; reducing the risk of liver cancer and potential death from end-stage liver disease and/or cirrhosis; reducing the impact of HCV on other organ systems; improving quality of life in relation to health indicators; and preventing further transmission to others.

HCV versus Hepatitis A and B

There is often confusion around the differences among Hepatitis A, B and C. See Table 1 on page 12.

Table 1: CDC outlines key differences among Hepatitis A, B and C¹¹

	Hepatitis A	Hepatitis B	Hepatitis C
Main Transmission	Fecal-oral	Blood & Sexual	Blood
Perinatal transmission	✗	✓	✓
Risk factors (1-4)	<ul style="list-style-type: none"> • Direct contact with someone with Hepatitis A • Traveling to or adopting a child from countries where Hepatitis A is common • Men who have sex with men • Injection or non-injection drug use • Homelessness • Clotting-factor disorders • Working with nonhuman primates 	<ul style="list-style-type: none"> • Born to infected mother • Sexual partners or household contacts with infected persons • Men who have sex with men • Injection drug use • Healthcare and public safety workers at risk for exposure to blood • Hemodialysis patients 	<ul style="list-style-type: none"> • Injection drug use • Specific types of healthcare exposures • HIV-positive • Born to infected mother
Number of acute infections reported in 2017	3,366	3,409	3,216
Adjusted number of acute infections in 2017*	6,700 (4,700-7,400)	22,200 (12,600-54,200)	44,700 (35,400-152,400)
Estimated prevalence of chronic infections	Not applicable	862,000 (668,000-1,056,000) in 2011–2016	2.4 million (2.0-2.8 million) in 2013–2016
Vaccine	✓	✓	✗
Treatment of Chronic Infections	Not applicable	Yes, not curative	Yes, curative

*CDC asserts that adjusted number accounts for under-ascertainment and under-reporting based on data from 2011.

Did You Know?*

Race & Ethnicity

Hispanics are

40%

more likely to die from HCV than whites.¹²

African Americans are 11% of the U.S. population, but make up



25% of people with chronic HCV.¹³

American Indian/Alaska Native individuals are

2x

as likely as non-Hispanic whites to have acute HCV.¹⁴



Age

Historically, baby boomers (born 1946-1964) were up to 5x as likely as other ages to have HCV,¹⁵

but recently,

young adults (20-39 years old) have had the highest incidence; attributed to the opioid epidemic.¹⁶

Geographic

More dramatic increases in HCV rates in

RURAL

communities than urban areas; attributed to the opioid epidemic.¹⁷



*Different groups experience disparities due to barriers and external factors beyond their control, such as lack of access to care, institutional racism, and implicit bias, all of which negatively impact their health and lead to these statistics.¹⁸

Data on HCV Increases from 2013 to 2017 and Relation to OUD

The most recent (2017) surveillance data from CDC suggests 2.4 million (range 2-2.8 million) people are living with HCV. HCV has been rapidly increasing since 2010, and 2013-2017 data continue to show constant increases in acute HCV infection across all states.¹¹

Results from several studies strongly suggest that this increase in HCV is associated with the opioid epidemic and reflect those most impacted by OUD.¹⁹

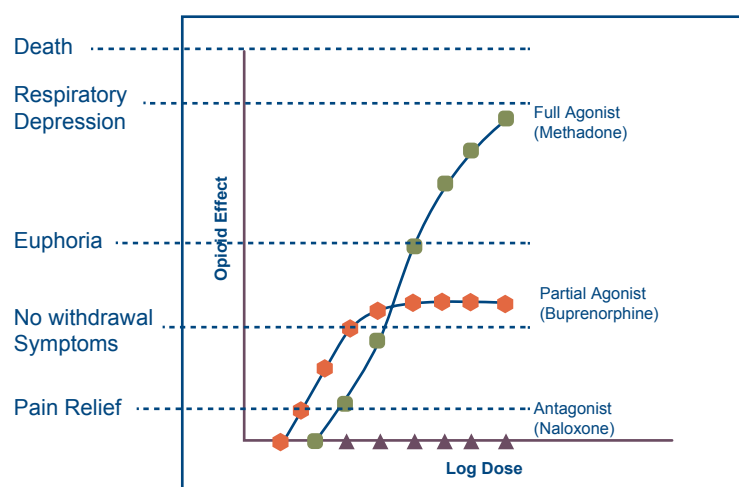
HCV rates have rapidly increased for adults aged 20-29 and 30-39. From 2015 to 2017, rates also increased among adults aged 50 and older. Key population data shows racial and ethnic disparities with significant increases in HCV among American Indian/Alaska Native and non-Hispanic white populations since 2010 and, more recently, within Hispanic and non-Hispanic Black populations each year from 2014 to 2017.²⁰

These data reinforce the need to ensure that all HCV-related interventions are culturally responsive and inclusive of all populations across the U.S. and its territories.

Evidence-Based Treatment for OUD as HCV Prevention

Evidence-based treatments for OUD — such as the FDA-indicated medications methadone and buprenorphine — are a critical part of lowering risk for contracting HCV, as they reduce the impetus to inject drugs by eliminating or managing short-term withdrawal symptoms (Figure 3). As Figure 3 shows, methadone is a full agonist, and buprenorphine is a partial agonist. With the appropriate dosage, both medications ensure pain relief and eliminate withdrawal symptoms. Methadone, buprenorphine and naltrexone are all effective in chronic or longer-term management of OUD.²¹ SAMHSA's Treatment Improvement Protocol (TIP) 63: Medications for Opioid Use Disorder provides a more thorough overview of these medications.²²

Figure 3: Graphic showing concept of how medications for addiction treatment differentially impact patients' symptoms²³



Comprehensive Approaches for People Who Use Drugs

Treating HCV in people with co-occurring disorders, such as people who use

drugs (PWUD), may require a more-comprehensive approach, due to barriers to access and care, as well as the increased likelihood of other mental-health issues. For PWID, there is also increased risk of HIV co-infection and greater risk of re-infection, increased disease progression, mortality, and HCV transmission to other PWID (if equipment is being shared).²⁴ Moreover, access to care for PWID is particularly challenging, as this population does not often access care in traditional healthcare settings due to stigma and discrimination.²⁵

The social determinants of health (SDH), which are the environments in which people are born, live, learn, work, play, worship and age, and include experiences with discrimination and racism, should be considered as part of a comprehensive approach, as they affect health outcomes and risk.¹⁸

The Institute of Medicine (IOM) advocates that prevention and treatment approaches for PWID and PWUD include an integration of HCV and substance-use services, including education, outreach, linkage to care and health coaching.²⁶ A 2011 systematic study showed that prevention strategies, including Medication-Assisted Treatment/Medication for Addiction Treatment (MAT), coupled with prevention counseling and/or MAT with SSP resulted in a 75% decrease in HCV incidence for people who had ever injected drugs.²⁷ This is supported by a 2019 systematic review that highlights that

integrated models of care, which include HCV and substance-use services, may improve engagement along the continuum of HCV care for PWID.²⁸

The Role of OTPs in Addressing HCV

OTPs play a critical role in comprehensive approaches to addressing HCV, and HCV-prevention services are already part of SAMHSA's 2015 guidelines for OTPs.²⁹

There are barriers to access and care that OTPs continually navigate and often overcome, and they can play a key role in retaining formerly incarcerated patients in care as they re-enter the community.³⁰

OTPs see their patients regularly, recognize that return to use is a part of recovery, have experience with co-occurring disorders, and may have on-site medical staff who can draw blood and provide case management. With a patient's consent, HCV screening can be seamlessly integrated into routine and/or initial physical exams and blood work.

A recent survey of OTPs suggested that **OTPs need to better integrate infectious disease services and expand their capacity to treat co-occurring disorders.**

87% of OTPs provide HIV-risk-reduction education, and more than 90% provide HCV services, including 86% who provide HCV-risk-reduction education and 61% who provide HCV testing. The challenge for OTPs addressing HCV can be seen in the areas of prevention and treatment, where only 12% offered treatment for HCV or comprehensive services related to preventing HCV.³¹

This may require a shift in some OTPs from an acute-care model to a patient-centered chronic-disease model of care that integrates treatment of co-occurring disorders and engages key community partners.

The opioid epidemic has brought unprecedented funding to address OUD and expectations that OTPs will expand service offerings and support the care continuum. As the majority of OTPs shift toward a more-integrated model of care, offering expanded MAT services and identifying strategies to address co-occurring disorders like HCV, they will play a pivotal role in the national action plan to eliminate HCV.³² Key to this will be increasing rates of HCV screening, increasing HCV-treatment access and engagement, and providing outreach and education to prevent re-infection.



promising practices and core components of integrating HCV services

Section Three

Integrated-Care Models for HCV Prevention and Treatment Services in OTPs

This section will outline core components of an integrated-care model related to HCV and OTPs and highlight some examples of how this has worked in different OTP settings and communities. This provides an opportunity to identify key steps toward an integrated model of care and outline approaches OTPs can take as they make the shift to implementing evidence-based HCV services.

There is considerable variation within and across OTPs in the U.S. as to size, staffing, infrastructure, capacity, geographic location, treatment populations, state restrictions and funding, policies and procedures, and other factors.

For many OTPs, the shift toward an integrated-care model may seem daunting and require significant organizational-culture changes, as well as policy, procedure and staffing updates to implement these changes. OTPs have cited barriers to integrated services, which include a lack of medical- and behavioral-health-provider capacity, insufficient patient demand, lack of

funding and/or regulatory concerns.³¹ While some of these barriers may require state or federal policy changes, SAMHSA and CDC are offering unprecedented support to build the capacity of OTPs and other healthcare organizations to address OUD, SUD, and other co-occurring disorders and needs. See “Resources” section for links to the Opioid Response Network and other capacity-building supports.

SAMHSA’s Levels of Integrated Healthcare

The SAMHSA Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions (CIHS) Standard Framework for Levels of Integrated Healthcare provides a six-level framework for integrated healthcare.³³ SAMHSA’s framework outlines the advantages and challenges of each level of integration, characteristics of the patient experience, and business and reimbursement considerations at each level. This continuum begins with collaboration (how resources are brought together) and moves through co-location and increasing levels of integration (how services are framed and delivered).³⁴



The Integrated-Care Model

Models of integrated care, which provide HCV-prevention and -care services in an existing **substance use treatment setting are critical to eliminating HCV, but there is no single evidence-based model for how this should work in OTPs or any clear steps for making this organizational change.** It is clear that, if barriers to access and care can be systematically addressed in a culturally appropriate and trauma-responsive environment, HCV assessment and treatment can be successful.³⁵ What is less clear is the model needed to optimize HCV-care access and outcomes and how OTPs can implement these organizational changes.^{28, 35}

The key outcome of integrated-care models is to improve healthcare outcomes for all individuals by removing traditional silos and barriers to care. Integrated services can lead to improved access to prevention, treatment and care; build stronger patient-centered relationships; increase adherence to treatment plans; and ultimately, enhance health, recovery and quality of life for persons receiving services for a variety of healthcare issues.

“
*My gratitude is
bigger than I
have words for.*

— Patient cured of HCV in
an OTP setting

”



Core Components of Integrating HCV Services

The remainder of section three is dedicated to describing core components of integrating HCV services in OTPs and doing so at different levels of integration. This includes outlining minimal requirements for offering HCV services, making enhancements to minimal services and ultimately, OTPs moving toward a fully integrated-care approach.

**MEETING MINIMUM
REQUIREMENTS**

**MAKING
ENHANCEMENTS**

**MOVING TOWARD
INTEGRATED CARE**

These levels of HCV service-integration are directed to different components of OTP operations and environment – not necessarily in a linear fashion or over the same period of time. In different OTPs, it may take years to fully move from one level to the next along the spectrum of integrated care. Core components of OTP operations and environmental conditions that must be addressed when integrating HCV-prevention and -care services include:

1. OTP facility
2. HCV screening and testing options
3. HCV-specific counseling and education
4. HCV treatment

Core Component 1: OTP Facility

Changes within the OTP facility and culture are foundational for sustaining any shift toward an integrated-care model that includes HCV services. OTPs should ensure that they dedicate the time and resources needed to effect organizational change and recognize that this may require hiring additional personnel. Many OTPs have operated as methadone-maintenance organizations for decades and have been tasked with both shifting toward an OTP that includes all types of MAT, as well as providing integrated, patient-centered services beyond the scope of their original mission. This may require significant changes in policies, procedures and workflow, along with overcoming any staff resistance. Building staff and leadership capacity to support, provide and sustain these services is critical. Outlined below are key ways in which OTPs can shift from minimally meeting regulatory requirements toward fully engaging staff and patients in a recovery-oriented, trauma-responsive, patient-centered integrated-care model that includes MAT and HCV services.

MEETING MINIMUM REQUIREMENTS

Comply with all federal and state regulations.

SAMHSA outlines clear federal guidelines for OTPs, and all OTPs need to ensure continued compliance with their accrediting body.²⁹ The Certification of Opioid Treatment Programs, 42 Code of Federal Regulations (CFR) 8 provides a system to accredit and certify OTPs. All OTPs must also

be licensed by the state in which they operate and must register with the Drug Enforcement Administration (DEA) through a local DEA office.³⁶

Train all staff in HCV.

A minimum requirement for OTPs is to ensure that staff understand the basics of HCV, the distinctions between HCV and Hepatitis A and B, and how to prevent reinfection. These basics were outlined in Section 1, and training and education resources are available in the “Resources” section of this guide. If staff will administer any HCV tests or offer treatment, they will need training in testing protocols, universal precautions and FDA-indicated treatment options.³⁷

While sharing printed and online materials is useful, successful implementation means providing opportunities and time for hands-on training and engagement.

OTPs must provide staff with clear and consistent messaging around HCV prevention, screening and testing, treatment and recovery to ensure there is standardized communication across the OTP.

Provide MAT to all patients.

OTPs are the only current setting that can provide all three FDA-approved MAT (methadone, buprenorphine and extended-release [injectable] naltrexone), which allow patients and their medical provider to select the best course of treatment. SAMHSA strongly encourages all OTPs to offer expanded MAT services beyond methadone

to address the diverse needs of those with OUD and to impact the opioid epidemic.³⁸ A recent survey of OTPs suggested that, while 96% of OTPs offer methadone, only 32% of OTPs offer all three MAT.³¹ SAMHSA offers technical assistance to all OTPs to encourage expanded MAT offerings.³⁶ OTPs that have not shifted toward all three MAT offerings may need to educate and train all staff and clinicians, as well as educate patients, about the benefits and risks of each medication so they can make informed choices.

SAMHSA offers a checklist to identify organizational readiness to integrate MAT.³⁹ Key issues to consider include leadership buy-in and support; staff capacity to describe MAT and waived providers to prescribe; capacity to offer/make referrals for supporting behavioral health and other needed services; Medicaid and insurance requirements; and ensuring compliance with all state and federal requirements.⁴⁰

MAKING ENHANCEMENTS


Address stigma. Maintain professional exterior and welcoming and inclusive interior.

