Opioid Response Network

Your Guide to Integrating Infectious Disease Testing and Treatment Services in Opioid Treatment Programs

Disclaimer

A note about links within this Guide: For ease of use, the authors have included direct links to relevant resources throughout the body of the Guide, as well as in the Resources and References sections. At the time of publication, all links were valid. The authors recognize that the hosts of these websites may make edits that cause the links to be broken or result in error messages. If you need assistance locating a resource due to a broken link, please email Kristen Zucht at zuchtk@umkc.edu.

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Your Guide to Integrating Infectious Disease Testing and Treatment Services in Opioid Treatment Programs is a continuation and expansion of work previously conducted by the Addiction Technology Transfer Center (ATTC) Network Coordinating Office (NCO), funded by SAMHSA. An earlier version of this guide, *Your Guide to Integrating HCV Services into Opioid Treatment Programs*, was published in 2020.

The ATTC Network, with guidance from SAMHSA, developed the earlier Guide to ensure that Opioid Treatment Program (OTP) staff had tools and resources available to help them integrate their response to the intersecting epidemics of Opioid Use Disorder (OUD) and infectious disease, particularly Hepatitis C (HCV). Over the course of several years working with OTPs to implement steps in the earlier Guide, it became apparent that the same steps being used to integrate testing and treatment for HCV in the OTP setting could be leveraged to deliver evidence-based HIV, HCV, and syphilis screening, testing, treatment and/or referrals.

While these ATTC NCO project activities were being carried out, federal agencies began to bring syndemic approaches forward. A syndemic is a population-level clustering of social and health problems, where two or more diseases or health conditions cluster within a population group. People who use drugs, and particularly people with OUD, are disproportionately impacted by the syndemic of HCV, HIV, and sexually transmitted infections. There is both a financial and community benefit to more holistic provision of interventions. Thus, the primary focus of the steps outlined in this updated Guide is on integration of infectious disease and OUD treatment services.[i]

The development of *Your Guide to Integrating Infectious Disease Testing and Treatment Services in Opioid Treatment Programs* was informed by national thought leaders in OUD, HCV, HIV, and other infectious disease treatment and service delivery. Some thought leaders have been contributing to project work under the original ATTC NCO SAMHSA-funded initiative through to the current Opioid Response Network SAMHSA-funded project. Interviews with staff of OTPs provided information for case studies, further context, and examples included in the guide. Finally, OTP staff in two separate learning communities focused on HCV integration shared lessons learned from their integration experiences in 2020 and 2021. We thank these individuals and organizations for their contributions.

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[i] Note: While this guide moves toward syndemic approaches, a truly syndemic approach is not fully outlined, as it would require more specific steps on addressing the social determinants of health of OTP clients.

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1. Introduction to the Guide

Since 2020 and driven by the COVID-19 pandemic, disruptions in care, physical isolation, logistical barriers, and an increasingly unsafe drug supply have profoundly impacted health outcomes related to illicit drug use in the United States (U.S.). Stark increases in substance use disorders (SUDs), overdose, and HCV and HIV infections attributable to injection drug use are causing greater morbidity, mortality, and inequity. Furthermore, the U.S. is also observing a rise in other infectious agents that tend to occur with HIV, such as sexually transmitted infections (STIs) like syphilis.

Substance Use Disorders

The proportion of Americans living with an SUD remained relatively stable between 2015-2019.[1] However, 13% of Americans reported initiating or increasing substance use in 2020, the first year of the pandemic.[2] Additionally, the COVID-19 pandemic exacerbated many risk factors associated with the development or worsening of SUDs. The CDC states that between April and June of 2020, the number of people reporting symptoms associated with anxiety and depressive disorder rose 30.9%, and symptoms of trauma- and stressor-related disorders rose by 26.4%.[2]

Despite evidence of increasing prevalence of SUD, there continues to be a large unmet need for SUD treatment programs. Of the 14.5% of the U.S. population living with an SUD in 2020, only 1.4% received any form of substance use treatment in either inpatient or outpatient settings.[1] More encouragingly, innovations in the regulation of opioid use disorders (OUDs) brought on by the COVID-19 pandemic have yielded promising results.

Overdose

The CDC estimates that 100,306 drug overdose deaths occurred between April 2020 and April 2021, a 30% rise from the same time period a year earlier and more than double the number of deaths from 2015.[3] In addition to opioid misuse, stimulant misuse is also contributing to the climbing overdose mortality rate. There were nearly three times as many deaths involving cocaine in 2020 than in 2015, and more than four times as many deaths involving methamphetamine.[4] The number of fatal overdoses involving both cocaine and opioids has outnumbered the number of cocaine-involved overdoses where opioids were not present since 2014. For the first time in 2020, the same was true for overdoses involving both methamphetamine and opioids.[4] These trends are likely caused by two factors: (1) the rise of unintentional opioid use due to a contaminated drug supply characterized by illicitly manufactured fentanyl, and (2) more frequent intentional mixing

of stimulants and opioids. The landscape of how opioids are used is also changing, with the CDC reporting in 2024 that the percent of overdose deaths with evidence of smoking increased 74%, while the percent with evidence of injection decreased 29%, making smoking the leading route of drug use involved in overdose deaths.[5]

The growing overdose mortality rate has magnified racial and socioeconomic health disparities. In 2020, the highest overdose death rate was among American Indian and Alaska Natives.[6] The highest growth in overdose mortalities by racial group, was among the Black/African American population in 2020 at 48.8%, significantly higher than the 26.3% growth experienced by White Americans.[6] The overdose mortality rate among people who are Black/African American surpassed that of their White counterparts in 2020 for the first time since 1999.[6] The Latinx population experienced relatively few overdose deaths, but saw 41% more fatalities in 2020 than in 2019.[6]

HCV

Injection drug use continues to be the most frequent route of transmission in the increasing number of new HCV cases.[7] In 2019, CDC estimated that 57,500 individuals were living with an acute HCV infection; up 43% from 2012.[7] The most significant increase in HCV was seen in people aged 20-39, consistent with the demographic with the highest rate of opioid misuse.[7,8] Despite the rising number of new HCV cases, the number of people initiating HCV treatment has either leveled off or decreased every year since 2015.[9] Between 2014 and 2020, the average number of people treated for HCV was 120,000, less than half of what it would take to eliminate HCV in the U.S. by 2030.[9]

The COVID-19 pandemic has also reduced the number of identified new HCV cases. The volume of HCV antibody tests fell 59% in March of 2020, but rebounded to near pre-pandemic levels by July of 2020.[10] However, the number of antibody–reactive results, RNA–positive results, and HCV treatment prescriptions dispensed remained substantially lower in July 2020 than the same time period in 2019.[10] The recovery in antibody testing paired with low case-findings indicates that people at higher risk of HCV were less likely to access testing and treatment services during the pandemic.[10]

> OTPs are uniquely poised to provide targeted HCV testing and treatment services given high prevalence rates of HCV among OTP patients.

HIV

Human Immunodeficiency Virus (HIV) diagnoses among people who inject drugs (PWID) rose throughout the country between 2015 and 2019, and CDC estimates that about 10% of new HIV cases overall, can be partially or fully attributed to injection drug use.[11] Recent trends in HIV transmission among PWID reflect growing racial and socioeconomic

disparities. In 2019, people who are Black/African American accounted for 29% of new HIV infections attributed to injection drug use, despite making up only 14% of the U.S. population.[12,13] Additionally, 43% of the 2,508 new HIV cases among PWID occurred in the South, the U.S. region with the highest poverty rate.[13,14]

Despite the rising rate of HIV transmission via drug injection, the use and awareness of pre-exposure prophylaxis (PrEP), a medication that lowers the risk of acquiring HIV, remains low among PWID.

> Research has shown that PWID in OTPs demonstrate high interest and value in PrEP, once made aware of it; methadone treatment programs that provide PrEP have seen high adherence rates amongst patients.[15-17]

Syphilis

Syphilis has been on the rise in the U.S., with cases increasing 80% between 2018 and 2022.[18] Syphilis also reflects racial disparities, with American Indian/Alaskan Native, Black/African American, and Native Hawaiian/Pacific Islander populations experiencing the highest rates in 2022.[19] Men who have sex with men are also highly impacted by syphilis, making up 46.5% of male cases.[19] While men overall make up most syphilis cases, the rate of syphilis is increasing most dramatically among women, a 217% increase between 2017-2021.[19] In parallel, congenital syphilis (CS), syphilis during pregnancy that can be passed to infants if not treated, is also on the rise. In 2022 there were 3,761 confirmed cases of newborn syphilis in the U.S., a tenfold increase from the 335 cases identified in 2012.[20] CS cases are extremely dangerous and can cause miscarriage, stillbirth, or infant death.

> People who can become pregnant who use drugs and/or are experiencing housing instability are particularly vulnerable to CS, making screening and provider education about CS in a variety of settings, including drug treatment programs, critical.

The Need to Integrate Infectious Disease Services at OTPs

The health conditions and inequities just described are urgent and interrelated, underscoring the importance of addressing them together, rather than in silos. OTPs offer an ideal opportunity to test and treat for HCV, HIV, and STIs, given the high prevalence in populations accessing services, and consistent, frequent contacts with patients. This Guide provides insights, examples, and strategies to support OTPs in integrating infectious disease services into behavioral health programming.

The next section explains how OTPs or other readers can navigate this guide.

2. How to Use the Guide

Intended 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 infectious disease prevention, screening, and treatment services for HIV, HCV, and syphilis. Integrating infectious disease services at OTPs has the potential to both (i) enhance prevention, screening, and treatment by addressing key gaps in patient care, and (ii) support patients' recovery journeys by improving their overall well-being.

The Guide is intended to be useful to a wide range of OTPs and those individuals or entities invested in OUD and infectious disease integration. While the Guide's primary audience is publicly funded OTP staff (e.g., administrators, physicians and physician assistants, nurse practitioners, nurses, case managers, counselors, patient navigators, peer support specialists), it may also be useful for community and healthcare coalitions, nonprofit organizations, community-based organizations, other substance use disorder and HCV treatment providers, community health providers, and policymakers.

Overview of the Guide

This Guide is divided into sections to provide a thorough overview of how OTPs might plan and implement integrated infectious disease and OUD services. In the remaining sections:

- **Section 3** provides background on (a) the syndemic of substance use, HIV, HCV, and syphilis in the U.S. and (b) justifies the critical role of OTPs in addressing this syndemic.

- **Section 4** describes core components of integrated care models for HIV, HCV, and syphilis (education, screening, and treatment). Recognizing the variety of OTP settings and resources, this section offers of a range of integration options rather than a single, pre-defined solution.

- **Section 5** discusses how to implement the integrated care models shared in Section 4, providing specific steps and considerations for how organizations might approach integration.

- **Section 6** shares information about financing and sustaining integrated OUD/infectious disease services and the challenges and opportunities facing OTPs that engage in this work.

- Additional sections offer a glossary and list of acronyms (**Section 7**), a library of currently available external resources (**Section 8)**, and **references.**
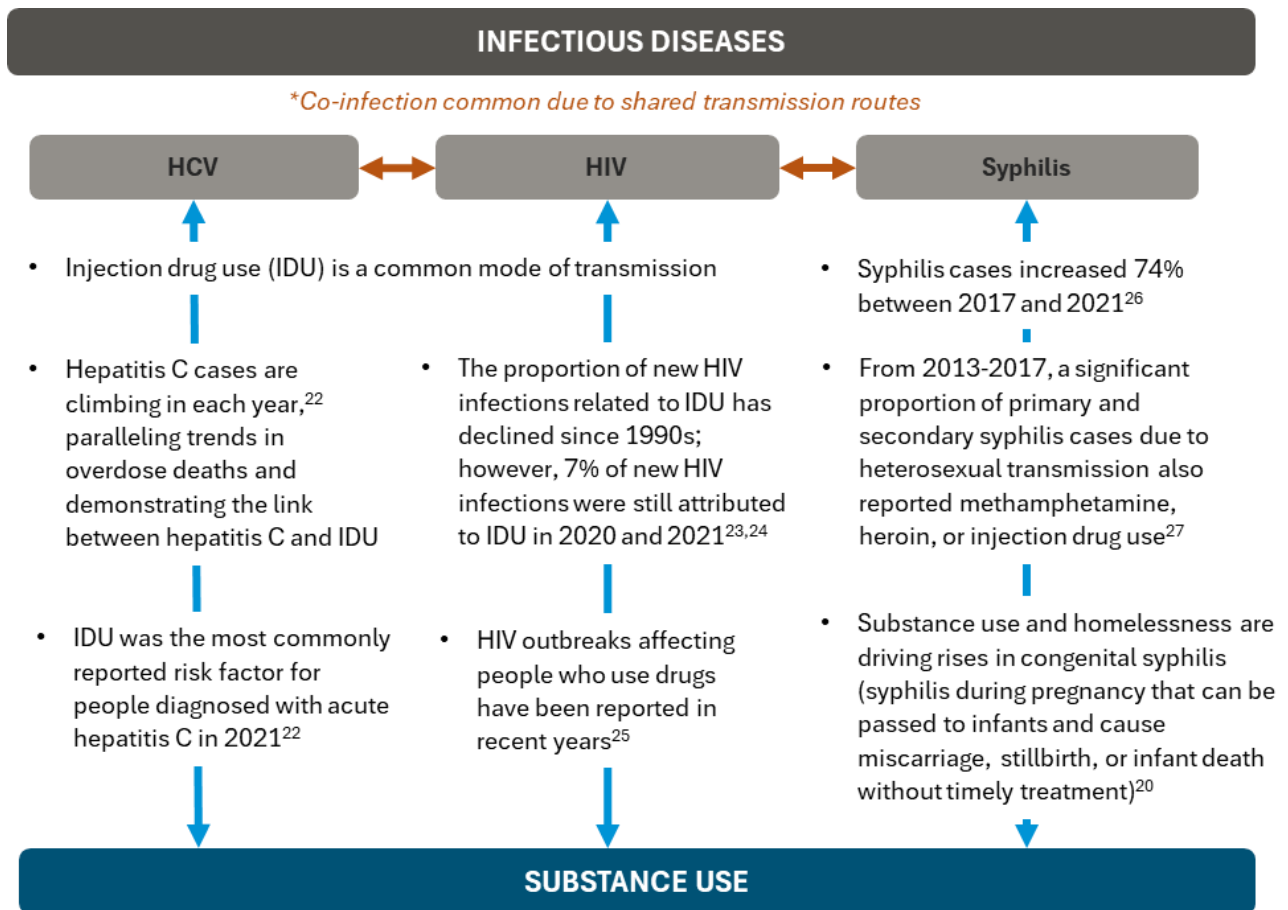
3. The Need for OTPs to Address Infectious Disease

This section makes the case for integrating HIV, HCV, and syphilis prevention and treatment services in OTP settings.

The Syndemic of Substance Use, HIV, HCV, and Syphilis[ii,iii]

Syndemics are epidemics of diseases or health conditions that interact with each other, exacerbating their adverse effects on communities that face inequities.[21] Substance use and overdose are part of a larger syndemic that includes HIV, HCV, and syphilis[iv] and disproportionately impacts people who use drugs.

INFECTIOUS DISEASES

*Co-infection common due to shared transmission routes

HCV	HIV	Syphilis

- Injection drug use (IDU) is a common mode of transmission

- Hepatitis C cases are climbing in each year,[22] paralleling trends in overdose deaths and demonstrating the link between hepatitis C and IDU

- The proportion of new HIV infections related to IDU has declined since 1990s; however, 7% of new HIV infections were still attributed to IDU in 2020 and 2021[23,24]

- Syphilis cases increased 74% between 2017 and 2021[26]

- From 2013-2017, a significant proportion of primary and secondary syphilis cases due to heterosexual transmission also reported methamphetamine, heroin, or injection drug use[27]

- IDU was the most commonly reported risk factor for people diagnosed with acute hepatitis C in 2021[22]

- HIV outbreaks affecting people who use drugs have been reported in recent years[25]

- Substance use and homelessness are driving rises in congenital syphilis (syphilis during pregnancy that can be passed to infants and cause miscarriage, stillbirth, or infant death without timely treatment)[20]

SUBSTANCE USE

[ii] Note: Hepatitis B, gonorrhea, and chlamydia also disproportionately impact people who use drugs. While these conditions are beyond the scope of this Guide, opportunities to integrate OTP-based services warrant investigation.

[iii] Several national initiatives have launched in response to the syndemic, including the U.S. Department of Health and Human Services (DHHS) initiative to End the HIV Epidemic, the DHHS sexually transmitted infection (STI) strategic plan, and the White House HCV Elimination Plan.

[iv] While SAMHSA's 2015 Guidance for Opioid Treatment Programs encouraged OTPs to take a proactive stance in HIV and HCV screening and treatment integration, significant recent increases in syphilis cases, as well as the intertwined relationship between syphilis and substance use necessitate the inclusion of syphilis services in integrated models.

Understanding HIV, HCV, and Syphilis

As HIV, HCV, and syphilis have overlapping transmission routes (see table below), co-infection is common. Co-infection tends to exacerbate each condition and can create problems for chronic disease management. Having an untreated syphilis infection, for example, can challenge management of HIV,[28] or increase vulnerability to HCV acquisition for men who have sex with men (MSM).[29] For people living with both HIV and HCV, HIV can cause chronic HCV to advance more quickly.[30]

	HIV[24,31-34]	HCV[35-37]	Syphilis[38,39]
What is it?	A virus that attacks the body's immune system and, if untreated, can progress to AIDS (Acquired Immune Deficiency Syndrome)	A virus that infects the liver and, if left unresolved, can lead to liver inflammation, cirrhosis, or liver cancer	A bacterial infection that, when untreated, can cause serious health problems like organ damage
How is it transmitted?	• Transmitted via blood and sexual fluids • Vast majority of cases occur via sexual transmission • ~10% of cases attributed to IDU or male-to-male sexual contact *and* IDU • Perinatal transmission is relatively rare (<1%)	• Transmitted primarily via blood • Vast majority of cases due to shared IDU equipment • Small numbers of cases attributed to perinatal or sexual transmission	• Sexual transmission or mother-to-child transmission during pregnancy
Prevention strategies	• Pre- and post-exposure prophylaxis (PrEP, PEP) medications can be highly effective at preventing HIV • Condom use can prevent sexual transmission of HIV • Using sterile syringes and injection equipment can prevent HIV transmission due to drug injection • People taking HIV treatment who have undetectable viral loads cannot transmit HIV	• Using sterile injection equipment can prevent HCV transmission due to drug injection • People who are treated and cured for HCV cannot transmit it to others	• Doxy-Pep (taking the antibiotic doxycycline <72 hours following condomless sex) can reduce risk of syphilis transmission • Condom use reduces the risk of syphilis transmission

Treatment/ Cure	• There is no cure for HIV, but it can be well-managed with HIV antiretroviral therapy (ART), which can reduce the amount of HIV in the body so one can remain healthy	• HCV resolves without treatment in 25-30% of cases • Direct-acting antivirals (DAAs) cure >95% of chronic HCV cases	• Curable with antibiotics (penicillin)

The Role of OTPs in Addressing Infectious Disease

The close relationships between substance use and HIV, HCV, and syphilis, as well as the implications of leaving any of these conditions untreated, make a strong case for addressing infectious disease in OTP settings. Addressing the broader syndemic can improve healthcare, recovery, and quality of life outcomes for OTP patients experiencing multiple health issues,

> OTPs are uniquely positioned to offer HIV, HCV, and syphilis screening and linkage to care due to their existing relationships with patients disproportionately impacted by these conditions.

through access to more trauma-informed prevention, treatment and care; stronger patient-centered relationships; and adherence to treatment plans. For example, studies have shown that that if barriers to access and care can be systematically addressed in a culturally appropriate and trauma-responsive environment, HCV assessment and treatment integrated care models can be successful.[40,41]

Taking an integrated approach, in which OTPs incorporate infectious disease screening, linkage, and treatment interventions alongside substance use services, is especially important given the interrelated vulnerabilities of OTP patients to infectious disease. OTP patients are also more likely to be experiencing housing instability or homelessness, poverty, and/or the impacts of structural racism, as well as other social determinants of health that drive negative health outcomes. OTP clients who are connected to primary care have been found to receive less chronic care management than their counterparts who are not in OTPs,[42] despite being disproportionately burdened with HIV, HCV, and/or syphilis. Furthermore, many OTP patients may not engage in primary care at all beyond required OTP visits, meaning that OTP settings may provide the *only* opportunities for patients to receive routinized infectious disease screening and linkage to care services.