Beyond compliance, OTPs can enhance services by addressing the stigma around OUD and HCV, HIV and OUD treatment that often exists in communities. While addressing stigma is a multi-level intervention and will be discussed throughout, there are clear steps OTPs can take in working with and educating communities on SUD and OUD. This includes: supporting public-awareness campaigns and providing education to the community on the science of addiction,

programs that help reduce harm and mitigate individual and community risk, the effectiveness of medications for OUD, and the role of OTPs in the continuum of care.⁴¹

In these efforts, building relationships with influential stakeholders is critical and may improve coordination of services in addition to addressing stigma. OTPs should consider engaging diverse stakeholders, such as: schools and youth organizations, recovery support services, county and state health departments, faith-based groups, harm reduction coalitions, organizations that represent communities of color, housing groups and healthcare organizations. Such stakeholders can help OTPs identify existing community assets, including trusted community leaders, who may be particularly critical for reaching populations reluctant to engage with the medical system, including some communities of color.⁴²

Finally, OTPs may curtail stigma and improve how the public perceives their services and patients by making updates to the physical environment. The site's exterior should be clean and maintain a professional curbside appearance, and the interior space should be welcoming and promote an inclusive environment.⁴³




See “Resources” section for useful tools related to engaging communities.

Gain leadership buy-in and prepare staff for organizational change.

It is critical to gain leadership buy-in, and organizational commitment to providing culturally responsive HCV services and dedicating budget and staff time to learning and offering these services.⁴⁴ Administrators

will need to establish new protocols, policies and procedures, reach out to community partners to create sharing agreements if referring out for services, and recruit new staff.

OTPs should also be sure to consider the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards), developed by the U.S. Department of Health and Human Services Office of Minority Health, when integrating HCV services. The CLAS Standards provide a helpful organizational framework aimed at improving healthcare quality and advancing health equity for the nation's increasingly diverse communities.⁴⁵ See "Resources" section for more information about the CLAS Standards.



As OTPs expand HCV services, administrators must recognize the time needed to recruit new staff, ramp up existing staff knowledge and learn new roles, as well as understand that adding in these services means staff must also adopt new policies and procedures.

There is likely to be some resistance among staff if the OTP is shifting from a methadone-maintenance model to a culturally and linguistically appropriate integrated-care model. Time should be taken to engage staff in this organizational-change process and to address any stigma or stigmatizing language related to infectious disease or IDU, especially any stigma that intersects with implicit biases toward particular races, ethnicities, abilities, genders, sexual orientations, etc.

Taking the time to assess and plan for change is critical. Implementing training and new policies and procedures without recognizing the implications for existing staff could negatively impact the success of this change. The implementation process and steps for organizational change are outlined in Section 4.

Link to care for co-occurring disorders.

Enhancing OTP services may also include providing formal linkages with providers that can address co-occurring disorders, such as other SUDs, mental health challenges, or physical health needs. There are a variety of approaches to linking patients to care for co-occurring disorders. OTPs may have a provider from a different organization visit on specific days and times, physically provide services in the same building and/or have a formal MOU or MOA in place to share medical information. **For many smaller OTPs, co-located services (where services are located in the same facility or with close collaboration) may not be feasible. However, the OTP can still inventory available local services and can partner with a community provider to better coordinate services for the patient.** This does not mean sending patients out the door with a referral and a list of places that offer services but rather coordinating these services with them and establishing formal linkages and agreements to share treatment records. This enhancement improves linkage to care but still lacks the whole-person care that individual patients may need. Peer navigators can support improved linkage to care for off-site programs and help OTPs working toward integrated care to improve system linkages and patient outcomes. See "Resources" section for more resources related to establishing partnerships.

MOVING TOWARD INTEGRATED CARE

Build capacity to be a recovery-oriented, trauma-responsive, patient-centered care organization.

Addressing stigma is a step toward building capacity toward the organizational-culture changes needed to be a recovery-oriented, trauma-responsive, patient-centered care organization. An Anti-Stigma Toolkit and other stigma-reducing information are available in the “Resources” section.

William (Bill) White’s Recovery-Oriented Methadone Maintenance (ROMM) approach is an integrated approach that “combines medication and a sustained menu of professional and peer-based recovery-support services to assist patients and families in initiating and maintaining long-term addiction recovery.”⁴⁶, page 14 Key to this is recognizing that there are multiple pathways to recovery, integrating peer support specialists into all aspects of the care continuum, reframing OTPs as medication-assisted recovery centers, facilitating greater connections with recovery supports and harm-reduction programs, and advocating for regulatory and funding changes that decrease stigma and discrimination and create a sustainable and inclusive recovery culture.⁴⁶

Complementing White’s ROMM model, SAMHSA outlines guidance for individuals and organizations to be trauma-responsive, highlighting how a “program, organization or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of

trauma in patients, families, staff and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures and practices; and seeks to actively resist re-traumatization.”⁴⁷

OTPs can unintentionally traumatize patients through basic procedures, such as how staff communicate with, assess and intake patients; if patients have to move from chair to chair in treatment waiting rooms, similar to criminal justice settings; and if patients feel safe in the physical environment of the OTP, including décor, colors, cleanliness and messaging. A trauma-responsive organization has individuals trained in and practicing trauma-informed care; practices, policies and procedures that support becoming trauma informed and responsive; staff building capacity to address their own and secondary trauma; a strong peer-support network; and leadership that promotes a trauma-responsive culture within the organization.

Becoming Recovery-Oriented and Trauma-Responsive

Recovery-Oriented Methadone Maintenance

In 2010, Bill White and his colleagues challenged the OTP community to establish a recovery-oriented methadone-maintenance (MM) approach. He noted that the “future of MM in the United States rests on the collective ability of OTPs to forge a more person-centered, recovery-focused medical treatment for opioid addiction and to confront methadone-related social stigma through assertive campaigns of public education and political/professional influence. It also rests on the mobilization of a grassroots advocacy movement of MM patients and their families.”⁴³

*Trauma-Informed Care
Implementation Resource Center*

This website offers tools and resources for the key steps to become trauma-responsive.⁴⁶ See “Resources” section for additional resources related to trauma-informed care.

Establish a coordinated HCV team, including peer support specialists, to provide on-site assessment, education, counseling and care. Implement regular quality improvement training for all staff.

Key to successful implementation is establishing a diverse team of people, including peer navigators and/or peer recovery-support specialists (PSS), who can champion and coordinate the integration and delivery of HCV services. These teams should include a point of contact from OTP leadership and consist of multidisciplinary staff such as clinicians and nursing staff, behavioral health providers, PSS, pharmacists and recovery-support services.

This team can collaborate to assess the OTP environment; identify OTP infrastructure and staff capacity needs; identify a clinical champion and establish a coordinated team for HCV service delivery; outline patient-education needs; determine a screening strategy and treatment protocols; identify monitoring and process-improvement metrics, including metrics for decreasing racial disparities; and ensure medication access and insurance coverage. Process-improvement metrics can support an organizational focus on learning and regular quality improvement for all staff.

Provide integrated, collaborative care that includes MAT and HCV services.

A shift toward an integrated collaborative-care model would ensure that mental health, HCV services and other co-occurring service needs could be addressed and managed within the OTP, either through partially integrated services with shared agreements, policies and procedures, or by fully merging practices. Integrating healthcare and other services is an evidence-based strategy for comprehensive healthcare delivery. It moves beyond just the location of services and includes addressing mission and vision, aligning processes and procedures, and adapting policy.⁴⁹ This requires OTPs to develop comprehensive care plans so that treatment information can be shared and co-managed. It also requires some extensive shifts in policies and practices to assess and care for patients needing wraparound services, engaging both providers and patients in a shared decision-making process.

The delivery of integrated HCV and OUD care and treatment in OTPs needs to be tailored to be culturally responsive to diverse patient populations, including materials and services that are age-appropriate, appropriate for PWID, who may not be receiving much-needed health and support services, and inclusive of patients traveling from distant geographical locations due to stigma and/or lack of local treatment capacity. By addressing a diverse patient population with needed HCV and OUD prevention, care and treatment services, OTPs can provide a patient-centered care program that increases access to these services.



The Importance of Peer Support Specialists on HCV Teams

Peer recovery-support specialists (peer support specialists; PSS) can be an excellent resource for engaging patients in discussions around HCV, risk-reduction strategies and reinforcing key messaging, especially among PWID. Stigma within the healthcare system and larger community toward PWID, PWUD and/or people in recovery has resulted in mistrust of healthcare providers and created a barrier to engagement and retention in treatment. Peer support has been successfully implemented for managing a variety of chronic diseases, especially for patients with co-occurring diseases. PSS not only advocate for including the voices of people with lived experiences, but they also support navigation across healthcare systems; increase treatment knowledge, engagement and retention; and improve treatment and service delivery.⁵⁰

PSS should be part of a culturally diverse workforce. The importance of employing Black/ African American PSS is demonstrated as one strategy of creating a culturally relevant and diverse workforce. Community Snapshot of Detroit Recovery Project Mobile Outreach Team in SAMHSA's issue brief provides real-world examples.⁴² PSS can play a wide range of roles, including taking patients to appointments and advocating for them in unfamiliar medical settings if requested by the patient. If licensed counseling is not available onsite, PSS can coordinate any needed counseling for patients diagnosed with HCV and follow up with them on appointments. Additionally, PSS can support the education of outside medical agencies around SUD/OD and outline the challenges those in recovery may face as they engage with treatment outside of the OTP. PSS and other staff can also ensure that patients are connected with harm-reduction services, such as SSPs, and have access to naloxone.

PSS can also support medical staff by engaging patients in dialogue around sensitive topics and reinforcing the need to fully disclose key medical information to support their treatment plan. As the example from OASIS shows (page 37), support groups co-facilitated by PSS can increase engagement and retention in treatment. For those patients with active HCV, support groups that are led by PSS trained in both OUD and HCV can create a safe space and reduce the risk of disease progression by providing counseling and education around the risk of alcohol and lifestyle supports needed to improve patient outcomes. PSS can also help dispel any myths and misinformation around HCV and reduce HCV stigma, guiding their peers to care through connections and trust.⁵⁰

The development of interdisciplinary HCV teams that include PSS signals a shift in OTPs' approach to working with people in recovery. Key to successful integration is to provide organizational resources for peer support, so that PSS are an equal member of the team and can plan and implement peer models. If OTP staff see PSS as patients, discriminate against PSS, and/or do not include them as a core part of the team, then PSS may feel isolated and less willing to disclose information pertinent to treatment and long-term recovery. When OTP HCV teams include PSS equally, support PSS financially, and value them as part of an integrated care approach, then OTPs often report transformation at the organization, and patients report increased satisfaction with services.⁵¹ See "Resources" section for resources related to integrating peer-support specialists into HCV teams.

Core Component 2: HCV Screening and Testing Options

Screening and testing protocols vary across OTPs, depending on on-site medical staff capacity, ability to do labs and blood work on-site versus point-of-care assays that use a finger-stick sample, and space resources. Many screening and testing procedures can be integrated into existing protocols for OUD services during intake or routine appointments at the OTP. As the majority of people who test positive for HCV do not know their HCV status, SAMHSA recommends routine, integrated screening and rapid testing with ongoing follow-up for all OTP patients.⁵² See “Resources” section for links to screening and testing guidelines.

The following are recommendations for scaling up from minimal HCV screening and testing to the integrated best-practice approach SAMHSA supports.

MEETING MINIMUM REQUIREMENTS

Screen, test or refer for testing for all new patients. Assess risk for existing patients.

Offering opt-out screening, testing or referral for testing for all new patients at intake is a minimal way to establish a screening process that leverages existing protocols. If no HCV services have previously been offered in the OTP, then a one-time assessment and outreach to all existing patients is needed, prioritizing patients who have ever injected drugs, are living with HIV, and/or were born between 1946 and 1964. Screening and testing activities include assessing risk for acquiring or transmitting

HCV, patient history of HCV infection, and conducting rapid testing, plus any follow-up testing needed to confirm diagnosis.⁵³ Screening can also be an opportunity for educating patients on HCV and its effects on health and sharing prevention strategies (such as harm-reduction strategies) to reduce the risk of infection, re-infection and/or transmission to others.

At intake, questions related to HCV risk factors and patient history can be added to the existing intake process as needed. Patients may be unclear on what previous blood work measured and if they have been tested for HCV recently, may conflate HIV testing with HCV testing, or may not understand reinfection, so it is optimal to offer opt-out testing, in which patients are told they will be screened for HCV unless they explicitly decline testing. Not having medical staff on-site should not be a barrier to offering initial screening and referring out for further testing.²⁶

If OTPs have on-site medical staff, HCV screening and initial testing can be integrated into existing procedures. As outlined in Figure 1 (page 9), screening for HCV involves rapid testing to initially detect antibodies, though a positive test result does not mean the person is currently infected. Further diagnostic testing is required.⁵⁴

If OTPs do not have on-site medical staff available, it is critical to establish a clear process for coordinating testing by working with local health departments and/or coordinating with medical facilities. All newly diagnosed cases of HCV will need to be reported by the testing facility, so it will be important to coordinate with local and state health departments to stay up to date on requirements. In fact, many states’

laboratories are already required to report positive results to the local or state health department.

All information related to screening, testing and reporting will need to be included in patient consent forms during intake and in the OTP's manual or written policies and procedures.

MAKING ENHANCEMENTS

Provide on-site screening for all patients at intake and during regular appointments. Provide on-site testing or coordinated testing for all patients as indicated by screening assessments during regular appointments.

Ongoing screening is recommended for all people who use and inject drugs. **Providing on-site screening during monthly/regular appointments increases opportunities to diagnose HCV at earlier stages, reduces the impact of chronic HCV, and improves communication around OUD and HCV prevention and care.**

When screening results indicate a risk, patients should be tested or referred for testing. If medical staff cannot provide on-site testing (initial and follow-up), the OTP should coordinate testing and establish a process to follow up and share results on HCV diagnosis and any treatment recommendations.

Coordinating testing moves beyond handing out a referral sheet and expecting patients to follow up and set appointments. Instead, the OTP needs to ensure several factors are in place:

1. Care should be coordinated with medical organizations that are educated on SUD and SUD treatment and will not stigmatize or traumatize patients from OTPs. Formal MOA/MOU may need to be in place.
2. Procedures are established for the OTP setting (or beginning the process of setting) appointments for HCV testing.
3. Procedures are established for following up and sharing data on appointment, diagnosis and treatment plans (if applicable) while maintaining confidentiality.

MOVING TOWARD INTEGRATED CARE

Provide routine, integrated screening for all patients, using EHR alerts, risk assessments, screening interviews and other validated tools. Provide routine, integrated rapid and follow-up lab testing for HCV.

Integrating HCV screening and testing into OTPs as part of a wider, comprehensive, integrated-care approach is the gold standard of care. This requires partly merged or fully collaborative merged models of care that include a comprehensive care plan across OUD and HCV services that engages both patients and any providers in healthcare decisions. An integrated system might also use EHR data to routinely screen

patients at higher risk during appointments and suggest rapid testing for those who report potential exposure, include the use of PSS to support disclosure of sensitive information, and ensure OTPs have the ability to share information and to co-manage patients with any collaborating agency. Formal policies and procedures are needed to establish clear agreements within and between organizations and to maintain patient confidentiality.