The following sections of this Guide will provide frameworks, guidance for, and examples of integration of HIV, HCV, and syphilis interventions in OTPs.

4. Core Components of Integrated Infectious Disease Services at OTPs

This section will outline three core components of integrating services related to infectious disease within OTP settings: (1) education, (2) screening, and (3) treatment.

Moving Toward a Syndemic Approach: Integrated Services

OTPs can move toward a more syndemic approach by integrating infectious disease education, screening, and treatment services with behavioral health programming. Integration recognizes the many issues that OTP clients experience and allows them to access traditionally siloed services for HIV, HCV, and syphilis in one familiar place. In this Guide, we recognize that integration:
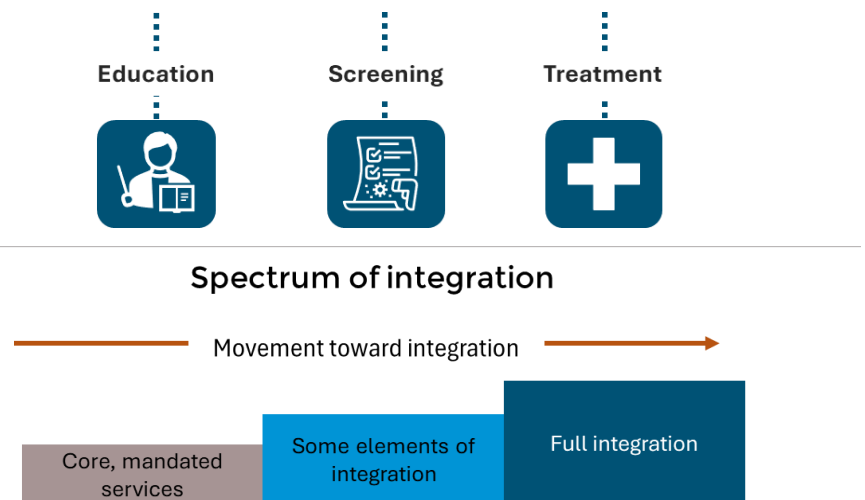
While this guide focuses primarily on fixed site OTPs, mobile methadone clinics may also be promising sites for integrated infectious disease services.

- **Is tailored to OTP conditions.** Integrated services for infectious disease are not a one-size-fits-all approach.[40,41] OTPs vary considerably in size, staffing, infrastructure, capacity, geography, treatment populations, state restrictions and funding, policies and procedures, and other factors that influence the optimal approach to integration.

- **Includes a spectrum of integration options**. Integrating services is not all-or-nothing. While full integration of infectious disease services may be most impactful for patient outcomes, any progress toward integration represents meaningful movement toward a more trauma-informed, patient-centered, and effective model of care.[43-46]

Core Components of Integrated HIV, HCV, and Syphilis Services

The core components of integrated HIV, HCV, and syphilis services include (1) education, (2) screening, and (3) treatment. Each core component is described on the following pages with a *spectrum* of integration options, ranging from less integration to more integration. As already noted, different levels of integration may be feasible and/or optimal for different OTPs.

Core Components of Integrated Infectious Disease Services

Education   Screening   Treatment

Spectrum of integration

Movement toward integration →

Core, mandated services

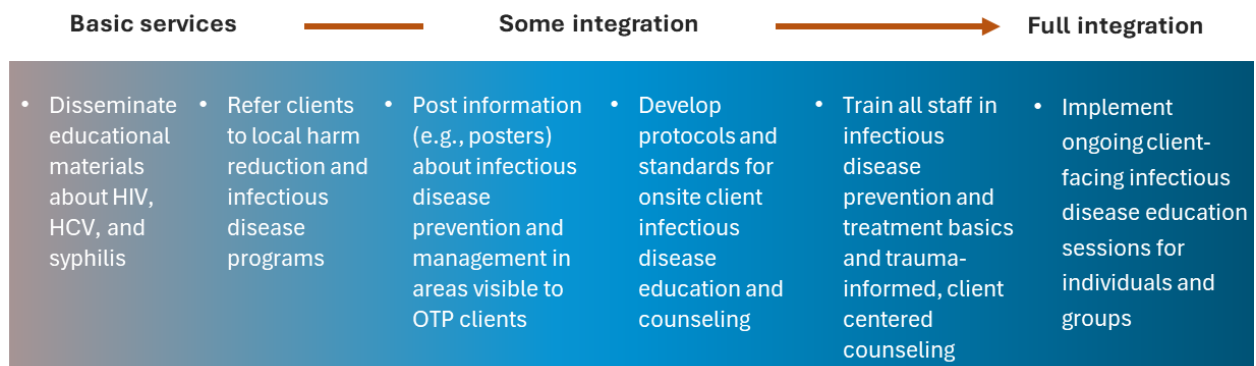Some elements of integration

Full integration

COMPONENT 1: INFECTIOUS DISEASE EDUCATION

Integrating education about infectious disease into OTP services can help patients who may experience higher risk of HIV, HCV, and/or syphilis access information about prevention, screening, and treatment. Below is a spectrum of ways that OTPs might integrate infectious disease education, ranging from less to more integration.

Integrating Infectious Disease Education

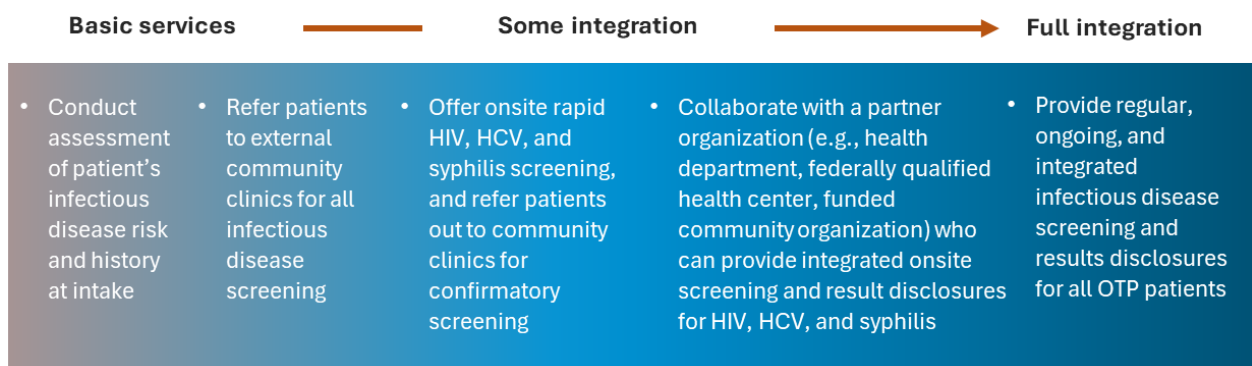| Basic services		Some integration			Full integration
• Disseminate educational materials about HIV, HCV, and syphilis	• Refer clients to local harm reduction and infectious disease programs	• Post information (e.g., posters) about infectious disease prevention and management in areas visible to OTP clients	• Develop protocols and standards for onsite client infectious disease education and counseling	• Train all staff in infectious disease prevention and treatment basics and trauma-informed, client centered counseling	• Implement ongoing client-facing infectious disease education sessions for individuals and groups

COMPONENT 2: HIV, HCV, AND SYPHILIS SCREENING

As people who use drugs experience higher rates of HIV, HCV, and syphilis, screening for these conditions within OTP settings can support timely diagnosis and linkage to treatment for OTP patients. Below is a spectrum of ways that OTPs might integrate infectious disease screening, ranging from less to more integration. Additional guidance for on-site HIV, HCV, and syphilis screening are provided on subsequent pages.

Integrating Infectious Disease Screening

Basic services		Some integration		Full integration
• Conduct assessment of patient's infectious disease risk and history at intake	• Refer patients to external community clinics for all infectious disease screening	• Offer onsite rapid HIV, HCV, and syphilis screening, and refer patients out to community clinics for confirmatory screening	• Collaborate with a partner organization (e.g., health department, federally qualified health center, funded community organization) who can provide integrated onsite screening and result disclosures for HIV, HCV, and syphilis	• Provide regular, ongoing, and integrated infectious disease screening and results disclosures for all OTP patients

Why Test for HCV if You May Not Be Able to Treat It?

The American Association for the Study of Liver Diseases recommends treatment "for all patients with chronic HCV infection, except those with a short life expectancy that cannot be remediated by HCV treatment, liver transplantation, or another directed therapy."[47] (This is similar to the standard of care in the U.S. for HIV and syphilis, both of which include universal initiation of treatment as soon as possible post-diagnosis).[48,49] Uptake of this HCV treatment guideline has varied in the U.S. due to challenges accessing medications and/or patients or providers being unaware of the new guidance recommending universal treatment.

Historically, particularly in the pre-direct acting antiviral (DAA) era, lack of or perceived lack of access to HCV treatment has had a chilling effect on HCV testing, as providers may question why testing for HCV is warranted or ethical if not paired with an offer for treatment.[50] In fact, even if access to treatment is hampered by restrictive Medicaid policies, lack of insurance, or lack of prescribing providers, there are several reasons to test for HCV anyway. These reasons include:

- Access to treatment has increasingly liberalized since the advent of DAAs for HCV in 2014 and continues to evolve as pressure generated by lawsuits, changing Medicaid policies, and patient assistance programs make it more likely that patients will be able to access treatment despite previous barriers. Even if an OTP is in a geographic location that has limited access to HCV treatment, there are continuously increasing pathways to treatment for patients. If patients are aware of their HCV status, many will continue to be motivated to explore treatment options and be ready to take advantage of opportunities for treatment as they arise.

- It is important to regularly assess the liver health and function of people with chronic HCV, and providers are only prompted to do this in the event of a positive HCV RNA test. Many people living with HCV have been infected for many years without knowledge of their infection. Living with liver disease may necessitate a variety of interventions to prevent further damage, including avoidance of Tylenol, alcohol, or foods with a high fat content.

- While it is important to provide all OTP patients with harm reduction education and encourage those who continue to inject drugs to access sterile supplies, participants who know they have HCV may choose to adjust their injecting behaviors to further minimize the risk of forward transmission. Knowledge of an HCV diagnosis may also prompt engagement in other HCV prevention interventions.

Many resources are available for clinical providers seeking to develop capacity to treat HIV, HCV, and syphilis. Some examples include:

- [Hepatitis C Practice Guidance](#)[51] (American Association for the Study of Liver Diseases)
- [Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV](#)[48] (U.S. Department of Health and Human Services)
- [STI Treatment Guidelines, 2021: Syphilis](#)[49] (Centers for Disease Control and Prevention)

Additional Considerations for On-site Screening

1. *Type of HIV, HCV, and syphilis tests*

   There are varying test options for HIV, HCV, and syphilis. OTPs should carefully consider what options are optimal for their specific program given budgetary and logistic constraints, as well as pros and cons of each type of screening technology:

Test Type	Pros	Cons
Rapid	• Patients get results in <20 min. • No blood draws are necessary, which is preferable for patients with damaged veins	• Must follow up with confirmatory screening • A positive HCV antibody rapid test or rapid syphilis test does not indicate whether a patient is (i) currently viremic or (ii) had a prior infection
Confirmatory	• Results are definitive in making a diagnosis	• Blood must be tested in a lab, which can take several days and be costly • Blood draws may be difficult or painful for patients with damaged veins
Dried blood spot (DBS)	• Can test for HIV, HCV, and syphilis with one sample • No blood draws needed, which is preferable for patients with damaged veins	• Sample must be mailed to a lab for results, which can take days • Not all labs test DBS samples • Analysis of samples can be costly

Promising Screening Model: Dried Blood Spot Screening (DBS)

As HIV, HCV, and syphilis disproportionately impact people experiencing substance use disorders, homelessness, and incarceration, multi-step diagnostic processes pose barriers to timely treatment. Further, for people with vein damage, blood draws can be difficult and traumatic.

DBS represents a potential paradigm shift in screening, as it requires only a fingerstick and blotting of blood on filter paper. The samples, which are highly stable when properly stored, are then shipped to a lab where they can be tested for multiple diseases, including HIV, hepatitis B, HCV antibody and confirmatory screening, and syphilis.

Dr. Andrew Seaman, Medical Director of Hepatitis and HIV services at Central City Concern in Portland, Oregon, is rolling out HCV elimination in Central City Concern's OTPs using DBS. Dr. Seaman has found OTP administrators amenable to implementing DBS for HCV screening because DBS can also be used to screen for syphilis, which is required by federal regulation. Routine integration of DBS screening therefore allows OTPs to internally screen for all required tests, plus other high impact infectious diseases like HIV and HCV.

2. *CLIA waiver: certification for screening outside of a laboratory setting*

In 1988, Congress passed the Clinical Laboratory Improvement Amendments (CLIA), which gave Congress the authority to establish standards for laboratory screening. CLIA applies to all laboratories that examine specimens from the human body in order to diagnose, prevent, or treat health conditions.[52] OTPs need to be CLIA-certified as these programs regularly conduct patient drug screening and may perform other clinical tests. Labs or screening sites can apply to be part of the CLIA program by completing and submitting [form CMS-166].[v]

However, **CLIA waivers** allow some tests to be used *outside* of laboratory settings, allowing greater flexibility in the use of these tests. Only tests that are CLIA-waived can be performed by a laboratory with a certificate of waiver.[53] A list of CLIA-waived tests, which includes the OraQuick HCV Rapid Antibody test and several HIV antibody and antigen tests, can be found on the Food and Drug Administration [website].

COMPONENT 3: HIV, HCV, AND SYPHILIS TREATMENT

Failure to diagnose and effectively treat HIV, HCV, and syphilis can cause significant organ damage and even death, underscoring the importance of efficient and effective linkage-to-care protocols for OTP patients with these conditions. Treatment options have advanced significantly. Direct acting antivirals for HCV are curative in >95% of patients with chronic infection.[37] Injectable penicillin can cure syphilis (and intravenous penicillin, for congenital syphilis), with dosage depending on the type and stage of syphilis.[38] While HIV is not curable, it can be effectively managed with anti-viral medications.[34]

Below is a spectrum of ways that OTPs might integrate infectious disease treatment, ranging from less to more integration. Additional guidance is provided on the next page.

Integrating Infectious Disease Treatment

Basic services → Some integration → Full integration

• Refer patients to external partner clinics for infectious disease treatment	• Integrate infectious disease treatment adherence goals into recovery goals, and monitor adherence via counseling sessions	• Provide directly observed therapy of infectious disease treatment alongside MAT (medication assisted treatment) dosing at the OTP	• Collaborate with a partner clinic to set up a satellite site at the OTP from which the partner clinic can dispense HIV, HCV, or syphilis treatment	• Provide HIV, HCV, and/or syphilis treatment to OTP clients onsite

[v] Note: CLIA certificate applications must be submitted to the State Agency of the state in which the laboratory is located. It is recommended to discuss any other state-specific requirements with the state agency.

Promising Treatment Practice: Telehealth and Mobile Health

Telehealth can play a key role in (i) retaining patients in care and (ii) supporting providers as they build their capacity to provide integrated treatment services, especially for complex cases or at sites with fewer resources to support integrated treatment (e.g., rural sites). Innovations in telehealth and mobile health (mHealth) enable OTPs with medical providers to offer the full continuum of HIV, HCV, and syphilis through various models:[54]

- *Teleconsultation*: Used by the Veterans Health Administration (VA), providers in under-resourced areas are linked with specialists who can support cases and share the most updated evidence-based practice around OUD and infectious disease.

- *Televisits*: Patients in rural or remote areas can use video technology to meet virtually with their provider one-on-one. Televisits can also work in urban areas, such as through partnerships between clinicians and community organizations that do not have the ability to screen or treat infectious disease.

- *Telemonitoring*: Patients are monitored remotely through specific apps or tablets that provide data reflecting disease progression, signs, and symptoms.

- *Hybrid Consultations*: 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.

Possible Challenges to Integrated Services at OTPs

For many OTPs, the shift toward a syndemic approach may seem daunting. Integrating infectious disease services into existing programs may require significant changes to organizational culture, policies, procedures, and staffing. Common barriers to integrated services at OTPs include a lack of medical and behavioral health provider capacity, insufficient patient demand, lack of funding, and/or regulatory concerns.[55] 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 infectious disease (see Resources section).

The next section offers more detailed guidance on the organizational steps that OTPs can take to implement the core components of an integrated approach.

Additional Tool: 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 that mirrors the "spectrum" of integration shown for the core components of integration (education, screening, and treatment) in this guide.[56] SAMSHA's tool offers a variety of options for OTPs to consider as they move along the integration continuum.

SAMHSA's framework includes a spectrum that ranges from "coordinated" (how resources are brought together) to "co-located" (the physical proximity of services) to fully "integrated" (how services are framed and delivered).[56] The framework outlines the key elements, advantages, and challenges of each level of integration, characteristics of the patient experience, and business and reimbursement considerations at each level.

5. How to Implement Integrated Services

This section provides a framework for implementing integrated services in OTP settings, including a checklist overview (below), followed by detailed steps for each phase.

Checklist for Implementing Integrated Services

Phase	Specific steps[vi,vii]
1. Preparing for organizational change	☐ 1A. Identify a clinical liaison or champion, and establish an infectious disease implementation team ☐ 1B. Prepare an infectious disease implementation team to engage in the organizational change process ☐ 1C. Develop goals and metrics for organizational change
2. Planning	☐ 2A. Determine an onsite education plan ☐ 2B. Determine onsite screening model and screening procedures ☐ 2C. Determine where patients will be treated for HIV, HCV, or syphilis
3. Braiding and leveraging funding	☐ 3A. Assess existing resources ☐ 3B. Identify program needs ☐ 3C. Identify funding sources
4. Building workforce capacity	☐ 4A. Provide training for staff around health disparities and syndemics, implicit bias, harm reduction principles, and client-centered counseling ☐ 4B. Provide staff with training around HIV, HCV, and syphilis, and their disproportionate impact on people who use drugs ☐ 4C. Develop and empower the infectious disease care team
5. Developing protocols and procedures	☐ 5A. Develop education policies and procedures defining how and where services occur ☐ 5B. Develop screening policies and procedures defining how and where services occur ☐ 5C. Develop linkage to care policies and procedures defining how and where services occur
6. Ensuring care, coordination, and linkage to services	☐ 6A. Ensure patient connection to health insurance coverage and treatment discount programs ☐ 6B. Coordinate recovery supports for patients undergoing HIV, HCV, or syphilis treatment
7. Assessing and evaluation	☐ 7A: Plan for iterative assessment and evaluation of services ☐ 7B: Implement assessment and adjust program activities as needed

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[vi] Note: Successful implementation may not require every step, but these steps, especially planning steps that engage staff, will increase organizational buy-in, allow you to anticipate barriers, and ensure you have the resources needed.

[vii] All steps should be culturally informed and reflect the diversity of the communities and patients served.

Phase 1: Preparing for Organizational Change

HIGH-LEVEL QUESTIONS:

- Is leadership on board with moving toward an integrated services model?
- Who are the key staff who can drive the process of organizational change?
- What are the underlying goals of the OTP's shift toward an integrated care model?