Core Component 3: HCV-Specific Counseling and Education

There are significant overlaps between screening and counseling, as screening provides a great opportunity to build stronger patient-provider relationships, engage patients in discussion around HCV and reinforce messaging and strategies around prevention, testing, treatment and recovery. During screening, counselors have an opening to provide knowledge about HCV, discuss harm-reduction strategies that reduce transmission, support the patient in identifying behaviors that may place them at greater risk of contracting HCV or HCV re-infection, outline disease progression, address other health needs and supports, and provide referrals to other services the patient may need. This reinforcement of messaging and strategies can motivate patients to address any concerns and take practical steps toward healthy outcomes.

When education and counseling are a part of the screening process, it can reduce concerns should the patient receive a positive HCV-test result. This can help navigate confirmatory follow-up testing and ensure that patients have the information needed to make informed decisions about their care and risk-reduction plan. Patients

with active HCV infections should be provided information about how to prevent transmission to others, how to manage their HCV and how alcohol may impact their HCV. This education and counseling support patients in making informed treatment decisions, reducing liver-disease progression, and reinforces the importance of testing for Hepatitis B, HIV, and other conditions that may accelerate liver fibrosis.

The following are recommendations for scaling up from offering minimal HCV education and counseling to an integrated approach.



See “Resources” section for tools related to HCV messaging.

“
*It's wonderful
to come here
for medication
assisted treatment
and find out
they can do
everything!*

— Patient cured of HCV in
an OTP setting.

”

MEETING MINIMUM REQUIREMENTS

Disseminate HCV and harm-reduction educational materials to all patients. Coordinate counseling, and refer patients with HCV to counseling services. Coordinate with prevention and harm-reduction services, such as syringe service programs (SSPs).

A minimal step OTPs can take is providing all patients with both HCV educational materials and harm-reduction strategies. While brochures can be useful, OTPs could also look to other media strategies to share information. Many OTPs share information related to infectious diseases and harm reduction by streaming YouTube channels through televisions or computers while in the waiting room. Other agencies send follow-up emails and use social media to reinforce messaging around harm reduction, prevention, treatment and care. Ensuring that messaging is posted clearly within the facility and that all staff are trained in key talking points to provide consistent messaging will support this effort. An HCV community resource list that includes accessing naloxone and SSPs should also be developed for both staff and patients.



See “Resources” section for tools related to counseling and education.

MAKING ENHANCEMENTS

Engage patient in dialogue around HCV risk factors, testing, prevention, treatment and access to naloxone. Collaborate with behavioral health partner to offer co-located behavioral-health services. Collaborate with prevention and harm-reduction services, such as SSPs.

OTPs looking to enhance HCV counseling and education services will need to establish clear routines for engaging patients in ongoing dialogue around HCV as part of routine appointments for OUD. EHR can be programmed to alert providers to ask patients about factors that may impact HCV infection, reinfection and medication adherence. All staff and patients should be trained on naloxone, and naloxone should be available on-site. HCV messaging around the facility should reinforce HCV risk factors, and staff should be trained on key talking points around HCV testing, prevention and treatment. If OTPs do not have co-located SSPs, then connections should be made with any local SSPs and/or harm-reduction coalitions to ensure patients and their families have access to harm-reduction services.

OTPs can collaborate with off-site behavioral health services by establishing clear MOA/MOU to share data and treatment plans to support patients with co-occurring disorders while maintaining patient confidentiality. If a full-time, on-site behavioral health staff member is not an option, OTPs can collaborate to offer part-time, co-located behavioral-health services by having a visiting behavioral staff member

on specific days, using PSS to transport patients off-site and by ensuring that patients receive support and care for both OUD and HCV and/or using telehealth to provide services. Telehealth models have been used effectively in rural areas and in tribal communities to connect HCV patients with behavioral-health and other medical services unavailable in their areas.⁵⁶

MOVING TOWARD INTEGRATED CARE

Make integrated education and tools for HCV risk factors, testing, prevention, treatment and naloxone available on-site. Offer integrated counseling services: an on-site counselor as part of the HCV team or a strong collaboration with a behavioral health partner as well as integrated prevention and harm-reduction services.

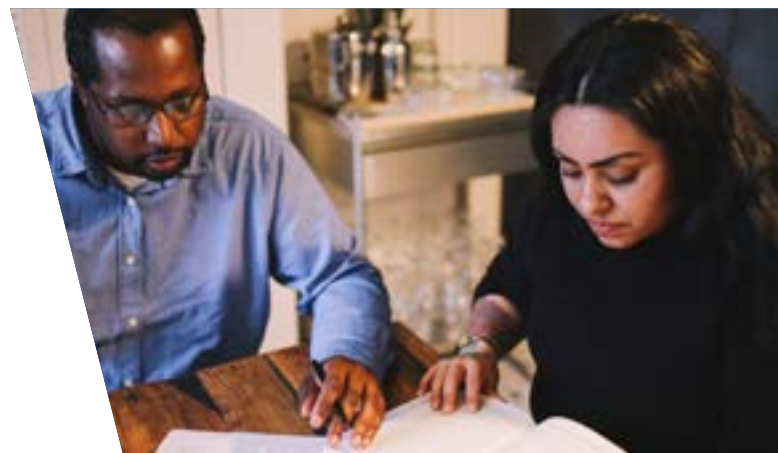
An integrated-care model for counseling and education ensures that PSS and behavioral health staff are part of an integrated HCV care team. If the OTP does not have the resources to integrate or fully merge with a behavioral health partner, then formalized policies and procedures, supported by an integrated EHR system, should streamline care. The HCV care team collaborates with patients to develop comprehensive care plans that include OUD and HCV treatment, co-manage patients, and ensure that patients are engaged with other recovery and treatment supports as needed.

In this model, OTPs offer ongoing HCV staff trainings and patient workshops, and HCV visuals, materials and social media messaging would be consistent. Staff

are trained in naloxone and have naloxone available on-site. Ideally, SSPs are co-located to provide a point of entry as people are ready to move toward treatment and recovery. Staff also retain an updated list of community resources and establish strong working relationships with community providers that provide recovery-support services.

Integrated counseling and behavioral health services are available to all patients and can address OUD, HCV and other healthcare needs. With appropriate training, supervision, and ongoing support, peer support specialists lead or co-facilitate support groups for HCV education and/or for those with active HCV.

While integrating care has many advantages, it is important for OTPs to understand the licensing requirements in the state in which they are located. In some states, such as California, drug treatment programs cannot bill for physical health services unless they are also licensed as a primary care clinic. OTPs should check with their state's substance use authority for specific information.



Core Component 4: HCV Treatment

Pharmacological treatment using DAA oral therapies for HCV continues to advance. While patients with cirrhosis or other complications may need advanced care outside of the OTP, the majority of OTPs are well equipped to offer HCV treatment on-site. OTPs have established teams for patient engagement; screening and assessment for OUD; for administrative needs around billing, insurance and funding OUD treatment; case management; established policies for accessing and dispensing MAT; and outlined procedures for monitoring treatment and recovery. While expanding services requires more resources and specific HCV medical expertise, these same processes and staff expertise around OUD can largely be adapted for providing on-site HCV treatment.

Providing on-site treatment for HCV in a location familiar to and trusted by patients with OUD impacts medication adherence and improves patient outcomes. If EHR data tracks and supports established policies and procedures while maintaining patient confidentiality, communication is improved across the healthcare team, and both diseases can be effectively monitored.

As OTPs scale up toward fully integrating treatment and build staff capacity to independently offer treatment, there are some minimal ways HCV treatment services can be included. **Smaller OTPs may lack the resources to fully integrate on-site treatment services but can formalize partnerships to collaborate effectively with HCV treatment organizations and other medical services.**

MEETING MINIMUM REQUIREMENTS

Coordinate treatment and offer referral. Monitor for treatment adherence, and assess side effects at routine appointments.

If OTPs are referring patients out for treatment for HCV, care needs to be taken to ensure that any medical staff working with patients with OUD understand the challenges for patients with co-occurring disorders. If patients feel stigmatized and/or medical providers lack the knowledge to support and treat patients with OUD, it could impact their HCV treatment and trigger a recurrence of symptoms related to their OUD. Before referring out to medical providers, OTPs need to establish relationships and ensure any potential partners are vetted to ensure that they understand addiction medicine and are patient-centered and inclusive. Partners should be able to support all people in an inclusive, equitable manner. They should be able to “meet the patient where they are” regardless of their use status and/or stage of recovery. If referring out for services, working with medical providers who can also provide comprehensive medical services (including HCV) not currently offered by the OTP may help to streamline healthcare for the patient.

If referring out for services, OTPs need to ensure that patients are monitored for treatment adherence for both HCV and OUD and that they discuss and assess for any side effects during routine appointments. EHR software can be

programmed to help prompt staff to check in with the patient during routine visits and monitor any reported side effects from treatment.

MAKING ENHANCEMENTS

Collaborate with partner to provide HCV treatment. Engage partner and patient to monitor treatment adherence and assess side effects at routine appointments.

OTPs that may lack the infrastructure for integrating comprehensive medical services can still partner with HCV treatment and other medical organizations to provide HCV and other treatments. This expands beyond coordination to ensure that formalized structures are in place to share important health information and treatment plans for both OUD and HCV, as well as maintain patient confidentiality. This enables both the OTP and any partners to coordinate care and monitor treatment adherence while assessing any side effects.

MOVING TOWARD INTEGRATED CARE

Offer integrated treatment services on-site as part of HCV team or through strong collaboration with healthcare partner. Offer integrated treatment assessment as part of routine care.

An integrated-service model that offers HCV assessment and treatment on site or through a strong collaboration with a healthcare partner will always be the most effective model for improving

patients' health outcomes and retention in treatment for both OUD and HCV. OTPs are uniquely positioned to offer integrated HCV treatment, as they have staff expertise in medication management, treatment adherence, insurance challenges around prior authorization and establishing clear screening and treatment protocols.

Providing on-site or collaborative services streamlines patients' recovery, enhances communication between OUD and HCV treatment providers, offers a greater opportunity to manage psychiatric services and includes the wraparound support services needed for patients who may have co-occurring disorders. HCV-care goals can be integrated into case-management assessment and reassessment as part of routine care. This may require an infectious disease specialist being on-site or working closely with an organization to build their capacity to provide treatment independently.



Telehealth Models: Telehealth can play a key role in retaining patients in care and supporting providers as they build their capacity to provide independent treatment services, especially for complex cases. Innovations in telemedicine and mobile health (mHealth) enable OTPs with medical providers to provide the full continuum of treatment options with a variety of telemedicine options.⁵⁶ These models include:

1. Teleconsultation

Used by the Veterans Health Administration (VA), where providers in under-resourced areas are linked with specialists who can support individual cases and outline updated evidence-based practice around OUD and HCV.

2. Televisits

Patients in rural or remote areas use video to meet virtually with their provider one on one.

3. Telemonitoring

Patients are monitored remotely through specific apps or tablets; it provides data to assess disease progression and measure signs and symptoms.

4. Hybrid Consultations

Where a specialist is virtually present to consult with a less-specialized provider and the patient. The virtual specialist can advise the provider on specific exams, tests, and other parts of the treatment plan.

The following pages include case examples from a variety of OTPs that are integrating HCV care into their facilities at varying levels.

Example: Project Lazarus' community-based engagement model

Wilkes County, North Carolina

While the following example extends beyond a single OTP and shares a community response to OUD, it emphasizes the importance of engaging key stakeholders, using local data to address the need for OTPs, the impact of OUD on the surrounding community and the effect of broad-based education efforts.⁴⁶

Issue	Prescription opioid death rate in rural county 4-5 times higher than state and national average
Challenge	Prevent overdose deaths, increase community understanding, address stigma, and improve responsible pain management
Approach	Community-based engagement model; increased prevention, treatment and recovery services
Strategy	Community coalition of local organizations, providers and stakeholders; use of local data to inform strategies
Core Components	<ol style="list-style-type: none">1. Building treatment resources for providers2. Enhancing linkages between medical providers, pain programs and substance use treatment services3. Working with state and local entities to better fund mental health services4. Public education campaign
Outcomes	<ol style="list-style-type: none">1. 69% decrease in overdose deaths from 2009 to 20112. 82% decrease in overdose deaths attributed to medications from local prescribers3. 15% decrease in ED visits attributed to overdose and OUDs
Key Lessons Learned	<ol style="list-style-type: none">1. Local data and broad-based educational efforts are vital to raising awareness2. Coalitions are a key way to engage community providers, agencies and organizations3. Engaging communities in decision-making around strategies increases buy-in and sustainability

Example: CODAC Behavioral Health

Rhode Island

Clinical Champion	Nurse who liaises with all staff (physicians, nurses, social workers and counselors) serving HCV and OUD patients
Community Partners	OTP builds relationships and establishes MOUs with key community partners, including pharmacists (Rhode Island College of Pharmacy) and corrections staff
Commitment to Staff Knowledge	Organization supports staff learning through trainings, state conferences and training dinners; staff opportunities to detail individual cases
Policy	Infectious disease training is required for all staff as part of chemical dependency licensing
Patient Education	CODAC uses every medium to reach out and educate patients, including videos in the facility and waiting room
Key Lessons Learned	Critical to have champion who can liaise with staff, network with key community partners, and support patient navigation; commitment to staff and patient education means creating and leveraging opportunities for learning

Example: The APT Foundation, New Haven, Connecticut⁶⁷

New Haven, Connecticut

The APT Foundation is a nonprofit that provides comprehensive OUD services within a central medical unit. These services include intensive outpatient services, residential treatment, on-site psychiatric care and on-site primary medical care. This example provides a brief overview of how APT expanded HCV (and HIV) services for patients and emphasizes that injection drug use should not be seen as a barrier to HCV treatment.

Issue	Demonstrate feasibility of routinizing HCV services, including treatment using direct-acting antivirals (DAAs) in OTP
Approach	Integrated approach to care through expansion of HCV services to offer on-site routine screening for HCV and treatment; 75 patients included in initial data
Core Components	<ol style="list-style-type: none">1. Clinical staff trained on HCV and integrated primary care team established2. Opt-out routinized HCV- and HIV-antibody screening with follow-up testing for all patients3. Education and treatment options for patients with HCV4. Patient option to engage family and request screening for contacts at risk5. Coordinated regular OUD (MAT) and HCV treatment with DAAs and in-house social workers and psychiatrists
Outcomes	<ol style="list-style-type: none">1. 99% adhered to HCV and OUD treatment; ongoing drug use (23%) and incarceration (13%) did not alter outcomes2. 98% obtained SVR; 83% achieved a rapid virologic response (RVR).
Key Lessons Learned	<ol style="list-style-type: none">1. An integrated-care model that uses DAAs as part of on-site treatment delivery is effective for PWID.2. Early detection, education and universal screening are key to impacting the epidemic.3. Ongoing drug use should not be a barrier to HCV treatment.