KEY STEPS, ACTIVITIES, AND CONSIDERATIONS

Activities	Considerations
Step 1A. Identify a clinical liaison or champion, and establish an infectious disease implementation team	
☐ Assess staff for appropriate people to fill various team roles (see next page) ☐ Assign roles to team members ☐ Ensure adequate work time is built into team members' schedules to address service integration implementation	Key features of a clinical champion include: - strong communication skills - passion for infectious disease service integration - a good foundation of understanding about co-occurring disorders
Step 1B. Prepare an infectious disease implementation team to engage in the organizational change process	
☐ Ensure team members are adequately informed about their roles and the purpose of their work ☐ Develop a decision-making process with the implementation team ☐ Ensure leadership buy-in for the implementation of infectious disease services ☐ Assess current agency policies and protocols with implementation team members	Taking time to review screening and linkage procedures provides an opportunity to streamline patient flow, staff communication, and team roles by updating/improving protocols Tools to support assessment: - *The Organizational Assessment Toolkit for Primary and Behavioral Healthcare Integration*[57] - *Medical Case Management (MCM) Toolkit*[58] (Hepatitis Education Project)
Step 1C. Develop goals and metrics for organizational change	
☐ Develop targets around both the OTP service integration process and patient outcomes (e.g., number of screenings, number of treatment initiations, etc.) ☐ Develop a monitoring plan and ensure iterative evaluation of new services	Tools to support goal development: - The SMART (**S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**imely)[59] method can support development of team goals that are feasible, actionable, and clear - The NIATx Model (niatx.net)[60] from the University of Wisconsin-Madison offers tools to support teams in making process improvements

EXAMPLES: INFECTIOUS DISEASE IMPLEMENTATION TEAM MEMBERS

Team Member	Roles and Responsibilities
Clinical Champion	- Passionate and knowledgeable about infectious disease 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 services and provides clinical expertise around both OUD and infectious disease - Will likely lead the Care Team (which will eventually replace the Implementation Team)
Behavioral Health Lead	Behavioral health (BH) provider who supports integrated infectious disease services and provides BH expertise around both OUD and infectious disease
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 or treated as a patient - See additional guidance on peer support specialists in Resources Section
Assessment and Evaluation Lead	Provides guidance on process improvement data, EHR, how to measure progress on infectious disease integration and evaluation data collection
Administrative Lead	Staff member knowledgeable about policies, procedures, finances and other key administrative issues

Phase 2: Program Planning

HIGH-LEVEL QUESTIONS:

- How will screening and treatment be offered?
- What are the key roles for the various processes and who will fill them?

KEY STEPS, ACTIVITIES, AND CONSIDERATIONS

Activities	Considerations
Step 2A. Determine an onsite education plan	
☐ Develop process for iterative staff education ☐ Develop plan to socialize patients to the programmatic shifts and educate them about HIV, HCV, and syphilis	• The clinical champion should lead this work • Centering both staff and patients in iterative, required educational efforts is key to increase the sense of buy-in needed for service integration • *Note:* The plan for staff education should include 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, and trauma-responsive integrated care
Step 2B. Determine onsite screening model and screening procedures	
☐ Develop screening process and protocols ☐ Develop partnerships with local clinics if the OTP won't manage the screening process internally	• For OTPs that have existing formalized agreements and coordinate with healthcare partners, the shift may be to better merge systems to provide integrated care • OTPs without existing partners may need to conduct an inventory of community and online resources to establish partnerships with healthcare organizations who understand addiction medicine and MAT • It is often helpful to have formalized Memorandums of Understanding (MOUs) with clinical partners to delineate roles and responsibilities (see next page)
Step 2C. Determine where patients will be treated for HIV, HCV, or syphilis	
☐ Develop linkage to treatment process and protocols ☐ Develop partnerships with local clinics if the OTP won't manage the treatment process internally	• For OTPs that have existing formalized agreements and coordinate with healthcare partners, the shift may be to better merge systems to provide integrated care • OTPs without existing partners may need to conduct an inventory of community and online resources to establish partnerships with healthcare organizations who understand addiction medicine and MAT • It is often helpful to have formalized Memorandums of Understanding with clinical partners to delineate roles and responsibilities

KEY CONSIDERATIONS FOR DEVELOPING MOUS WITH PARTNER AGENCIES

☑ **Do your homework!**

- Make sure you know who the other providers are in the area that work with PWUD.

- Research local HIV and homeless service organizations, FQHCs, and infectious disease or gastroenterology practices.

☑ **Put in some face time!**

- Request to have in-person meetings or coffee dates if possible

- Bring any clinic info and/or "swag" you can offer (pamphlets, branded pens or pads of paper, etc.)

- Focus on overlaps in your respective scopes of work and populations served

☑ **Be prepared!**

- Come with specific ideas about possible collaborations between your agencies or practices. These may include:

   ▪ Referral pathways for infectious disease treatment and/or co-location of services

   ▪ Working together on specific grant applications or other funding opportunities

☑ **Make yourself useful!**

- Offer to do an in-service for a potential partner organization's staff about your services, or MOUD in general.

- Volunteer to be their "warm handoff" touchpoint.

☑ **Be patient.**

- Relationship building can take some time, but consistency is key to the process's success.

Phase 3: Planning for Funding and Sustainability

HIGH-LEVEL QUESTIONS:

- How can existing funding be leveraged for the shift to an integrated services model?
- How might partnerships and subcontracts be utilized to support this work?
- What grant opportunities should be considered?
- How might the state or local Health Department be able to support this work?

KEY STEPS, ACTIVITIES, AND CONSIDERATIONS

Activities	Considerations
Step 3A. Assess existing resources	
☐ Determine if any existing funding streams can help cover costs of infectious disease services	• OTPs should think broadly about what resources support their program
Step 3B. Identify program needs	
☐ Tabulate the costs associated with staffing, lab fees, nursing times and other programmatic costs to more clearly define the program budget	• The type of screening implemented by the OTP will influence program cost (lab processing fees, the costs of rapid test kits, etc.)
Step 3C. Identify funding sources	
☐ Assess the landscape of possible local or federal grants that are a good fit for your program	• There are several tools that can offset the costs of treatments in the event that it is not fully covered
☐ Meet with the viral hepatitis coordinator at your city or state Health Department to get a sense of where hepatitis funding in your state is directed	• Section 6 provides additional resources on this topic and examples of funding sources
☐ Forge partnerships with entities and organizations funded to do infectious disease screening and management work	

Phase 4: Building Workforce Capacity

HIGH-LEVEL QUESTIONS:

- What are the education needs of staff and patients?
- Who is available to provide education sessions to OTP staff and patients?

KEY STEPS, ACTIVITIES, AND CONSIDERATIONS

Activities	Considerations
Step 4A. Provide training for staff around health disparities and syndemics, implicit bias, harm reduction principles, and client-centered counseling	
☐ Identify training materials and resources for staff training ☐ Audit agency policies and replace stigmatizing language with more inclusive language ☐ Ensure training happens on an ongoing basis	• The Opioid Response Network, NASTAD, and the National Harm Reduction Coalition all offer free trainings relevant to a variety of substance use and infectious disease topics
Step 4B. Provide staff with training around HIV, HCV, and syphilis, and their disproportionate impact on people who use drugs	
☐ Ensure staff have foundational knowledge and buy-in around HIV, HCV, and syphilis in OTP populations ☐ Encourage staff to include goal setting around infectious disease prevention and care as part of OTP treatment planning and counseling ☐ Develop consistent messaging for all staff to adopt regarding the importance of accessing HIV, HCV, and syphilis prevention, screening, and care services	• Training processes should be adaptable to staff needs and concerns • Ongoing training, conversations, and support around integration help prevent loss of institutional knowledge in the event of staff turnover
Step 4C. Develop and empower the infectious disease care team	
☐ Identify staff recruitment needs to sustain expanded services ☐ Provide ongoing supervision and support to the Care Team and broader staff	• Note: The Care Team will eventually replace the Implementation Team • Telehealth models 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 voice valid concerns and highlight training or program needs

Phase 5: Developing Protocols and Procedures

HIGH-LEVEL QUESTIONS:

- Are there existing protocols and procedures at other OTPs that would be useful for inspiration and/or adaptation?
- Is it necessary to develop MOUs with partner agencies?
- Will the program adopt an opt-out model?
- How will education be integrated into the screening process?

KEY STEPS, ACTIVITIES, AND CONSIDERATIONS

Activities	Considerations
Step 5A. Develop education policies and procedures defining how and where services occur	
☐ Identify an existing curriculum to use, and/or develop an OTP-specific curriculum ☐ Develop MOUs with partnering agencies ☐ Ensure that staff are aware of and understand the reasoning behind new policies	• If OTPs are collaborating with off-site providers, care should be coordinated with medical organizations who (i) are educated on SUDs and SUD treatment and (ii) will not stigmatize or traumatize patients from OTPs • Note: Additional guidance on developing MOUs is provided on page 23
Step 5B. Develop screening policies and procedures defining how and where services occur	
☐ Identify an existing curriculum to use (see resources section on page 43 for examples), and/or develop an OTP-specific curriculum ☐ Develop MOUs with partnering agencies ☐ Ensure that staff are aware of and understand the reasoning behind new policies	• SAMHSA recommends offering opt-out routine, integrated screening, and rapid screening with ongoing follow-up for all OTP patients[62] • Many screening and screening procedures can be integrated into existing protocols for OUD services, during intake or routine appointments at the OTP • Identifying and leveraging how screening services can be integrated into current workflow will minimize burden on staff and patients and support patient engagement, making patients less likely to opt out
Step 5C. Develop linkage to care policies and procedures defining how and where services occur	
☐ Adapt an existing OTP policy, and/or develop one for a specific OTP ☐ Develop MOUs with partnering agencies ☐ Ensure that staff are aware of and understand the reasoning behind new policies	• Telehealth models have been used effectively in rural areas and in tribal communities to connect patients with behavioral health and other medical services unavailable in their areas[63]

Phase 6: Ensuring Care, Coordination, and Linkage to Services

HIGH-LEVEL QUESTIONS:

- Can directly observed therapy for infectious disease treatment be offered with MAT dosing?
- What prescribing providers will the program work with?
- If treatment is not prescribed onsite, how can the program assure warm and efficient handoffs to other programs?

KEY STEPS, ACTIVITIES, AND CONSIDERATIONS

Activities	Considerations
Step 6A. Ensure patient connection to health insurance coverage and treatment discount programs	
☐ The care coordination team should ensure familiarity with patients' commonly used insurance plans, options for patient assistance programs, 340B coverage, and co-pay assistance programs	• This will likely look different in states that have expanded Medicaid and have lower proportions of uninsured patients, and states that have not, which will likely have higher numbers of uninsured patients • For patients who are uninsured or underinsured, medications may be available to OTPs at a significant discount through the 340B program[64] • OTP staff can support patients by identifying options for medication and treatment, such as patient-assistance programs (PAPs) and co-pay programs[65]
Step 6B. Coordinate recovery supports for patients undergoing HIV, HCV, or syphilis treatment.	
☐ Care coordination should ensure familiarity with local support services and options related to transportation, housing, mental health support, and medical care ☐ Provide counseling, education, and harm reduction resources to prevent overdoses and HCV or syphilis reinfection	• Barriers to retention in care for patients with OUD and infectious disease 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 • Syringe service programs (SSPs) promote a point of entry into treatment, and people who inject drugs who use SSPs are five times more likely to enter OUD treatment[66]

Phase 7: Assessing and Evaluating

HIGH-LEVEL QUESTIONS:

- What are the metrics and targets?
- What is an attainable evaluation design, and whose role will it be to implement it each year?
- How often will evaluation process occur?

KEY STEPS, ACTIVITIES, AND CONSIDERATIONS

Activities	Considerations
Step 7A: Plan for iterative assessment and evaluation of services	
☐ Develop an attainable evaluation plan at the outset of the service integration process ☐ Define goals and metrics of the program ☐ Identify key staff on the Care Team to carry out the evaluation work	• 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 • Logic models and care cascades can be useful evaluation tools (examples on next page)
☐ Adjust the electronic health record (EHR) to automate data collection and performance measurement	• A clinical-decision support system embedded into an EHR can summarize important data, provide reminders to staff to collect key data points, and support care coordination across systems (if data-sharing agreements are in place) • Patient forms, charts, and the EHR will likely need to be adapted to capture the required elements for patient records and reporting; OTPs should also consider their capacity to extract EHR data, as it may be necessary to consider the costs of technology consultants or software • It is key to train necessary staff on EHR modification to ensure quality data capture; see Resources section for tools related to Health Information Technology
Step 7B: Implement assessment and adjust program activities as needed	
☐ Continue ongoing assessment and evaluation at regular intervals ☐ Make program improvements based on what is learned through evaluation	• Share findings with staff to ensure team-wide understanding of program learnings and changes

Useful Tools: Logic Models and Care Cascades

- 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 models[67] and capturing key program inputs and data points.

- The cascade of care is a way to organize and assess how a linkage model moves patients through a sequence of engagement in care, from prevention to screening to treatment to cure (if applicable).[68] By identifying the key steps between engagement in care and treatment (or cure), care cascades can help conceptualize interventions and identify key evaluation activities and metrics at each step of the cascade. Examples of care cascades for HCV[69] and HIV[70] are shown below.

HCV Care Cascade

HCV antibody positive → HCV RNA positive → Treatment initiated → Treatment completed → Sustained Virologic Response

HIV Care Cascade

Diagnosed with HIV → Linked to HIV Care → Received Care → Retained in Care → Achieved/ maintained viral suppression

Lessons from the Field: Additional Tips for Integrated Services

FOUR ADDITIONAL TIPS TO KEEP IN MIND THROUGHOUT IMPLEMENTATION[viii]

(i)   **Be aware of state policies and resources related to HIV, HCV, and syphilis screening and linkage**. For example, different states may have [different Medicaid restrictions][71] for HCV treatment or different eligibility criteria for support of the AIDS Drug Assistance Program (ADAP). It is essential to be aware of policy-driven barriers to infectious disease screening and treatment that may impact OTP patients, such as sobriety or prescriber restrictions, and to develop strategies around maneuvering these barriers and communicating them to patients. Having a strong foundational knowledge in these areas supports efficient clinic workflow.

(ii)   **Universal screening simplifies and streamlines integration**. As the majority of patients in many OTPs could be considered high risk for HIV, HCV, and/or syphilis, universal, "opt-out" testing, in which all patients are offered screening by default unless they refuse, may be more expedient than identifying high risk patients through assessment.

(iii)   **Drivers of effective workflow are diverse.** A variety of strategies contribute to workflow efficiency. For some OTPs, improving workflow might take the form of an in-house lab that processes all initial test results. For other OTPs, EHR flags have helped identify patients requiring follow up screening or treatment appointments. Other forms of workflow efficiency have included formal MOUs with FQHCs to provide treatment, peer support specialists who follow patients through treatment, and using telehealth for consultation between on-site and external clinicians about HCV treatment.

(iv)   **Anticipating and addressing patient barriers to care is key to patient access.** OTP patients may experience major barriers to accessing integrated or coordinated screening or treatment, such as a lack of access to transportation for external appointments and competing basic needs. Addressing these barriers, such as through rideshare vouchers, providing transportation, and using contingency management (motivational incentives like gift cards or small cash payments for completing care steps or appointments), is key to success.

[viii] These tips come from an interactive learning community focused on integration of HCV services in OTPs, hosted by the Addiction Technology Transfer Center Network Coordinating Office at University of Missouri Kansas City. The learning community included representatives from seven OTPs of varying sizes, in eight states. All participating programs completed action plans related to service integration at their site and tracked their progress through a set of change indicators. While this particular group was solely focused on HCV integration, their lessons learned are generalizable to addressing other areas of the syndemic.

Case Study: Integrating Infectious Disease Screening into OTP Workflows
Arizona's CODAC Clinic

CODAC is one of Arizona's oldest and most respected community providers of specialty care for mental illness, addiction, and trauma. What began as a grassroots drug abuse prevention program has grown into a multi-faceted organization that provides services across the entire spectrum of behavioral health care. The 380 clinic is located in Tucson, Arizona, and in 2018, CODAC turned its clinic into a program that operates twenty-four hours a day, seven days a week. The CODAC team has a goal to complete patient assessments and inductions as quickly as possible, with a target of having a patient onboarded and dosed within a three-and-a-half-hour window. Medication Assisted Treatment (MAT) is just one of the services that CODAC offers its patients—employment programs, pain management services, including acupuncture, primary care, OBGYN care, psychiatric services, nursing services, and individual and group counseling are also available at the clinic.

This drive to treat the whole patient underpinned CODAC staff's motivation to address HCV in-house. Staff noticed the high prevalence of HCV infection among their MAT patients and knew that these patients were more likely to complete treatment if it was offered onsite where they already came for methadone every day. CODAC staff started by identifying people from different departments who would play an integral role in HCV treatment protocols. They got feedback from other providers in the community who were treating HCV and began regularly consulting with a gastroenterologist in the community who was part of Project ECHO, a program that used telehealth and conferencing to increase clinical capacity to treat HCV. They also joined the University of Missouri-Kansas City Addiction Technology Transfer Center's HCV learning community, which was a group of several OTPs from around the U.S. who were starting to integrate HCV services into their substance use treatment services. This peer-based group exchanged their strategies, successes, and lessons learned.

Training staff onsite about the benefits of (i) curative HCV treatment and (ii) providing directly observed therapy for methadone patients taking HCV meds was one of the activities CODAC staff attribute to helping move their process along. While completing prior authorization requests for HCV treatment was initially the most intimidating and time-consuming piece of the HCV treatment process, CODAC HCV team members met with a representative from one of the insurance companies that commonly covered CODAC patients for targeted training and technical assistance. This intervention significantly reduced the time required to successfully complete the prior authorization process from as long as ten hours to about ten minutes.

As a result of having embraced the structural changes described above (identifying an HCV team and each team members' roles, seeking consultation with HCV experts, providing internal trainings about the benefits of HCV treatment, and seeking support to improve the likelihood of prior authorization requests being approved the first time), CODAC has seen impressive results. In the first five months of 2022, CODAC offered HCV antibody screening to 411, or almost half of its 870 MAT intake patients, identifying 92 patients who were antibody positive, and 38 patients who were RNA positive. CODAC continues to work toward universal HCV screening of all patients, and CODAC staff encourage other OTPs starting to integrate HCV screening and treatment protocols to seek guidance and support so as not be intimidated by the various steps in the HCV treatment process.

> **In the first five months of 2022, CODAC offered HCV antibody screening to 411, or almost half of its 870 MAT intake patients, identifying 92 patients who were antibody positive, and 38 patients who were RNA positive.**

Case Study: Working with Community-Based Clinical Providers Toward Service Integration The UCSF DeLiver Van and Fort Help Methadone Partnership

The DeLiver van is a program of the University of California San Francisco (UCSF) Liver Clinic and functions as a mobile, one-stop shop for HCV screening and treatment for marginalized communities in San Francisco. The DeLiver team partners with community-based organizations, homeless service sites, and drug treatment programs to offer HCV screening and treatment to patients accessing those services. In 2019, The DeLiver van piloted its services in partnership with the Fort Help methadone program in San Francisco, creating a model OTP/liver clinic partnership.

Prior to any screening activities at or near Fort Help, the DeLiver team met with the Fort Help clinic staff to give them information about what the DeLiver van could offer in terms of HCV services, including HCV antibody and RNA screening, as well as HCV treatment via telemedicine. They also met with a few Fort Help patients to talk to them about their HCV needs. They learned that insurance barriers can be difficult to overcome in efforts to implement universal HCV screening campaigns, which makes OTP/clinic partnerships an attractive work-around.