Key Components of the APT Foundation's Integrated Care Model⁵⁷

Type of OTP	Nonprofit
Key Components	<ol style="list-style-type: none"> 1. Syringe-disposal boxes installed in exam rooms 2. MAT services offered (buprenorphine and methadone) 3. Psychiatric care, including psychotherapy, and individual treatment and medication counseling are available 4. HIV services are also provided on-site 5. HCV testing, counseling and treatment are provided 6. HCV screening is provided at no cost 7. For patients with HCV, contacts may be approached anonymously 8. Supportive care from social workers, PSS and psychiatrists as needed 9. List of community resources, including SSPs, available

Example: Organization to Achieve Solutions in Substance-Abuse (OASIS) Clinic

Oakland, California; Vancouver, Canada; New York

Issue	Rate for HCV in PWID in catchment area was 90%, but limited services available for marginalized community members
Challenges	Many patients had co-occurring disorders and were homeless, injecting/using drugs or returning to use and at high risk of infection and/or transmission to others
Approach	Funding from CDC, HRSA and NIDA to develop medical and educational program to integrate HCV services and engage, educate, assess and treat PWID
Strategy	<ol style="list-style-type: none"> 1. Training and mentorship provided for clinical staff PSS 2. PSS' role clearly established and supervision offered 3. PSS recruit patients, co-facilitate groups for education, support and treatment, conduct peer interventions, escort patients to off-site procedures and engage in follow-up 4. Screening, assessment and treatment conducted with peer support
Core Components	<ol style="list-style-type: none"> 1. An integrated-care model that uses DAAs as part of on-site treatment delivery is effective for PWID. 2. Early detection, education and universal screening are key to impacting the epidemic. 3. Ongoing drug use should not be a barrier to HCV treatment.
Outcomes	<ol style="list-style-type: none"> 1. Significant increase in people in high-risk groups being assessed and treated for HCV 2. Improved health outcomes for patients engaging in groups 3. PSS helped overcome barriers to care, increased engagement in care, and improved OUD and HCV services 4. Significant and durable increase in knowledge around HCV and OUD
Key Lessons Learned	<ol style="list-style-type: none"> 1. PSS-based models can support an integrated-care model that includes HCV services in OTPs and community clinics 2. Supervision and mentorship for PSS is crucial 3. Resources for peer support are essential for ensuring peer is treated as equal partner and can plan peer interventions

Example: Patient-Centered Outcomes Research Institute (PCORI) study in twelve sites in New York State^{58,59}

PCORI five-year study

Seven OTPs across twelve sites in New York

Issue	Demonstrate feasibility of using virtual HCV care with in-person care at OTP for patients with OUD and HCV; patients in OTPs being referred out are not being retained in HCV care
Approach	Telehealth approach to providing patient-centered HCV care for people on MAT ⁶⁰
Core Components	<ol style="list-style-type: none"> 1. OUD patients participated in biweekly telemedicine sessions between a hepatologist and physician assistant during the entire HCV treatment course 2. All pretreatment labs (HCV RNA, genotype and noninvasive fibrosis assessments) obtained on-site and DAAs were co-administered with methadone, using modified directly observed therapy
Outcomes	<ol style="list-style-type: none"> 1. 45 treated patients; 42 (93%) achieved SVR; 99% adhered to HCV and OUD treatment; ongoing drug use (23%) and incarceration (13%) did not alter outcomes. 2. 98% obtained SVR; 83% achieved a rapid virologic response (RVR)
Key Lessons Learned	<ol style="list-style-type: none"> 1. An integrated-care model supported by telemedicine is effective for HCV treatment in OTPs 2. Marriage and a mental health diagnosis other than depression were correlated with engaging in treatment; being divorced, separated or widowed negatively impacted treatment engagement

Issue	Gaps in chronic HCV diagnosis, evaluation and treatment have resulted in less than 5% of PWID receiving HCV treatment
Challenge	People with HCV and OUD receive fragmented care; removing barriers to care for PWID by providing HCV services in a trusted location that provides OUD treatment
Approach	Integrated HCV screening, care and treatment in OUD-treatment setting
Strategy	Medical staff partnered with PSS to develop and deliver services and establish clear roles for PSS; PSS co-facilitated self-help groups and therapeutic communities, and conducted peer-led interventions; HCV screening, testing and treatment integrated into clinics
Core Components	<ol style="list-style-type: none"> 1. All OUD-treatment providers trained in HCV pre- and post-counseling, plus DAAs 2. All patients screened for HCV and HIV 3. All patients with HCV offered treatment on-site 4. Infectious disease specialist on-site for mentoring clinicians and supporting patients 5. Participating in HCV Project ECHO^{62, 63} to support ongoing learning 6. Repurposing OUD staff expertise around prior authorization and medication management for HCV
Outcomes	<ol style="list-style-type: none"> 1. 740 patients screened; 22.5% of patients diagnosed with HCV 2. On-site cure rate of 85% using intention to treat analysis; 98% for those with SVR data 3. In Clean Slate facility without co-located treatment, only 10% entered treatment
Key Lessons Learned	<ol style="list-style-type: none"> 1. Co-location of HCV and OUD services reduces attrition for PWID, as it provides an existing trusted location for services 2. Ensuring that clinical staff have mentor available on-site or through Project ECHO builds organizational capacity to offer treatment independently

implementation

Section Four

Implementation Checklist

The Implementation Checklist (Table 2) and key activities can support OTPs during their shift to integrating services and provide an initial framework for discussions guiding implementation.

Successful implementation may not require completion of every single action step, but completing these action steps, especially preparation and planning steps, will increase the chance of successful implementation within your organization. Taking time to plan, prepare and engage staff in these organizational changes will increase buy-in across the organization and provide opportunities to identify potential barriers.



Table 2: Implementation Checklist

KEY IMPLEMENTATION ACTIVITIES* FOR INTEGRATING HCV SERVICES INTO OTP:

1. Preparing for Organizational Change

- o Identify a clinical liaison or champion.
- o Establish an HCV Implementation Team.
- o Educate Implementation Team, and develop decision-making processes.
- o Assess current policies and procedures.
- o Ensure that there is buy-in from leadership and staff throughout your organization.
- o Develop goals and action steps.
- o Monitor progress.

2. Planning

- o Determine your on-site screening and testing procedures.
- o Determine how treatment will be offered (if off-site, include how this will be coordinated and integrated into care).
- o Outline your plan for counseling and behavioral health services.
- o Determine your approach to PSS and recovery supports.

3. Building Workforce Capacity

- o Engage staff in dialogue related to health disparities, implicit bias, person-first language, harm reduction principles and stigma or resistance around MAT and/or infectious disease treatment delivery.
- o Develop and provide resources for peer-support workforce.
- o Provide staff training, and gain buy-in around HCV, MAT, stigma, integrated services and peer support.
- o Develop an HCV Care Team.
- o Identify any staff recruitment needs for expanded services.
- o Provide ongoing staff supervision and support.

4. Developing Protocols and Procedures

- o Determine how on-site HCV services will be offered.
- o Establish partnerships, and develop agreements with core partners/off-site services.
- o Develop opt-out screening and ongoing testing protocols and procedures.
- o Develop pre- and post-testing education and counseling guidelines.
- o Determine treatment protocols and procedures.
- o Develop protocols and procedures for engaging PSS in HCV services.

5. Ensuring Care, Coordination and Linkage to Services

- o Connect patients to health insurance coverage and treatment discount programs.
- o Coordinate recovery supports and other resources with community providers.
- o Provide education and harm-reduction resources to prevent overdoses and HCV reinfection.

6. Assessing and Evaluating

- o Identify a plan for accountability and assessment.
- o Identify key metrics to monitor progress and evaluate impact.
- o Adapt EHR to implement assessment and evaluation.

7. Planning for Funding and Sustainability

- o Assess existing resources.
- o Determine program needs.
- o Identify funding sources.

**All steps should be culturally informed and reflect the diversity of communities and patients served.*

Step 1: Preparing for Organizational Change

OTPs that dedicate the time and resources needed to effect organizational change will help sustain any shift toward an integrated-care model that includes HCV services. Many OTPs have operated as methadone-maintenance organizations for decades and have been tasked with both shifting toward an OTP that includes all types of MAT and providing integrated patient-centered services beyond the scope of their original mission. This may require significant changes in policies, procedures and workflow, along with overcoming any staff resistance. Building staff and leadership capacity to support, provide and sustain these services is critical.

Identify a clinical liaison or champion, and establish an HCV Implementation Team.

A clinical champion and an HCV Implementation Team that is representative of all stakeholders, including PSS, will support and streamline implementation efforts. An established and informed Implementation Team can effectively communicate and reinforce key messaging around integrating HCV services, increase buy-in from leadership and staff, identify needs around workforce development, policies and procedures, and monitor progress toward HCV-integration goals.

Clinical champions communicate well, engage others, are passionate about integrating HCV services into OTPs, and are educated about co-occurring disorders. Having a clinical background enables this person to engage providers across HCV

and OUD. Key to this role is ensuring that they can commit time and resources to leading this effort and guiding the Implementation Team.

The HCV Implementation Team will coordinate the planning, implementation and evaluation of the HCV-integration effort. This team needs to include diverse staff members, clinical and non-clinical, at multiple levels of the organization. While smaller organizations may have a smaller Implementation Team, it is critical that this team reflects the voices of people with lived experience of OUD and, preferably, includes a peer-support specialist (Table 3).

“
“I [now] have the
luxury of dying
from old age...
That's incredible.”

— Patient cured of HCV in
an OTP setting.



Table 3: HCV Implementation Team Members

Team Member	Roles and Responsibilities
Clinical Champion	Passionate and knowledgeable about HCV and OUD. Communicates across organization and leads Implementation Team. Can commit time and resources to leading effort.
Clinical Lead	Medical provider (MD, NP, PA, NP, RN) who supports integrated HCV services and provides clinical expertise around both OUD and HCV. Will likely lead HCV Care Team.
Behavioral Health Lead	Behavioral health (BH) provider who supports integrated HCV services and provides BH expertise around both OUD and HCV.
Peer Lead	Peer support specialist or volunteer with lived experience. Provides a voice for people with lived experience but is a core team member and not seen as a patient.
Assessment and Evaluation Lead	Provides guidance on process-improvement data, EHR, how to measure progress on the HCV integration and evaluation data collection.
Administrative Lead	Staff member knowledgeable about policies, procedures, finances and other key administrative issues.

Educate Implementation Team, and develop decision-making processes.

In the initial stages, the team may need to commit to educating themselves on recovery-oriented models, patient-centered care models, stigma, social determinants of health (SDH), implicit bias, harm reduction principles, and HCV and HCV integration in OTPs to develop consensus across the team on key terms and concepts. As the team builds consensus and a shared understanding, their communication and messaging becomes more consistent when liaising outside the team and educating other staff members and leadership. As Implementation Team members may be in different positions across the organization, there should also be a commitment to a shared decision-making process and established procedures on ensuring equal voices during team meetings.

Assess current policies and procedures.

The team will collaborate to review existing procedures and policies, staff capacity to provide HCV services, financial resources and organizational culture. This review should help the team identify any barriers to implementation of HCV services, establish a list of recommendations, and outline a plan for HCV service integration.



**Useful Tools:
Organizational Assessment**

The Organizational Assessment Toolkit for Primary and Behavioral Healthcare Integration⁶⁴ has four useful tools to support integrating HCV services. These include building partnerships for HCV, conducting organizational observation and analysis, assessing administrative readiness, and developing continuous quality improvement. These tools can support an implementation team in engaging around discussion of OTP needs, identifying barriers to integrating HCV services, and guiding plan development.

The Hepatitis Education Project (HEP) has created a comprehensive Medical Case Management (MCM) Toolkit, which focuses on helping people with HCV get linked, engaged and retained in care. Organizations can assess their readiness to engage in MCM through an assessment tool based on the Stages of Change model. The Toolkit provides monitoring and service evaluation tools: MCM Toolkit.⁶⁵

Ensure that there is buy-in from leadership and staff throughout organization.

If a barrier to effecting change is lack of buy-in from leadership or across the organization, the Implementation Team should identify and address any key areas of concern. Developing a team statement that addresses these issues and uses data to support HCV service integration as a high-value intervention will support consistent and effective communication. Leadership is consistently cited as playing a key role in effective implementation of HCV services. Leaders who are kept up to date on evidence-based resources around HCV services are more likely to integrate HCV prevention, screening and treatment.⁶⁶

Develop goals and action steps.

Assuming there is buy-in and support from leadership and staff, the team can develop goals using either the SMART (**S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**imely)⁶⁷ method. Key to any goal setting is that the goal is clearly understood and can be stated by the whole team, with actionable items that the team feel are achievable in the given time frame and relevant to their vision of integrating HCV services. Once the team has established goals, they should review together and assess the cohesion of this set of goals, ensuring they are setting themselves and the organization up for success.

Monitor progress.


Implementation of HCV services can be time consuming and impacted by multiple factors within and outside of the OTP. The HCV Implementation Team needs to build in time during meetings to assess and monitor progress toward goals. Documenting the implementation process and lessons learned will support the ongoing process and enable the team to reflect on what changes need to be made, what support or further resources may be needed, and enable the team to communicate any changes that need to be made to goals and timelines. The Implementation Team will also need to decide, at the outset, the type of evaluation data that will need to be collected and how to collect it.

Useful Tools: The NIATx model

The NIATx Model (niatx.net),⁶⁸ from the University of Wisconsin-Madison, shares easy-to-use tools to support teams making process improvements to impact patient outcomes.

Step 2: Planning

The initial organizational assessments conducted by the Implementation Team should provide clear guidance on what level of HCV integration is appropriate for the OTP and how they might scale this up over time. This will depend largely on the size of the OTP, leadership support, staff capacity and capability, current engagement of PSS, patient population, available community resources, and resources available within the OTP to support this organizational change.



The assessment process should also direct the Implementation Team to any organizational development needed to support a cultural shift, ensuring that time is built in to address stigma and other supports needed to promote inclusive, equitable, patient-centered, trauma-responsive integrated care.

The Implementation Team should assess where the organization currently is regarding: providing HCV services; how expanded HCV services could be integrated into existing policies and procedures; what staffing needs exist for offering expanded HCV services and support; and what community resources are available to support any gaps, such as recovery-support services and harm reduction. For OTPs that have existing formalized agreements and coordinate with healthcare partners, the shift may be to better merge systems to provide integrated care. Other OTPs may need to conduct an inventory of community and online resources to establish partnerships with healthcare organizations

who understand addiction medicine and MAT. All OTPs should be able to work toward the minimal requirements outlined in Section Three of this guide and should include recommendations for the following:

- o On-site HCV education for all patients
- o Harm-reduction services, such as syringe exchange and naloxone
- o On-site screening and initial (HCV antibody) testing procedures for all patients
- o Follow-up/referral process for HCV RNA and other recommended tests
- o Pre- and post-test counseling, behavioral health and support groups
- o Engaging PSS and recovery-support services
- o Engaging patients in treatment (if off-site, how this will be coordinated and integrated into care)

A matrix for planning how and where OTPs will offer HCV services is listed in Table 4. This will be impacted by what HCV services the organization is currently offering and what resources the OTP is prepared to commit to this change. As outlined in Section Three, there is variation in how OTPs offer these services, but there should be a plan for coordination or integration of each service.