As Fort Help staff and patients expressed interest in moving forward with a partnership, the DeLiver team reserved a parking spot outside of the Fort Help clinic and began parking there weekly, offering rapid HCV screening to patients walking in and out of the clinic. If rapid tests were positive, the DeLiver team would do the venipuncture for confirmatory screening that same day, send it to the lab, and disclose the results to the patient when the van returned to Fort Help the following week. If the patient was viremic, DeLiver staff offered counseling options, and if the patient wanted to be treated by the DeLiver team, DeLiver staff would collect insurance information and pre-treatment labs and have a clinic visit that day. DeLiver would continue to see the patient through the full course of their treatment, utilizing a telehealth model on the van. This included discussing a treatment plan about how often they would like their medication and delivering the medications to the patients from the van.

Throughout this process, DeLiver and Fort Help worked together to optimize the screening and treatment opportunities for patients. Fort Help staff would proactively send patients to the van for screening and follow up appointments. Fort Help staff were also responsive to DeLiver's requests to flag patients and send them out when necessary. DeLiver staff attribute the effectiveness of the partnership to early and ongoing communication about each party's respective roles and responsibilities, and efforts to ensure the smooth ongoing functioning of the client identification, screening, and treatment processes.

Fort Help's Mission campus was the pilot site for the DeLiver van, and DeLiver screened 69 patients there, 39 (52%) of whom were HCV antibody-positive. Of the 12 patients who were RNA positive, DeLiver successfully treated and cured 8 patients. The DeLiver van then went to a second Fort Help campus, where they tested an additional 112 patients, 73 (65%) of whom were antibody-positive. At the second campus, DeLiver treated an additional 15 patients of the 27 who were RNA-positive. Ultimately, in the past three years, DeLiver has treated and cured dozens of patients in partnership with a variety of city settings, including methadone programs, shelters and navigation centers, and single-room occupancy hotels.

"Being open to listening and different ideas and being creative is really helpful."

- Dr. Jennifer Price, Medical Director of the UCSF Liver Clinic and DeLiver program

6. Financing and Sustaining Integrated Infectious Disease Services

This section will discuss considerations for financing and sustaining integrated infectious disease services in OTP settings.

Key Financing Challenges and Opportunities

While funding is a concern for many OTPs looking to implement integrated infectious disease services, there are increasing studies demonstrating the population benefits and the cost-effectiveness of increasing access to infectious disease treatment and care for PWID.[72-75] Identifying cost-effective screening and treatment approaches is key to financing and sustaining integrated services and providing life-saving medications.[75] Notably, federal funding mechanisms like SAMHSA and CDC are starting make key changes in funding structures to allow for a less siloed, more integrated approach to behavioral health care and infectious disease prevention and treatment.

While the costs of medications themselves can pose barriers to access (most notably in the cases of HIV and HCV, and in non-Medicaid expanded states), identifying financial support for the operational costs associated with infectious disease service integration at OTPs is crucial to the success of programming. This section will outline some possibilities for seeking financial support.

Are you aware of how infectious disease activities are funded in your state? Check in with your local and/or state health department!

The CDC PS21-2102 grant funds U.S. community-based programs to develop high impact HIV programs. The CDC PS21-2103 grant funds 49 states, Puerto Rico, and 8 US cities. These grants are focused on hepatitis disease surveillance, elimination planning, and related activities. There are additional federal grants that address syphilis and other STIs (see next page).

Get to know your state or local HIV team and hepatitis coordinators! They will be interested in how OTPs are addressing HIV, HCV, and STIs. Here are some helpful inquiries to consider in communication with Health Department viral hepatitis staff.

- What activities are funded under our state/city HIV, hepatitis, and STI grants?
- What other health department funding streams support infectious disease activities (e.g., SAMHSA)?
- Is it possible to utilize unspent/carry-forward funds for activities related to our OTP HCV screening and linkage program? (e.g., bulk purchasing rapid test kits, phlebotomy certification for staff)
- Are there community-based organizations or clinical staff you can connect our program to that can better support our efforts to test and treat our patients for HIV, HCV, and syphilis?
- Are there any special projects related to HIV, HCV, or syphilis—such as a health plan that is doing a demo project or a quality improvement effort, or 340B-funded efforts that you are aware of?

Strategies and Resources for OTPs Pursuing Funding

The table below lists strategies available to OTPs looking to integrate HIV, HCV, and syphilis screening and treatment.

Strategy	Additional Information
Pursuing grant funding	Federal agencies such as SAMHSA, CDC, NIDA, and HRSA, under the Department of Health and Human Services (DHHS), as well as the Department of Justice, are all offering grant funding to address the opioid epidemic and/or the intersection of OUD with HCV.[76] Foundations such as Aetna Foundation[77] 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.[78] CDC has an initiative specific to addressing the infectious disease consequences of the opioid epidemic.[79] State Targeted Response (STR) and State Opioid Response (SOR) funding supports OTPs looking to expand MAT and integrate HCV services.[80]
Braided and blended funding	Braiding and blending funding are strategies that local health departments often employ to combine funding streams to support a particular public health goal or initiative.[81] 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. While a single one of these grants may not pay for entire infectious disease program at an OTP, different combinations of smaller funding streams may be able to support various aspects of programming.
Partnering with grant-funded infectious disease programs	OTPs that have not secured adequate funding for integration of testing and treatment services may find success in partnering with agencies that are funded to do this work. Local and state health departments frequently fund community-based organizations to perform community-based infectious disease testing with high-risk populations; these programs are often equipped to offer some degree of mobile testing and may be more than willing to test regularly at OTP sites to satisfy their grant requirements.
340B Funding[82]	The 340B Pricing Program provides financial support to clinical entities serving vulnerable communities. The program allows manufacturers participating in Medicaid to sell outpatient drugs at discounted prices. 340B programs, then, can utilize medication cost savings to support programmatic staffing and infrastructure costs.

Medicaid Policy and HCV Treatment Access:
A Case Study of Advocacy and Incremental Change

When the highly effective, direct-acting antiviral medications for HCV first became available in 2014, the "$1,000 per pill" price tag for the lifesaving treatment drew considerable media attention and criticism from patient advocacy groups.[83] The perceived high cost of the treatment prompted insurance payors to establish various criteria around which patients could be prescribed HCV treatment because they were nervous about the cost to treat the large number of Americans who were living with HCV. Treatment restrictions are enforced using prior authorization, a process whereby health care providers must get advance approval from a payor, who will decide whether to cover a medication or service.

Medicaid treatment restrictions are especially relevant because people newly infected with or living with HCV are disproportionately insured under Medicaid, compared with private insurance,[84] and commercial insurers often follow the lead of Medicaid policy and adopt similar restrictions. In 2017, the National Viral Hepatitis Roundtable and the Center for Health Law and Policy Innovation of Harvard Law School partnered to launch "Hepatitis C: State of Medicaid Access," a project to track these restrictions and grade state Medicaid plans on their HCV treatment accessibility.

The project focused on three common restrictions: (1) liver disease progression, or requiring a certain stage of liver disease (i.e., fibrosis) be reached before treatment, (2) sobriety requirements, and (3) prescriber requirements, which dictate that only certain healthcare providers are eligible to prescribe HCV treatment. The 2017 full report, available on the [Hepatitis C: State of Medicaid Access website](#),[71] summarizes the widespread use of these restrictions across the U.S.

Over time, the combined forces of (i) advocacy, supported by these reports, and (ii) more competitive pricing for HCV medications resulting from additional HCV regimens coming to market, contributed to a general trend toward expanded HCV treatment access nationally. The Hepatitis C: State of Medicaid Access January 2022 progress report notes that "33 states have either eliminated or reduced fibrosis restrictions, 29 have loosened their sobriety restrictions, and 28 have scaled back their prescriber restrictions."[71] Eleven additional states have removed prior authorizations to access HCV treatment for most patients entirely.

While these victories are significant and crucial, restrictions persist in many states. Moving forward, the National Viral Hepatitis Roundtable and the Center for Health Law and Policy Innovation of Harvard Law School are now taking a broader approach and will soon begin tracking additional restrictions based on feedback from patients, providers, and other stakeholders about ongoing barriers to treatment. For example, the group is monitoring whether managed care organizations are adhering to the same policies as fee-for-service organizations, as required by law. The group also plans to look at increased barriers to care for individuals seeking retreatment, compared to those seeking initial treatment.

Treatment Cost Support Resources for Patients

Medication costs are prohibitive for some patients, but HIV and 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 medications, and pharmaceutical companies may offer patient-assistance programs or co-pay programs to support enhanced patient care.

Resource	Description
ADAP	The AIDS Drug Assistance Program (ADAP) is under the Ryan White HIV/AIDS Program Part B and can help cover the costs of FDA-approved medications for those who are low-income and living with HIV. Eligibility for ADAP support varies by state.
340B program	As part of an emergency response plan to meet treatment needs, HRSA provides eligible healthcare organizations (340B Eligibility[85]) discounted prices on prescription medications from drug manufacturers. This includes medications for OUD as well as for HCV.[64]
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. Examples of PAPs include: • Gilead Support Path: https://www.mysupportpath.com/ • AbbVie Patient Assistance Program: https://www.mavyret.com/ • Merck C Ahead Patient Support: https://www.merckhelps.com/ZEPATIER • Bristol Myers Squibb Patient Assistance: Foundation: https://www.bmspaf.org/
Co-pay	Fair Pricing Coalition (FPC) has negotiated co-pay programs with virtually every major hepatitis drug manufacturer.[65]
Help-4-Hep	Help-4-Hep[86] 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 screening 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[87] helps qualifying patients without prescription drug coverage get the medicines they need by matching them with the right assistance programs. (888-477-2669)

7. Glossary and List of Acronyms

List of Acronyms Used

ACRONYM	MEANING
AASLD	American Association for the Study of Liver Diseases
ADAP	AIDS Drug Assistance Program
ART	Antiretroviral therapy
ATTC	Addiction Technology Transfer Center
ATTC NCO	Addiction Technology Transfer Center Network Coordinating Office
BH	Behavioral health
CDC	Centers for Disease Control and Prevention
CIHS	Center for Integrated Health Solutions
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
DAA	Direct-acting antiviral
DBS	Dried Blood Spot Screening
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
HCV	Hepatitis C Virus
HIV	Human immunodeficiency virus
HRSA	Health Resources and Services Administration
IDU	Injection drug use
MAT	Medication-assisted treatment
MCM	Medical case management
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MSM	Men who have sex with men
NIATx	Network for Improvement of Addiction Treatment
NIDA	National Institute for Drug Abuse
ORN	Opioid Response Network