Table 4: Using a matrix to plan for HCV Services

HCV AND RELATED SERVICE	ON-SITE	ESTABLISHED PARTNER	NEW PARTNER	TELEHEALTH
EDUCATION				
HARM REDUCTION				
PRE-TEST COUNSELING				
SCREENING				
TESTING: HCV ANTIBODY				
TESTING: HCV RNA				
POST-TEST COUNSELING/ SUPPORT GROUPS				
PEER SUPPORT AND PATIENT NAVIGATION SERVICES				
TREATMENT				
CARE COORDINATION AND/OR MEDICAL CASE MANAGEMENT				

Step 3: Building Workforce Capacity

Building staff and leadership capacity to support, provide and sustain HCV services is critical. This process requires dedicated time and resources to effect the organizational changes necessary to successfully integrate expanded HCV services. Staff training and education around HCV is essential, and significant changes in policies, procedures and workflow may be required. Addressing and overcoming any staff resistance to these changes is a key part of this process, and leveraging opportunities to integrate HCV activities into current workflow will promote buy-in. Expanded HCV services may require a multidisciplinary HCV Care Team, which may consist of members from the initial Implementation Team but will require a senior clinical lead. Staff with expertise in HCV and OUD may need to be recruited and onboarded.

Engage staff in dialogue related to health disparities, implicit bias, people-first language, harm reduction principles, and stigma or resistance around MAT and/or infectious disease treatment delivery.

OTPs should provide space to engage staff in dialogue related to stigma, implicit bias, risk mitigation approaches, and/or resistance around either MAT or infectious disease treatment delivery. Providing time for in-person training, storytelling by PSS and/or engaging staff in dialogue related to their beliefs can help staff better understand the impact of their beliefs on care and patient outcomes.

Organizations can support this through simple organizational changes such as visuals of stigmatizing vs. non-stigmatizing

language (Figures 4 and 5). OTPs can also conduct a language audit starting with English and then adding other common languages spoken in the communities served: review internal (e.g., mission statements, policies) and external (e.g., patient forms, brochures) materials for stigmatizing language.

“
*The practice of
medicine can often
be isolating, and to
have this collaborative
relationship with
another physician,
providing care for
another health issue,
helps you learn things
from another physician.*

— OTP physician

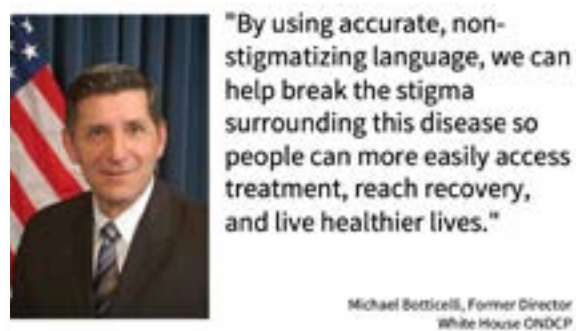
”

Use a “find and replace” feature to update stigmatizing language to person-first and less-stigmatizing language. The ADDICTIONary⁶⁹ is a useful source for identifying stigmatizing language as it contains “stigma alerts” to raise awareness of how language plays a role in perpetuating stigma. In addition to language, visual representations in documents need to include actors and images of people who look like the intended audience.⁴²

Figure 4: Example of simple graphic/visual that can be used to reinforce non-stigmatizing language (Opioid Response Network)

Don't Say	Do Say
Substance abuse	Substance use or misuse
Former addict	Person in recovery
Alcoholics & Addicts	People with alcohol or other drug problems
Clean or dirty urine drug screen	Positive or negative screen
Lapse or relapse	Return to use or recurrence
Replacement therapy/replacing one drug for another	Medication-assisted recovery; medications to treat addiction

Figure 5: Statement on stigma from Michael Botticelli, the former Director of the White House Office of National Drug Control Policy (ONDCP) and a person in long-term recovery.



Develop and provide resources for peer-support workforce.

As noted on page 24, peer recovery-support specialists (peer support specialists; PSS) are a critical part of OUD and HCV treatment. PSS advocate for those in recovery, support navigation across healthcare systems, increase treatment knowledge, engagement and retention, and improve treatment and service delivery. Key to successful service integration is to provide organizational resources for peer support so PSS are an equal member of the team and can plan and implement peer models. When OTP HCV teams include PSS equally, support PSS financially, and value them as part of an integrated-care approach, OTPs often report transformation at the organization, and patients report increased satisfaction with services.⁷⁰

Provide staff training and gain buy-in around HCV, MAT, stigma, integrated services and peer support.

All staff will need basic training around HCV and any new policies and procedures. Further training needs will be dependent on staff knowledge and resistance, direct patient engagement, and what services are being offered on-site. The “Resources” section includes training resources for OTPs.

OTPs should develop and display key messaging for all staff and patients that reinforces the prevention-and-care continuum and addresses any myths and misconceptions around HCV. At a minimum, all staff should be trained in the basics of HCV and OUD, HCV prevention and harm reduction, screening and testing for HCV, and the use of DAA to treat HCV. Other training needs will depend on the HCV Care Team.

Embedding HCV training into existing staff training activities, including new employee orientation and annual training events, will encourage consistent messaging on HCV testing and treatment, as well as continuation of institutional knowledge despite potential staff turnover.

Develop an HCV Care Team.

The HCV Care Team will eventually replace the Implementation Team. Some team members will overlap. HCV Care Teams will differ based on whether services are being offered on-site or off-site and the size of the OTP and patient population. The

HCV Care Team should include a point of contact from OTP leadership and consist of multidisciplinary staff such as clinicians and nursing staff, case managers, behavioral health providers, PSS, pharmacists, and recovery-support specialists. Engaging PSS who frequently interact with patients as equal members of the team is critical and signals a shift in the OTP approach to working with people in recovery.⁵¹

Building on the work of the HCV Implementation Team, the HCV Care Team can continue to assess the OTP environment, identify ongoing OTP needs as to infrastructure and staff capacity, identify a clinical champion and establish a coordinated team for HCV service delivery, outline patient-education needs, determine a screening strategy and treatment protocols, identify monitoring and process-improvement metrics, and ensure medication access and insurance coverage. Process-improvement metrics can support an organizational focus on learning and regular quality improvement for all staff.

See the “Resources” section for examples related to building HCV Care Teams.

Identify any staff recruitment needs for expanded services.

OTPs should build in time and resources for staff recruitment, especially if newly engaging with the peer workforce or bringing in medical specialists for HCV. Any infectious disease/medical providers that are not addiction medicine specialists should be provided with the tools and resources needed to ensure they provide culturally responsive care for HCV, OUD and other services.



Provide ongoing staff supervision and support.

After the initial training process, OTPs will need to provide ongoing support and supervision to reinforce key changes in the organization and build staff capacity. Telehealth models such as Project ECHO (shown in the example of Clean Slate Addiction Treatment Centers on page 39) can provide mentorship and support ongoing learning, building the OTP's capacity to offer treatment independently.⁶¹ The Implementation Team should liaise with staff and invite them to identify gaps in procedures, voice valid concerns, and highlight training or program needs.

Step 4: Developing Protocols and Procedures

As OTPs determine which HCV services are offered on-site, they will need to establish policies, protocols, and procedures for *how* and *where* this will happen. HCV education, screening and initial testing may be able to be integrated into routine appointments, but expanded services such as follow-up labs and lab services, counseling and support groups, HCV-specific treatment, and dispensing medications will require logistical coordination. EHR will need to be adapted to support these expanded services. If OTPs are expanding the role of PSS, they will also have to develop protocols and policies for engaging PSS as part of the HCV team.

Establish partnerships and develop agreements with core partners/off-site services.

Many OTPs will be establishing partnerships and formalizing agreements to support HCV services. If OTPs are collaborating with off-

site providers, care should be coordinated with medical organizations that are educated on SUDs and SUD treatment and will not stigmatize or traumatize patients from OTPs. Telehealth models have been used effectively in rural areas and in tribal communities to connect HCV patients with behavioral health and other medical services unavailable in their areas.⁵⁵

A key part of effective partnering is maintaining patient confidentiality while finding ways to effectively communicate and share information across providers to support improved patient outcomes.

OTPs can formalize partnerships through MOA/MOU or through establishing Organized Healthcare Arrangements to become an Organized Healthcare Delivery System. The SAMHSA-sponsored Center of Excellence for Integrated Health Solutions⁷¹ and the Center of Excellence for Protected Health Information⁷² can provide technical assistance and support OTPs with navigating the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2.

Develop opt-out screening and ongoing testing protocols and procedures.

SAMHSA recommends offering opt-out routine, integrated screening, and rapid testing with ongoing follow-up for all OTP patients.⁵² Many screening and testing procedures can be integrated into existing protocols for OUD services during intake or routine appointments at the OTP. Identifying and leveraging how HCV services can be integrated into current workflow will minimize burden on staff and patients, and

support patient engagement, making them less likely to opt out due to time burdens.

Develop pre- and post-testing education and counseling guidelines.

Pre-testing education may be integrated into screening and can reinforce messaging and strategies around prevention, testing, treatment and recovery. This can reduce concerns should the patient receive a positive HCV result and help navigate next steps as far as confirmatory follow-up testing and treatment.

PSS, behavioral health workers, case managers, nurses, and other clinical and non-clinical staff can all support education through consistent messaging. OTPs can create key messaging to guide people through HCV diagnosis. The Hepatitis C Harm Reduction Project⁷³ outlines key messaging for counseling, along with risk-reduction strategies. All HCV visuals, materials, and social media messaging should be consistent across the OTP. Staff should be trained in naloxone and have naloxone available on-site.⁷⁴ If SSPs, harm-reduction programs and recovery supports are not co-located, the OTP should maintain an updated list of community resources and key contacts to support patients.



Determine treatment protocols and procedures.

HCV Treatment Guidelines are kept updated by the AASLD.¹⁰ Telehealth models can support retention in HCV treatment by engaging the patient in the safe space of the OTP. As the PCORI example (page 38) showed, telehealth models have effectively supported OTPs without HCV medical providers on-site by providing virtual HCV treatment on-site using a physician assistant.⁵⁸ See “Resources” section for links to more information about treatment protocols and telehealth.

Develop protocols and procedures for engaging PSS in HCV services.

Establishing protocols to ensure OTP staff and HCV teams include PSS equally, support PSS financially, and value them as part of an integrated-care approach is critical to using PSS effectively.

When PSS are valued and provided appropriate training, resources and supervision, they are instrumental in improving patient outcomes.

As the example from OASIS (page 37) showed, support groups co-facilitated by PSS can increase engagement and retention in treatment. For those patients with active HCV, support groups that are led by PSS trained in both OUD and HCV can create a safe space and reduce the risk of disease progression by providing counseling and education around the risk of alcohol and lifestyle supports needed to improve patient outcomes. PSS can also help dispel

any myths and misinformation around HCV and reduce HCV stigma, guiding their peers to care through connections and trust.⁵⁰ See the “Resources” section for additional information related to successfully engaging PSS in OUD and HCV treatment.

Step 5: Ensuring Care, Coordination and Linkage to Services

Connect patients to health insurance coverage and treatment discount programs.

Costs and coverage for HCV treatment can vary substantially between pharmacy and insurance plans and are often based on an individual’s medical history. For patients who are uninsured or underinsured, medications may be available to OTPs at a significant discount through the 340B program.⁷⁵ However, for many people living with HCV, costs of successful treatment options may continue to be prohibitive and a barrier to care. OTP staff can support patients by identifying options for medication and treatment, such as patient-assistance programs (PAPs) and co-pay programs.⁷⁶ Table 5 outlines some resources OTPs can connect with to coordinate treatment supports.



Table 5: Treatment Supports

Resource	Description
340B program	As part of an emergency response plan to meet treatment needs, HRSA provides eligible healthcare organizations (340B Eligibility ⁷⁷) discounted prices on prescription medications from drug manufacturers. This includes medications for OUD as well as for HCV. 340B Drug Pricing Program ⁷⁵
Patient-assistance programs (PAPs)	PAPs offer free prescription HCV-treatment medication for patients who meet the income-eligibility criteria and are not enrolled in a publicly funded prescription program such as Medicare or Medicaid.
Co-Pay	Fair Pricing Coalition (FPC) has negotiated co-pay programs with virtually every major hepatitis-drug manufacturer. Paying for HCV Treatment ⁷⁶
Help-4-Hep	Help-4-Hep ⁷⁸ is a nonprofit, peer-to-peer helpline where counselors work with patients to meet the challenges of HCV. Help-4-Hep provides information and resources about finding financial help to pay for low-cost testing and finding a free or low-cost clinic, and about financial help with payment for treatments. 877-HELP4HEP (877-435-7443)
Partnership for Prescription Assistance	The Partnership for Prescription Assistance ⁷⁹ helps qualifying patients without prescription-drug coverage get the medicines they need by matching them with the right assistance programs. 888-477-2669

Coordinate recovery supports and other resources with community providers.

Barriers to retention in care for patients with OUD and HCV are often related to the social determinants of health, such as inadequate or lack of housing, transportation, employment and access to the wraparound services needed to meet their needs. Case managers or care coordinators should include these referrals as part of the comprehensive care plan. PSS can help coordinate recovery supports with other OTP staff to address patients' ongoing resource needs. PSS can also transport patients and facilitate linkage to care by coordinating appointments and services, and by identifying community supports in partnership with the patient. At minimum, OTPs can maintain an updated list of community resources and key contacts to support patients.



Provide education and harm-reduction resources to prevent overdoses and HCV reinfection.

Regardless of level of integration of HCV services, OTPs should offer ongoing HCV staff trainings and patient workshops, ensuring that HCV visuals, materials and social media messaging are consistent,

use person-first language, and avoid stigmatizing language and images. Staff, patients and family members should be trained in harm-reduction strategies and naloxone, and the OTP should keep naloxone available on-site. Ideally, SSPs would be co-located to create easy access for people to move toward treatment and recovery. SSPs promote a point of entry into treatment, and PWID who use SSPs are five times more likely to enter OUD treatment.⁴ At minimum, staff should retain an updated list of harm-reduction resources and establish strong working relationships with SSPs and other community providers.

Step 6: Assessing and Evaluating

Assessment and evaluation will enable programs to track key data related to process improvements, HCV service implementation, and impact on patient-health indicators. Identifying data points that will support program improvements as well as provide outcome and impact data will support use of data for organizational learning. Assessment data is related to process indicators and enables OTPs to see where time and resources are being used, clinic flow and where workflow bottlenecks may occur, progress toward implementation, and other quality improvements that will support program development and overall goals. Evaluation focuses on impact and outcome to demonstrate that the OTP is achieving program goals and engaging people in OUD and HCV care. Explaining clearly to staff how data will be collected and used to improve programs and patient outcomes will improve data accuracy. Data that is accurate, relevant, reliable, timely and complete will help inform process and program improvements. Sharing key data in meetings, letting the data tell the story of your program, and using data to inform

strategic improvement will help staff see the usefulness of capturing information and support the data-collection process.