OTP	Opioid treatment provider/program
OUD	Opioid use disorder
PAP	Patient assistance program
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
PSS	Peer support specialist (peer recovery-support specialist)
PWID	People who inject drugs
RNA	Ribonucleic acid
RVR	Rapid virologic response
SAMHSA	Substance Abuse and Mental Health Services Administration
SMART	Specific, Measurable, Achievable, Relevant, Timely
SOR	State Opioid Response
SSP	Syringe service program (syringe exchange program)
STI	Sexually transmitted infection
STR	State Targeted Response
SUD	Substance use disorder
SVR	Sustained virologic response
VA	Veterans Affairs

Glossary of Terms

The terms below include some key concepts and linked resources. Additional glossaries we recommend that more comprehensively cover terms related to healthcare, infectious disease, and recovery are:

- ☐ The [Addictionary](#), 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](#)

- ☐ The healthcare.gov [Glossary](#)

TERM	DEFINITION
Antibody test	Antibody tests check for the presence of antibodies, which are proteins that your immune system makes to fight foreign substances. A positive antibody test does not necessarily mean there is a current infection; it may only be an indication of a prior infection.
Antigen test	An antigen test detects the presence of a specific viral antigen, which suggests current infection.
Co-occurring disorders	Alternatively referred to as dual diagnoses, a [co-occurring disorder](#) 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.

TERM	DEFINITION
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.
Evidence-based practice	Evidence-based practice (EBP) is the conscientious use of current best evidence in making decisions about patient care.[88] It is a problem-solving approach to clinical practice and administrative issues that integrates: • A systematic search for and critical appraisal of the most relevant evidence to answer a burning clinical question • One's own clinical expertise • Patient preferences and values[89] 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.
Extrahepatic impact	Impact of HCV on brain and mood changes, as well as exacerbating existing diseases, such as diabetes, kidney disease and arthritis.
Fee-for-service	A method in which doctors and other healthcare providers are paid for each service performed. Examples of services include tests and office visits.
Harm reduction	According to the National Harm Reduction Coalition, 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.
Memorandum of Agreement/ Understanding	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.

TERM	DEFINITION
Motivational interviewing	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 screening which incorporates motivational interviewing skills.
Patient assistance programs	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.
Person-centered care (Client-centered care, Patient-centered care)	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.
Rapid initial screening	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 screening.
Rapid virologic response	Rapid virologic response (RVR) is defined as non-detection of HCV RNA four weeks after starting treatment.
Recovery	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."

TERM	DEFINITION
Recovery-oriented systems of care	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."
Return on investment (ROI)	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.
Sustained virologic response	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.
Syringe service programs (syringe exchange programs)	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, screening, 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 screening, 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.
The Stages of Change Model	Also known as The Transtheoretical Model, this theory of change model 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. 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.

TERM	DEFINITION
Trauma-informed care	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, including sexual and physical abuse, for women who use substances 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.

8. Resources

General HIV Information

WEBSITES AND FACT SHEETS

- CDC's **HIV Basics video -** https://youtu.be/12vTnXekJu8

- CDC's **HIV 101 Fact Sheet** - https://www.cdc.gov/hiv/pdf/library/consumer-info-sheets/cdc-hiv-consumer-info-sheet-hiv-101.pdf

- CDC's **Resources for People Living with HIV** - https://www.cdc.gov/hiv/basics/livingwithhiv/resources.html

- The White House's **National HIV/AIDS Strategy 2022-2025 -** https://files.hiv.gov/s3fs-public/NHAS-2022-2025.pdf

ONLINE TRAININGS

- AIDS Education and Training Center's **National Coordinating Resource Center -** https://aidsetc.org/training

- NY Department of Health's **Overview of HIV Infection and AIDS -** https://www.hivtrainingny.org/Account/LogOn [Note: You will need to create a free account in order to access this page.]

HIV SCREENING

- CDC's **HIV Screening Materials** - https://www.cdc.gov/hiv/clinicians/materials/screening.html

- New York State Department of Health's AIDS Institute **HIV Testing Clinical Guidelines -** https://www.ncbi.nlm.nih.gov/books/NBK581840/

HIV TREATMENT PROTOCOLS

- HIV.gov **Clinical Guidelines** - https://clinicalinfo.hiv.gov/en/guidelines

- CDC's **HIV Treatment and Care -** https://www.cdc.gov/hiv/clinicians/treatment-care/index.html

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 2021-2025** https://www.hhs.gov/sites/default/files/Viral-Hepatitis-National-Strategic-Plan-2021-2025.pdf

- CDC's **Viral Hepatitis Prevention Point of Contact** contains contact information for state HCV coordinators - https://www.cdc.gov/hepatitis/policy/2103_CoAg-contacts.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

- SAMHSA's **HCV Screening in the Behavioral Healthcare Setting** - https://store.samhsa.gov/sites/default/files/sma15-4917.pdf

- CDC's **Hepatitis C: Information on Screening and Diagnosis** - https://www.cdc.gov/hepatitis/hcv/pdfs/hepcgeneralfactsheet.pdf

- University of Washington's **HCV Diagnostic Screening** - https://www.hepatitisc.uw.edu/go/screening-diagnosis/diagnostic-testing/core-concept/all

- FDA's **HCV Screening** - 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/screening-and-linkage

- AASLD's **Simplified HCV Treatment for Treatment-Naïve Patients Without Cirrhosis** https://www.hcvguidelines.org/treatment-naive/simplified-treatment

- Office of Infectious Disease and HIV/AIDS Policy's **Payment and Reimbursement for Integrated Hepatitis C Services** - https://www.hhs.gov/sites/default/files/payment-reimbursement-models-integrated-hepatitis-c-services.pdf

HCV MESSAGING AND COUNSELING

- 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://stacks.cdc.gov/view/cdc/31565

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/resource-hub/e-learning/roles-and-responsibilities-it-takes-team

General Syphilis Information

WEBSITES AND FACT SHEETS

- CDC's **Syphilis Basic Fact Sheet** - https://www.cdc.gov/std/syphilis/stdfact-syphilis.htm

- CDC's **Syphilis and MSM Fact Sheet -** https://www.cdc.gov/std/syphilis/stdfact-msm-syphilis.htm

- CDC's **Congenital Syphilis Fact Sheet** - https://www.cdc.gov/std/syphilis/stdfact-congenital-syphilis.htm

- Department of Health and Human Services' **Sexually Transmitted Infections National Strategic Plan for the United States 2021-2025 -** https://www.hhs.gov/sites/default/files/STI-National-Strategic-Plan-2021-2025.pdf

ONLINE TRAININGS

- University of Washington's National STD Curriculum's **Self-Study STD Lessons: Syphilis -** https://www.std.uw.edu/custom/self-study/syphilis [Note: You will need to create a free account in order to access this training.]

SYPHILIS SCREENING

- CDC's **Screening Recommendations and Considerations Referenced in Treatment Guidelines and Original Sources** - https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm

- JAMA Patient Page's **Screening for Syphilis -** https://jamanetwork.com/journals/jama/fullarticle/2796689

SYPHILIS TREATMENT PROTOCOLS

- CDC's **Sexually Transmitted Infections Treatment Guidelines, 2021: Syphilis -** https://www.cdc.gov/std/treatment-guidelines/syphilis.htm

- CDC's **Sexually Transmitted Infections Treatment Guidelines, 2021: Syphilis, Managing Persons Who Have a History of Penicillin Allergy -** https://www.cdc.gov/std/treatment-guidelines/penicillin-allergy.htm

General OTP Management Information

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/assets/pdfs/EnhancedNationalCLASStandards.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.racialequitytools.org/resources/fundamentals/resource-list

- SAMHSA TIP 59: **Improving Cultural Competence** - https://store.samhsa.gov/sites/default/files/sma14-4849.pdf

ENGAGING COMMUNITY SUPPORT FOR OTPS

- **Inclusive Civic and Community Engagement Resources** - https://www.racialequitytools.org/act/strategies/civic-or-community-engagement

ESTABLISHING PARTNERSHIPS

- 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/resources/medication-assisted-treatment-mat-for-opioid-use-disorder-in-jails-and-prisons-a-planning-and-implementation-toolkit/

- 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

- 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 **Trauma-Informed Care 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/Trauam%20Informed%20Organizational%20Survey_9_13.pdf

INTEGRATING PEER SUPPORT SPECIALISTS (PSS)

- NYC Department of Health and Mental Hygiene's **Workforce Integration of Peer and Community Health Workers Toolkit** - https://www.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/ToolkitForPeerAdvocates_0.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

- SAMHSA's **How can a Peer Specialist Support My Recovery From Problematic Substance Use? For People Seeking or In Recovery** is a client-centered resource to help clients understand how peer specialists might support their recovery journey - https://store.samhsa.gov/sites/default/files/how-can-peer-specialist-support-my-recovery-problematic-substance-use-for-people-seeking-recovery-pep23-02-01-004.pdf

TELEHEALTH

- The Association of State and Territorial Health Officials' (ASTHO) **Telehealth Resource Guide** - https://legacy.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://telehealthresourcecenter.org/collections/

- **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 the ECHO model - https://projectecho.unm.edu/

  - For an example of an HCV-specific Project Echo model - https://viralhep.ucsf.edu/echo

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 - https://hepatitisc.pafcareline.org/

- **Hepatitis Patient Assistance Program**, co-pay programs, and other resources for viral hepatitis drugs - https://www.hepmag.com/basics/liver-health/paying-treatment

INTEGRATED CARE

- 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. The framework includes a spectrum that ranges from "coordinated" (how resources are brought together) to "co-located" (the physical proximity of services) to fully "integrated" (how services are framed and delivered). The framework outlines the key elements, advantages, and challenges of each level of integration, characteristics of the patient experience, and business and reimbursement considerations at each level. - https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56

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