Useful Tools: Logic Models

Having a clear vision and visual of your program that outlines key outcomes and how you will get to those outcomes can support the process of assessment and evaluation. The Kellogg Foundation shares free tools around building logic models⁸⁰ and capturing key program inputs and data points.

Identify a plan for accountability and assessment.

As the Implementation Team develops a plan for integrating HCV services, they will also outline how to monitor progress toward this plan and what data will speak to successful outcomes for the program and patients. Assessment and quality-improvement data should focus on capturing process indicators and information that will help clarify what is working, what is not working, what the barriers to success are, and what facilitates success.

Identify key metrics to monitor progress and evaluate impact.

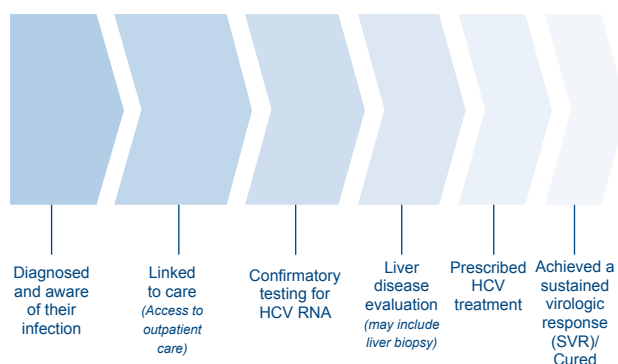
Whether using the NIATx model⁶⁸ or other quality improvement tools (see “Resources” section), metrics that have value to program staff and reflect improvements for patients should be prioritized. Data-sharing agreements and/or data-use agreements will need to be in place for OTP programs referring out for HCV services.

While quantitative data is needed, it will be important for the Implementation and HCV Care Team to build in opportunities to interview staff and patients impacted by any changes to support and inform quantitative data.

Evaluation data is critical to demonstrate impact, and OTPs need to establish a tracking system that, at a minimum, provides data to support improved patient outcomes and the increased costs for prevention, education, screening and testing, and treatment activities. The HCV cascade of care has been proposed as a way to organize specific actions and assess how a linkage model moves patients through a sequence from prevention to testing to treatment to cure.¹ OTPs adopting the linkage model can use a cascade-of-care approach to engage partners and evaluate successful handoffs or linkage breakdowns within the chain. OTPs can outline a patient’s course through the steps of their system to address gaps, breakdowns and lack of communication and coordination in referrals and appointment follow-ups. The steps that those who are infected with HCV take is depicted in Figure 6.

Figure 6: HCV Care Cascade³²

The steps that those who are infected with HCV take:





Data elements to support impact on HCV cascade.

HCV-services data will need to include demographics (already captured in OUD data system), time stamps for activities, and key quantitative (and preferably qualitative) elements that support the HCV care cascade, including:

- o in OUD treatment
- o screened (and time frame)
- o engaged in pre-counseling (if separate from screening)
- o opted out from screening (plus any reasons for opting out, if not overly burdensome)
- o receiving HCV antibody testing (and type of testing)
- o opted out from testing (plus any reasons for opting out, if not overly burdensome)
- o tested positive for HCV antibody (reactive)
- o tested negative for HCV antibody (nonreactive)
- o who received HCV RNA confirmatory and genotype testing (and time frame)
- o HCV RNA not detected
- o HCV RNA detected
- o engaged in treatment (where and what type of treatment)
- o not engaged (plus any reasons)
- o completed treatment
- o achieved sustained virologic response (optimal if not overly burdensome)
- o engaged in counseling
- o engaged in co-occurring testing or treatment (for HIV or other related health issues)

Qualitative metrics should capture key data related to patient satisfaction, staff

satisfaction and information on how this has impacted clinic flow and patient engagement and retention in OUD treatment.

Adapt EHR to implement assessment and evaluation.

Effective assessment and evaluation is supported by automated data collection and performance-measurement tools. A clinical-decision support system embedded into an EHR can summarize important data, provide reminders to staff, and support care coordination across systems (if data-sharing agreements are in place). Adding in to existing online data-collection tools is easier than creating a new system. An EHR can prompt staff to collect data on key points and reduce the burden of data collection. Patient forms, charts, and the EHR will likely need to be adapted to capture the required elements for patient records and financial and other types of required reporting. OTPs should also consider their capacity to extract data from the EHR. It may be necessary to consider the costs of technology consultants or other software to pull and analyze data.



It is key to train necessary staff on these additions to ensure quality data capture. The “Resources” section contains useful tools related to Health Information Technology.

Step 7: Planning for Funding and Sustainability

Financing and sustaining HCV services and additional staffing costs are often reported as barriers to implementation in OTPs. A 2020 report highlighted federal, state and local policies that may impact OTP service delivery related to HCV due

to prior-authorization policies, lack of data integration and sharing, financing and reimbursement limitations, and same-day billing restrictions for OUD and HCV treatment.⁴⁹ Although it is a long-term strategy, OTPs are encouraged to work with states and health departments to advocate for policy changes to effectively implement and sustain HCV services. There are additional strategies for funding and sustaining OUD and HCV integrated treatment.

Assess existing resources.

OTPs looking to implement HCV services will need to identify available funding sources based on their program needs and approaches, as well as their existing funding sources. Funding for HCV treatment and Medicaid coverage differs across states. OTPs need to identify available resources, insurance coverage, prescription discount programs, and whether any existing funding streams can absorb the costs of HCV testing, treatment or provider time.

Determine program needs.

OTPs looking to offer enhanced or integrated HCV services should review the economic costs and health benefits of offering HCV services to outline the value of integrated HCV services to funders and any leadership or board members. OTPs can use the state-level models and calculators to outline the benefits of offering HCV services in OTPs. The National Nurse-Led Care Consortium (NNCC) HCV cost calculator⁸¹ uses a numerical value-based model of health center staff training, screening and treatment regimen to output comparisons in cost, revenue, and cost-benefit return on investment (ROI). This can demonstrate the cost-effectiveness of



adding services to an existing organizational structure or partnering with other agencies. It can also support the argument for providing integrated-care coordination, screening and testing, behavioral health and peer coordination, and on-site HCV treatment.

Identify funding sources

OTPs may be able to apply for grant funding through federal agencies, foundations and rural agencies, state or local health departments, or through their state's block-grant funds. The following section discusses financing and sustaining HCV services in detail.

“

[Providing HCV services on-site] started as a little bitty idea and has blossomed into something huge.

— OTP Management Staff

”

financing and sustaining **HCV services**

Section Five

Financing and sustaining HCV services and additional staffing costs are often reported as barriers to implementation in OTPs. A 2020 report highlighted federal, state and local policies that may impact OTP service delivery related to HCV due to prior-authorization policies, lack of data integration and sharing, financing and reimbursement limitations, and same-day billing restrictions for OUD and HCV treatment.⁴⁹ This section provides an overview of state and healthcare-system challenges and strategies for billing and reimbursement, funding medications, using grant funding, commercial-insurance reimbursement, Medicaid/Medicare, and medication-assistance plans. It provides guidance on establishing relationships with third-party payers and establishing business-office protocols to maximize payment. OTPs are encouraged to work with states to advocate for policy changes needed to effectively implement and sustain HCV services. The section will provide examples of ways OTP can finance and sustain HCV services. The next section will outline how to assess and identify funding needs.

Key Challenges

While the economic challenge of funding is of concern for many OTPs looking to implement HCV treatment, there are increasing studies demonstrating

the population benefits and the cost-effectiveness of increasing access to HCV treatment and care for PWID.⁸²⁻⁸⁵ Identifying cost-effective screening and treatment approaches is key to financing and sustaining HCV services and providing medications.⁸⁵ Costs and coverage for HCV treatment can vary substantially between pharmacy and insurance plans and are often based on an individual's medical history. For individuals who are uninsured or underinsured, medications may be available to OTPs at a significant discount through the 340B program.⁷⁵ However, for many people living with HCV, costs of successful treatment options may continue to be prohibitive and a barrier to care. With the emergence of new, cheaper drugs, increasing competition, and new payer options, affordable HCV treatment for patients in OTPs is promising.

Successful treatment of chronic HCV infection shows key economic benefits, including the reduced use of healthcare resources and associated medical costs within the first five years following treatment.⁸⁵

However, healthcare systems and states continue to struggle with the high resource use of these new therapies and must find

ways to work with the pharmaceutical industry, healthcare payers and other stakeholders for new drug-pricing schemes and payment options to treat those infected with HCV. OTPs looking to implement HCV services need to be aware of financing challenges within states and any state regulations and cost concerns related to specific medications.



Financing Challenges for States

Despite the long-term and well-documented advantages to population health, the costs for HCV screening and treatment remain unaffordable and unsustainable for many healthcare systems and states. While the emergence of DAA treatments for chronic HCV infection has changed the landscape of treatment, private health insurance plans and Medicaid programs continue to struggle to find ways to absorb the high cost of DAA therapies.

Private Health Insurance

Private health insurance companies play a major role in the treatment of patients with HCV infection. Health plans ensure pharmacological treatment and care management, and collaborate with government agencies and stakeholders to

diversify their coverage and reimbursement rates for HCV treatment. However, several financing challenges for states remain. Private insurance companies often have separate pharmacy and medical budgets and use pharmacy-benefit managers (PBMs) to negotiate drug pricing and determine formulary placement. This can directly impact the choice of regimens and out-of-pocket expenses for states and patients. For example, some private health insurers restrict access to medications and establish selective criteria for reimbursement to offset the high costs of new DAA regimens.⁸⁶ Also, a single insurance company can cover private health insurance and managed-care Medicaid and Medicare plans, and have different formularies for each line of business, further adding to business infrastructure and workforce challenges for states and healthcare systems that are forced to manage multiple contractual requirements that are often duplicative across funding streams.⁸⁷

Challenges for patients include varying levels of insurance coverage for HCV treatments, depending on a person's insurance policy and overall health.

Some insurance plans will pay for people whose HCV has not responded to less-expensive treatments or for those who are already showing signs of liver damage. Other insurance companies may require a person to prove they have received SUD treatment before authorizing treatment for HCV. Some studies have observed that HCV treatments for commercially insured patients are denied more often than for patients enrolled in Medicaid or Medicare.⁸⁸



Programs such as the Health Resources and Services Administration's (HRSA) 340B medication-discount program⁷⁵ can help eligible OTPs reduce medication costs and support better outcomes for patients. For reimbursement for patient services, there remain significant variations in the Medicaid-reimbursement scheme for DAAs, with health insurance plans in Medicaid Expansion states receiving a higher rate of reimbursement for DAAs.

Government Programs

As with private health insurance companies, Medicaid coverage for HCV treatment varies significantly by state. Traditional fee-for-service (FFS) Medicaid requires a 23% discount for brand-name drugs and allows states to negotiate even greater cost-saving strategies. At the same time, traditional Medicaid affords states the ability to impose more stringent restrictions on access to HCV treatment. For example, some states may require prior authorization, use of preferred drug lists, and coverage of only the sickest patients. A 2017 study of Medicaid-reimbursement criteria for available DAAs across the country found that liver damage (fibrosis) restrictions was the number one barrier to accessing DAAs in state Medicaid programs.⁸⁸

Patients in SUD treatment are often excluded from HCV treatment or given lowest priority. Despite studies demonstrating people in OUD treatment and PWID can successfully complete HCV treatment, some states require patients to be retained in SUD treatment for a designated period before providing HCV treatment. These restrictions have resulted in several lawsuits across the country, and states are increasingly offering greater transparency on their treatment criteria and

have eliminated many of the restrictions that limit treatment.⁸⁸ In fact, some states have lifted all restrictions in Medicaid for HCV treatment, and more states are planning to do so.⁸⁹

Provider restrictions have also posed a challenge to states. With Medicaid FFS programs, some states require HCV treatment to be provided by a specialist only, such as hepatologists, while other states require HCV treatment to be done in consultation with a specialist. This restriction can be especially challenging for medically marginalized communities, such as rural counties, where sub-specialty care is not easily accessible.

State Efforts to Decrease Cost for HCV Medications

Some states, like California, have found innovative ways to offer rebates and set-asides to cover HCV medications for its Medicaid patients. California has also lifted restrictions for HCV medications and committed to treating everyone with HCV in its state prisons.⁹⁰ Other states, like Missouri, have partnered with neighboring states to start purchasing consortiums that negotiate discount pricing with pharmaceutical companies in return for exclusive or preferred status of their drug.⁹¹

The “Netflix Model” for HCV Treatment

Louisiana and Washington are adopting a “Netflix Model” for HCV treatment.⁹² Both states pay a flat rate to pharmaceutical companies to provide enough medication to treat Medicaid patients and people in correctional settings each year. Washington will later expand this to state employees, retirees and teachers.

Patient Resources

Variations in health insurance coverage leave many patients uninsured or underinsured. Prescription costs, co-pays and high deductibles can be prohibitive to patients seeking treatment for HCV. In response, many pharmaceutical companies and other organizations have worked with the Fair Pricing Coalition to create patient assistance programs (PAPs) and co-pay programs. PAPs offer free prescription HCV-treatment medication for patients who meet the income-eligibility criteria and are not enrolled in a publicly funded prescription program such as Medicare and Medicaid. For patients who are enrolled in a government-funded prescription plan, advocacy programs may be able to assist patients with identifying affordable HCV medication and treatment as well as with navigating other issues related to access to care. Additionally, many pharmaceutical companies can assist with referring patients directly to patient advocacy organizations that can help cover the costs of HCV medications.⁷⁷

Opportunities and Resources for OTPs

While there are clearly environmental challenges to funding and sustaining HCV services in OTPs, there are also extensive resources available to OTPs looking to integrate HCV screening, testing and treatment.

Depending on their approach, OTPs may be able to apply for grant funding through federal agencies, foundations or rural agencies, or through their state’s block

grant funds. Local health departments and other regional organizations may also offer smaller grant opportunities. Routine screening and testing for HCV and HCV treatment are high-value interventions, and OTPs can make valid cost-benefit arguments for expanding and integrating services.⁸¹ Medication costs are prohibitive for some patients, but HCV medications are available at a discount to eligible OTPs through HRSA's 340B program. Other state funding or approaches may offset the costs of HCV medications, and pharmaceutical companies may offer PAPs or co-pay programs to support enhanced patient care.



Grant Funding for OTPs

OTPs looking to implement HCV services will need to identify available funding sources based on their program needs and approaches, as well as existing funding sources.

Federal agencies such as SAMHSA, CDC, NIDA and HRSA, under the Department of Health and Human Services (DHHS), and the Department of Justice are all offering grant funding to address the opioid epidemic and/or the intersection of OUD with HCV.⁹⁴ Foundations such as Aetna Foundation⁹⁵ have state-specific resources

as well as national resources to impact HCV and the opioid epidemic. For rural areas, Rural Health Information Hub has a number of resources to support rural implementation of OUD and HCV services.⁹⁶ CDC has an initiative specific to addressing the infectious disease consequences of the opioid epidemic.⁹⁷ State Targeted Response (STR) and State Opioid Response (SOR) funding supports OTPs looking to expand MAT and integrate HCV services.⁹⁸ The table below includes links to more information regarding funding opportunities.

Funder	Website
Consolidated list of resources, including state-specific funders	https://my.astho.org/opioids/resources/funding-entities
CDC-specific funding related to PWID and infectious diseases	https://www.cdc.gov/pwid/ido.html
Aetna Foundation	https://www.aetna-foundation.org
Rural Health Information Hub	https://www.ruralhealthinfo.org/topics/opioids/funding

Cost/Benefit Analysis

OTPs looking to offer enhanced or integrated HCV services should review the economic costs and health benefits of offering HCV services in order to outline the value of integrated HCV services to funders and any leadership or board members. Increasingly, programs are asked to justify the value of new programming, and OTPs can use the state-level models and



calculators to outline the benefits of offering HCV services in OTPs. The National Nurse-Led Care Consortium (NNCC) HCV cost calculator⁸¹ uses a numerical-value-based model of health-center staff training, screening and treatment regimen to output comparisons in cost, revenue and cost-benefit return on investment (ROI). This can demonstrate the cost-effectiveness of adding services to an existing organizational structure or partnering with other agencies, and it can support the argument for your OTP providing integrated-care coordination, screening and testing, behavioral-health and peer coordination, and on-site HCV treatment.

Useful Tools: Financing and Sustaining Integrated OUD and HCV Services

Cost-Benefit Analysis to Support Integrated Care

The National Nurse-Led Care Consortium (NNCC) conducted a four-part webinar series related to HCV programming, which included a training⁹⁹ related to conducting an economic cost-benefit analysis to outline the value of integrated-service models and sharing an online calculator. This model and calculator can be used by OTPs to assess and outline enhanced- and integrated-care models and provides data that can be used in grants and/or for approaching leadership and other funders. See “Resources” section for a list of sites offering patients assistance with obtaining HCV medications.

glossary and list of acronyms

Section Six

LIST OF ACRONYMS USED

ACRONYM	MEANING
AASLD	American Association for the Study of Liver Diseases
ATTC	Addiction Technology Transfer Center
ATTC NCO	Addiction Technology Transfer Center Network Coordinating Office
BH	Behavioral health
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CIHS	Center for Integrated Health Solutions
CMS	Centers for Medicare & Medicaid Services
CSAT	Center for Substance Abuse Treatment
DAA	Direct-acting antiviral
DEA	Drug Enforcement Agency
DHHS	Department of Health and Human Services
EBP	Evidence-based practice
ECHO	Extension for Community Healthcare Outcomes
EHR	Electronic health records
FDA	Food and Drug Administration
FFS	Fee-for-service
FMS	Foundations Medical Services
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HEP	Hepatitis Education Project
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human immunodeficiency virus
HRSA	Health Resources and Services Administration
IDU	Injection drug use
IMPACT	Improve, Measurable, Positively stated, Call forth action, Timely
IOM	Institute of Medicine

IRETA	Institute for Research, Education, and Training in Addictions
MAT	Medications for addiction treatment
MCM	Medical case management
MCO	Managed Care Organization
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
NIATx	Network for Improvement of Addiction Treatment
NIDA	National Institute for Drug Abuse
NNCC	National Nurse-Led Care Consortium
ONDCP	Office of National Drug Control Policy
OTP	Opioid treatment provider
ODU	Opioid use disorder
PAP	Patient assistance program
PBM	Pharmacy benefit manager
PSS	Peer support specialist (peer recovery-support specialist)
PWID	People who inject drugs
PWUD	People who use drugs
RNA	Ribonucleic acid
ROI	Return on investment
RVR	Rapid virologic response
SAMHSA	Substance Abuse and Mental Health Services Administration
SDH	Social determinants of health
SMART	Specific, Measurable, Achievable, Relevant, Timely
SOR	State Opioid Response
SSP (SEP)	Syringe service program (syringe exchange program)
STR	State Targeted Response
SUD	Substance use disorder
SVR	Sustained virologic response
TIP	Treatment Improvement Protocol (SAMHSA)
USPTF	US Services Preventative Task Force
VA	Veterans Affairs

GLOSSARY OF TERMS

The terms below include some key concepts and linked resources. Three further glossaries we recommend that comprehensively cover terms related to healthcare, HCV and recovery are:

The Addictionary (<https://www.recoveryanswers.org/addiction-ary/>) created by Facing Addiction and the Recovery Research Institute, is a comprehensive glossary of key terms for addiction and recovery.

The World Health Organization Glossary (<https://www.ncbi.nlm.nih.gov/books/NBK442279/>) for Hepatitis terms.

The Healthcare.Gov (<https://www.healthcare.gov/glossary/>) Glossary

TERM	DEFINITION
Co-occurring disorders	Alternatively referred to as dual diagnoses, is when an individual has a substance use disorder and a mental health disorder. This also means a disorder of each type is diagnosed independently of the other and each is not primarily a cluster of symptoms resulting from one disorder type. Persons with both disorders commonly present in addiction treatment settings. Numerous population surveys have found that about half of individuals with SUDS experience a mental illness during their lifetimes. In 2003, the Dual Diagnosis Capability in Addiction Treatment Index was developed to measure addiction treatment program services. Programs could be categorized as either Addiction Only Services (AOS), which do not accommodate individuals with mental disorders, dual diagnosis capable, meaning that the program could accommodate people with stable mental disorders, or dual diagnosis enhanced, meaning the SUD program can accommodate individuals with acute or unstable mental disorders.
Direct-acting antiviral	Direct-acting antivirals (DAAs) are a relatively new class of medication that acts to target specific steps in the HCV viral life cycle. The goals of DAAs are to shorten the length of therapy, minimize side effects, target the virus itself, and improve sustained virologic response (SVR) rate.

<u>Evidence-based practice</u>	<p>Evidence-based practice (EBP) is the conscientious use of current best evidence in making decisions about patient care (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). It is a problem solving approach to clinical practice and administrative issues that integrates:</p> <p>A systematic search for and critical appraisal of the most relevant evidence to answer a burning clinical question</p> <p>One's own clinical expertise</p> <p>Patient preferences and values (Melnik & Fineout-Overholt, 2014)</p> <p>The EBP process is a method that allows the practitioner to assess research, clinical guidelines, and other information resources based on high-quality findings and apply the results to practice.</p>
<u>Extrahepatic impact</u>	Impact of HCV on brain and mood changes, as well as exacerbating existing diseases, such as diabetes, kidney disease and arthritis.
<u>Fee-for-service</u>	A method in which doctors and other healthcare providers are paid for each service performed. Examples of services include tests and office visits.
<u>Harm reduction</u>	<p>Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.</p>
<u>Hepatitis C antibody test</u>	Initial test used to identify presence of HCV; a positive result does not mean active HCV infection
<u>Memorandum of Agreement</u>	A Memorandum of Agreement (MOA), also known as a Memorandum of Understanding (MOU), is a formal business document used to outline an agreement between separate entities, groups or individuals.
<u>Memorandum of Understanding</u>	A Memorandum of Understanding (MOU), also known as a Memorandum of Agreement (MOA), is a formal business document used to outline an agreement between separate entities, groups or individuals.

<u>Motivational interviewing</u>	A collaborative, person-centered form of guiding to elicit and strengthen motivation for change. Because it explores a person's ambivalence about change, motivational interviewing is often used in conjunction with the Stages of Change model. ATTC has developed a training module to address patient ambivalence about HCV testing which incorporates motivational interviewing skills.
<u>Patient assistance programs</u>	Patient assistance programs (PAPs), which are usually sponsored by pharmaceutical manufacturers, are promoted as a "safety net" for Americans who have no health insurance or are underinsured. The goal of these programs is to provide financial assistance to help these patients access drugs for little or no cost.
<u>Person-centered care</u>	A collaborative process built upon a person's self-identified goals and aspirations. It builds upon the person's strengths and engages a team of professional care providers as well as natural support such as family, friends and recovering peers. The person in treatment participates in the development of his or her treatment plan, fostering self-efficacy, resiliency, and increasing engagement with the care team. Providers striving to embed person-centered care into their systems often start with the simple but powerful role of the language they use to communicate with and about people in treatment: Person First Guidelines. Faces and Voices of Recovery, a national advocacy organization dedicated to fighting stigma and building support for the recovery movement, maintains a resource library with an emphasis on addressing and changing stigma related to addiction: <u>Addressing Stigma</u> .
<u>Rapid initial testing</u>	The OraQuick HCV Rapid Antibody Test is available as a point-of-care rapid test, and this test can be used for initial HCV antibody screening. Often finger stick or blood spot testing.
<u>Rapid virologic response</u>	Rapid virologic response (RVR) is defined as non-detection of HCV RNA four weeks after starting treatment.
<u>Recovery</u>	SAMHSA defines recovery as, "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

<u>Recovery-oriented systems of care</u>	SAMHSA defines recovery-oriented systems of care as, “coordinated networks of community-based services and supports that are person-centered and build on the strengths and resiliencies of individuals, families and communities to achieve abstinence and improved health, wellness and quality of life for those with or at risk of alcohol and drug problems.”
<u>Return on investment</u>	Healthcare ROI encompasses more than money saved or earned; it must take into account both qualitative benefits such as improved patient safety and improved relationships with patients, as well as streamlined clinical operations among other measures.
<u>Sustained virologic response</u>	Achieving and sustaining a virus negative state for six months or longer after completing treatment for a virus, such as hepatitis C. A sustained virologic response is considered a virologic cure for HCV
<u>Syringe service programs (syringe exchange programs)</u>	Syringe services programs (SSPs) are community-based prevention programs that can provide a range of services, including linkage to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and linkage to care and treatment for infectious diseases. SSPs protect the public and first responders by facilitating the safe disposal of used needles and syringes. Providing testing, counseling, and sterile injection supplies also helps prevent outbreaks of other diseases Nearly thirty years of research shows that comprehensive SSPs are safe, effective, and cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV and other infections.
<u>The Stages of Change Model</u>	Emphasizes that an important consideration when engaging individuals in treatment with a person-centered approach is an assessment of their readiness to make behavior changes. Also known as The Transtheoretical Model, it guides interventions and strategies based on the idea of “meeting the person where he or she is at.” The model is flexible and encourages providers to recognize that people in treatment may be at different stages of change for different behaviors. A person may be taking necessary action to reduce their drug use but may report that they are not ready to address other health problems such as HCV. Interventions can then be tailored to encourage and support the person to move to the next stage of change.

<p><u>Trauma-informed care</u></p>	<p>Trauma-Informed Care recognizes that individuals in treatment for SUD frequently present with symptoms of trauma and that SUD treatment providers can expect that up to 70% of their participants have a history of trauma exposure. Trauma rates for women who use substances, including sexual and physical abuse, may be even higher, ranging from 70 to 99%. Additionally, OUDs are a risk factor for ongoing intimate partner violence, particularly among women, as continued drug use often puts users in high-risk situations for violence. Treatment programs vary in how they address trauma. Some may offer comprehensive services to directly treat and address trauma, while others focus on creating safe and strength-based environments that recognize the symptoms and work to reduce further traumatization.</p>
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resources

General HCV Information

Websites and Fact Sheets

- CDC's **Hepatitis C Information for the Public** - <https://www.cdc.gov/hepatitis/hcv/cfaq.htm>
- CDC's **Hepatitis C Information for Health Professionals** - <https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm>
- CDC's **Patient Education Resources** - <https://www.cdc.gov/hepatitis/hcv/patienteduhcv.htm>
- Office of HIV/AIDS and Infectious Disease Policy's **National Viral Hepatitis Action Plan 2017-2020** <https://attcnetwork.org/sites/default/files/2018-11/National%20Viral%20Hepatitis%20Action%20Plan%202017-2020.pdf>
- CDC's **Viral Hepatitis Prevention Point of Contact** contains contact information for state HCV coordinators - <https://www.cdc.gov/hepatitis/partners/hepatitiscoordslist.htm>

Online Trainings

- ATTC's **HCV Snapshot: An Introduction to Hepatitis C for Health Care Professionals** - <https://attcnetwork.org/centers/global-attc/hcv-snapshot-introduction-hepatitis-c-health-care-professionals>
- The University of Washington provides free and comprehensive HCV education in the form of self-study course modules: <https://www.hepatitisc.uw.edu/>
- CDC's **Viral Hepatitis Trainings and Resources** - <https://www.cdc.gov/hepatitis/index.htm>

HCV and Substance Use Disorder (SUD)/Injection Drug Use (IDU)

- SAMHSA's **Addressing Viral Hepatitis in People with Substance Use Disorders**. Treatment Improvement Protocol (TIP) Series 53 - <https://attcnetwork.org/centers/global-attc/product/samhsas-tip-53-addressing-viral-hepatitis-people-substance-use>
- CDC's **Hepatitis and IDU Fact Sheet** - <https://www.cdc.gov/hepatitis/hcv/pdfs/FactSheet-PWID.pdf>
- CDC's **Reducing Harms from IDU and OUD with Syringe Service Programs** - <https://www.cdc.gov/hiv/pdf/risk/cdchiv-fs-syringe-services.pdf>

HCV Screening and Testing

- SAMHSA's **HCV Screening in the Behavioral Healthcare Setting** - <https://store.samhsa.gov/system/files/sma15-4917.pdf>
- CDC's **Hepatitis C: Information on Testing and Diagnosis** - <https://www.cdc.gov/hepatitis/hcv/pdfs/hepctesting-diagnosis.pdf>
- University of Washington's **HCV Diagnostic Testing** - <https://www.hepatitisc.uw.edu/go/screening-diagnosis/diagnostic-testing/core-concept/all>
- FDA's **HCV Testing** - <https://www.fda.gov/vaccines-blood-biologics/blood-donor-screening/hepatitis-c>

HCV Treatment Protocols

- AASLD's **HCV Treatment Approaches and Guidelines** - <https://www.hcvguidelines.org/evaluate/testing-and-linkage>
- AASLD's **Simplified HCV Treatment for Treatment-Naïve Patients Without Cirrhosis** - <https://www.hcvguidelines.org/treatment-naive/simplified-treatment>

Addressing Stigma

- ATTC's **Anti-Stigma Toolkit** - <https://attcnetwork.org/sites/default/files/2019-04/Anti-Stigma%20Toolkit.pdf>
- Recovery Research Institute's **Addictionary** acknowledges that eliminating stigmatizing language is a critical part of addressing stigma. It contains a comprehensive glossary of key terms for addiction and recovery. <https://www.recoveryanswers.org/addiction-ary/>

Capacity Building Support

- The American Association of Opioid Dependence, Inc. - <http://www.aatod.org/>
- CDC's **Capacity Building Branch** offers free capacity building support around HIV - <https://www.cdc.gov/hiv/programresources/capacitybuilding/index.html>
- SAMHSA's **Opioid Response Network** offers free capacity building support around OUD - <https://opioidresponsenetwork.org/>

Culturally and Linguistically Appropriate Services

- National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare (National CLAS Standards) - <https://thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf>
- A Practical Guide to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities and Sexual and Gender Minorities - <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf>
- Racial Equity Tools provides a list of key sites, research, and practices related to health equity within communities of color - <https://www.raciaequitytools.org/plan/issues/health-and-healthcare>
- SAMHSA TIP 59: Improving Cultural Competence - <https://www.ncbi.nlm.nih.gov/books/NBK248428/>

Engaging Community Support for OTPs

- Centre for Addiction and Mental Health's **Methadone Maintenance Treatment: A Community Planning Guide** contains a useful review of engaging communities to support OTPs. https://www.porticonetwork.ca/documents/77404/475940/mmt_community_guide.pdf/7848440b-634b-499c-bff0-ec3548c2c23f
- Inclusive Civic and Community Engagement Resources - <https://www.racialequitytools.org/act/strategies/civic-or-community-engagement>

Establishing Partnerships

- The Partners in Health Mental Health, Primary Care, and Substance Use's **Interagency Collaboration Toolkit** provides guidance on establishing business and services partnerships, sample MOUs/MOAs, and guidance on navigating privacy and confidentiality issues. <http://www.ibhpartners.org/wp-content/uploads/2016/04/IBHPlinteragency-Collaboration-Tool-Kit-2013-.pdf>
- Partnerships with jail and prison programs can support the continuum of care for incarcerated individuals in OUD treatment when they are released. The National Council for Behavioral Health's **Medication-Assisted Treatment for OUD in Jails and Prisons Toolkit** is an excellent resource for planning and implementation. <https://www.thenationalcouncil.org/medication-assisted-treatment-for-opioid-use-disorder-in-jails-and-prisons/>
- The National Rural Health Research Center's **MOU/MOA Primer** - <https://www.ruralcenter.org/sites/default/files/MOA%20Primer%20for%20Networks.pdf>

Trauma-Informed Care

- 10 Key Ingredients for Trauma-Informed Care handout - <https://www.traumainformedcare.chcs.org/wp-content/uploads/2018/11/Infographic-TIC.pdf>
- What is Trauma-Informed Care? (3-minute video) - <https://www.traumainformedcare.chcs.org/video-what-is-trauma-informed-care/>
- Laying the Groundwork for Trauma-Informed Care Brief - http://www.traumainformedcareproject.org/resources/Laying-the-Groundwork-for-TIC_012418.pdf
- Key Ingredients for Successful TIC Implementation Brief - <https://www.chcs.org/media/Brief-Key-Ingredients-for-TIC-Implementation-1.pdf>
- Trauma-Informed Organizational Self-Assessment Tool - http://www.traumainformedcareproject.org/resources/Traumam%20Informed%20Organizational%20Survey_9_13.pdf

Integrating Peer Support Specialists into HCV Teams

- NYC Department of Health and Mental Hygiene's **Workforce Integration of Peer and Community Health Workers Toolkit** - <https://www1.nyc.gov/assets/doh/downloads/pdf/peer/needs-based-toolkit.pdf>
- Integrating Peers into Primary Care **Presentation** - <https://pcpcc.org/sites/default/files/Peer%20Support.pdf>
- Health Resources and Services Administration HIV/AIDS Bureau's **Integrating Peers into Multidisciplinary Teams: A Toolkit for Peer Advocates** <https://targethiv.org/sites/default/>

[files/supporting-files/Integrating%20Peers%20into%20Multidisciplinary%20Teams.pdf](#)

- SAMHSA's **Bringing Recovery Supports to Scale Technical Assistance Center Strategy** (BRSS-TACS) offers a number of tools and virtual training resources to support supervision of PSS and integrating PSS - <https://www.samhsa.gov/brss-tacs>

HCV Messaging and Counseling

- CDC's **Hepatitis C Support Project HCV Advocate** provides tools for helping guide people through HCV diagnosis. - <https://npin.cdc.gov/publisher/hepatitis-c-support-project-hcv-advocate>
- The Hepatitis C Harm Reduction Project's **Hepatitis C Counseling Best Practice Manual** - <https://harmreduction.org/wp-content/uploads/2011/12/HCVcounselingManualEnglish.pdf>
- ATTC's **Motivational Interviewing to Address HCV** is a series of video vignettes to encourage people to get tested for HCV - <https://attcnetwork.org/centers/global-attc/product/motivational-interviewing-address-hepatitis-c-vignettes>
- CDC's **A Guide to Comprehensive Hepatitis C Counseling and Testing** - <https://www.cdc.gov/hepatitis/resources/professionals/pdfs/CounselingandTestingPC.pdf>

Building HCV Care Teams

- The National Nurse-Led Care Consortium's presentation **HCV Care Team Formation and Linkage to Care** - <https://nurseledcare.phmc.org/past-learning-collaboratives/item/525-part-2-hcv-care-team-formation-and-linkage-to-care.html>
- Arizona State University's Center for Advancing Interprofessional Practice, Education and Research's presentation **Roles and Responsibilities: It Takes a Team!** introduces the roles and responsibilities of interprofessional primary care team members - <https://ipe.asu.edu/curriculum/elearning-module-roles-and-responsibilities-it-takes-team>

Telehealth

- The Association of State and Territorial Health Officials' (ASTHO) **Telehealth Resource Guide** - <https://www.astho.org/Health-Systems-Transformation/Medicaid-and-Public-Health-Partnerships/Telehealth-Resource-Guide/>
- The National Consortium of Telehealth Resource Centers is a collaborative of 12 regional and 2 national centers funded by the Health Resources and Services Administration (HRSA) to help organizations and practices implement telehealth - <https://www.telehealthresourcecenter.org/>
- Project ECHO, which originated at the University of New Mexico, aims to democratize knowledge by connecting groups of community providers with specialists at centers of excellence in collaborative sessions designed around case-based learning and mentorship. For information about HCV ECHO clinics: <https://echo.unm.edu/telecho-programs/hcv-community>

Quality Improvement

- SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) Program's **Evaluation & Quality Improvement Toolkit** - https://www.integration.samhsa.gov/pbhci-learning-community/toolkit-evaluation-quality-improvement#Getting_Started

- SAMHSA's PBHCI's **Assessment Tools for Organizations Integrating Primary Care and Behavioral Health** - <https://www.integration.samhsa.gov/operations-administration/assessment-tools>
- Book: Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. More information about the book is available here: <http://www.ihl.org/resources/Pages/Publications/ImprovementGuidePracticalApproachEnhancingOrganizationalPerformance.aspx>

Health Information Technology

- SAMHSA's **Resource Guide for Health Information Technology** is a tool for supporting the workforce requirements anticipated during the widespread adoption of electronic health records - https://www.integration.samhsa.gov/operations-administration/Resource_Guide_for_HIT.pdf

Patient Assistance for HCV Medications

- The American Liver Foundation's **Support for Patients with HCV** web page includes a list of organizations, programs and websites offering financial help - <https://liverfoundation.org/for-patients/about-the-liver/diseases-of-the-liver/hepatitis-c/support-for-patients-with-hepatitis-c/>
- Patient Advocate Foundation (PAF) **Hepatitis C CareLine**: 800-532-5274
- Hepatitis Patient Assistance Program, co-pay programs, and other resources for viral hepatitis drugs - <https://www.hepmag.com/basics/hepatitis-c-basics/paying-hepatitis-c-treatment>

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appendix A
***integrating peer
support workers into
interdisciplinary care
teams***



BRSS TACS

Bringing Recovery Supports to Scale

TECHNICAL ASSISTANCE CENTER STRATEGY

Issue Brief

Integrating Peer Support Workers in Interdisciplinary Care Teams

June, 2019



What Are Interdisciplinary Care Teams?

Members of interdisciplinary care teams (ICTs)* work collaboratively to meet patient needs. ICTs manage care and services to avoid fragmentation, ensure access to appropriate and person-centered care, and provide a team approach to address clinical, social, and mental and substance use disorder needs.¹

ICTs may include medical and mental and substance use disorders health specialists, nurses, social workers, physician assistants, and nonclinical staff. In addition to providing advanced medical care, interdisciplinary teams offer care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social supports.² A health plan care manager, another lead ICT team member, or multiple team members may be responsible for implementing and reviewing care plans.³

Teams use *person-centered principles* and *recovery-oriented approaches*. These approaches employ shared decision-making, culturally competent practices, and recognize that there are many pathways to recovery.⁴ Thus, team members accompany each individual as they strive for improved health, a self-directed life, and realization of their full potential.⁵

A successful person-centered and recovery-oriented team empowers individuals to participate in healthcare decisions.⁶ ICTs also improve overall health and reduce the cost of services.⁷

* This document is a technical assistance resource supported by BRSS TACS. This TA resource aligns with the priorities of the SAMHSA FY2019-2023 Strategic Plan to reduce opioid misuse, use disorder, overdose, and related health consequences, through the implementation of high quality, evidence-based prevention, treatment, and recovery support services and improve the supply of trained and culturally competent professionals and paraprofessionals to address the nation's mental and substance use disorder healthcare needs across the lifespan through the implementation of the comprehensive set of recommendations put forward by the Interdepartmental Serious Mental Illness Coordinating Committee. These priorities include improving treatment and recovery by improving access to, utilization of, and engagement and retention in prevention, treatment, and recovery support services, along with supporting the use of credentialed peer providers and other paraprofessionals as an integrated component of the comprehensive care provided by the primary and specialty care systems in order to prevent substance use disorder and to address the needs of individuals living with mental and substance use disorders and their families.



Peer Support Workers	How Can Peer Support Workers Contribute to the Interdisciplinary Care Team?	
<p>Peer support workers can be volunteers or paid employees with lived experience who are in recovery from serious mental illness or substance use disorders.^{8,9} Trained and certified to engage and support others who are on or considering a recovery journey, peer support workers have a variety of titles such as:</p> <ul style="list-style-type: none"> ▪ Certified peer specialists ▪ Forensic peer specialists ▪ Peer bridgers ▪ Recovery coaches ▪ Peer navigators ▪ Family peer advocates (those working with children, parents, and other caregivers) 	<p>Improve Engagement and Retention in Care</p> <p>Peer support workers are cultural and recovery ambassadors. They use outreach and engagement to bridge the divide between healthcare providers and the people who providers struggle to engage and serve, such as individuals with serious mental illness and complex substance use disorders. As members of an integrated care team, peer support workers make contributions such as these:¹⁰</p> <ul style="list-style-type: none"> ▪ providing health education to individuals and communities¹¹ ▪ giving practical assistance to achieve and sustain complex health behaviors like those needed to manage serious mental illnesses and substance use disorders ▪ helping people develop mechanisms to cope with health-related stressors¹² ▪ advocating for people seeking services and teaching people to advocate for themselves¹³ ▪ building relationships based on trust and mutual respect rather than expertise¹⁴ <p>These and other peer-provided supports can be adapted to meet the needs of many populations across a variety of healthcare settings.¹⁵</p>	<p>Promote Recovery and Health Care</p> <p>Peer support workers embody <i>person-centered principles</i> and <i>recovery-oriented approaches</i> for two reasons: they have lived experience and they frequently come from the communities they serve. These traits enable them to inspire peers by sharing personal stories, listening, and providing encouragement.</p> <p>Because peer support workers are engaged with individuals outside of clinical settings, they have information to share with others on the care team. For example, a peer support worker can attest to an individual's ability to manage his or her own care and convey the nature and consequences of barriers that he or she may encounter within and outside of care settings. However, peer support workers are expected to follow confidentiality laws and rules and respect individual's rights for privacy.¹⁶</p> <p>Peer support workers can also assist in the delivery of follow-up services and offer practical, social, and emotional support to those individuals who are taking steps to implement care plans and reach self-management goals.</p>

Organizational Readiness for the Inclusion of Peer Support Workers

Integration is combining parts to produce a unit greater than the sum of its parts. The first step in successfully integrating peer support workers is to ensure that all interdisciplinary team members and the organization commit to *person-centered principles* and *recovery-oriented approaches* to providing care.¹⁷ Preparing for—and then implementing—subsequent changes is a process, not a single event, and includes anticipating and addressing barriers while ensuring the sustainability of new approaches to care.

Organizational Readiness	Integrating Peers	Anticipating Barriers
<p>Preparations for including peer support workers on interdisciplinary care teams involve an honest, transparent assessment of the organization's readiness.^{18,19} The organization and its members must share the values of teamwork and collaboration, be committed to peer integration, and have the capacity and skills to adopt new principles, framework, and practices. It is also important for each organization to develop an action plan that:</p> <ul style="list-style-type: none"> ▪ includes the voice and presence of peers at all levels of planning; ▪ specifies each care team member's role and how members work together; ▪ identifies how peer support workers complement and expedite the team's priorities and outcomes (for example, access, continuity, coordination, and communication); ▪ provides policies and procedures that use person-first recovery language throughout; and ▪ stipulates how organizational personnel evaluate progress, and when applicable, how people using services assist in the evaluation.^{20, 21} 	<p>The development of interdisciplinary care teams and the inclusion of peer support services signals a change in the approach to working with people with mental illness and substance use disorders. This change requires more than simply hiring peer support workers. It necessitates providing active and ongoing support in the following ways:</p> <ul style="list-style-type: none"> ▪ The hiring process should ensure that peers both meet the skill requirements of job and fit well with the organization.²² ▪ The organization should clearly define peer workers' roles and responsibilities and distribute this information to relevant staff.²³ ▪ Training could surpass standard peer certification requirements²⁴ to include programs such as Whole Health Action Management²⁵ and Motivational Interviewing techniques.²⁶ ▪ Employers should provide regular, ongoing supervision of peer support workers.²⁷ When possible, other peer support workers should be given this supervisory responsibility. ▪ Organizations should choose individuals to act as <i>peer champions</i> within the organization to help promote peer support services and encourage frequent, ongoing staff communication.²⁸ 	<p>Integrating peer support workers into an organization can be challenging and is likely to encounter the following obstacles:</p> <ul style="list-style-type: none"> ▪ Underutilization and devaluation of peer services: To meet the challenge, organizations should offer multiple opportunities for staff to learn about peer services.²⁹ ▪ Practitioner and staff reluctance to integrate peer support services: To aid integration, organizations should consider using phased implementation and regular outcome assessments.³⁰ ▪ Incidences of <i>peer drift</i> may occur where peer support workers try to appease others and fit in to overly hierarchal clinical understandings of, and interactions with, the people they serve: Regular supervision can help identify and mitigate this trend. <p>Sustaining Change</p> <p>Sustainable innovations are woven into organizational culture, policy, budgets, and day-to-day practices. To promote the sustainability of peer support workers, include these promising practices:</p> <ul style="list-style-type: none"> ▪ Inclusive policies and procedures that promote a peer workforce and value peers' unique orientation and expertise.^{31,32} ▪ Ongoing funding supports for the compensation and continuing education of the peer workforce.³³ ▪ Organizational feedback loops that include peer support workers.³⁴ ▪ A culture that emphasizes a team approach to care delivery and recognizes how collaboration can contribute to high quality health outcomes.³⁵ ▪ Program outcomes tracking to identify where a program excels and where the organization may need to make modifications.³⁶

Notes

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