Hepatitis C Telehealth Toolkit:

An Implementation Guide for Clinicians and Healthcare Agencies

DEVELOPED IN COLLABORATION WITH

CEI Clinical Education Initiative, New York State Department of Health AIDS Institute

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REACH

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HCV Telehealth Toolkit

Acknowledgements: This toolkit was developed in collaboration with the New York State Department of Health AIDS Institute Bureau of Hepatitis Health Care and Epidemiology, the New York City Department of Health and Mental Hygiene Viral Hepatitis Program and the New York State Office of Addiction Services and Supports (OASAS).

Introduction

Telehealth can facilitate clinical monitoring and interaction between a clinician and a client in disparate locations. It seeks to reduce geographic and temporal barriers to healthcare access, and expand the reach of healthcare services beyond the traditional clinical setting. Telehealth grew rapidly in 2020 due to the SARS-CoV-2 (COVID-19) pandemic and, its acceptance, effectiveness and feasibility have been demonstrated across most aspects of medicine and healthcare.

Telehealth for hepatitis C virus (HCV) education, evaluation and treatment has been shown to be a valuable tool for providing care to individuals who live in rural areas and/or areas that are resource scarce.[1-3] In general and for HCV care specifically, telehealth is also useful for expanding access to HCV treatment for people who do not engage with traditional healthcare settings. It provides a safe option for clients to receive healthcare when and where they need it, in the most effective manner possible. This is particularly supportive for those who are impacted by healthcare inequities and/or negatively impacted by social drivers of health. This includes people who use drugs (PWUD) who are more likely to contract HCV.[4-6]

Telehealth is particularly successful when integrated into non-traditional settings frequented by PWUD, such as syringe service and harm reduction programs and substance use disorder treatment programs, among others.[4-6] These non-traditional settings typically foster destigmatizing environments where engaged PWUD may be more likely to accept and adhere to treatment if it is delivered in a location that is convenient, supportive and familiar.[5,6] Integrating telehealth for HCV treatment into these settings may also help ensure that clients have access to necessary technology and broadband requirements through onsite care coordination.[4] Co-locating HCV telehealth within substance use disorder treatment programs is also beneficial, as other program attendance requirements and structure can help facilitate HCV treatment.[4]

In addition to co-locating telehealth within frequented settings by creating partnerships, assessments of telehealth programs for PWUD and HCV have identified several key facilitating factors. These include endorsement from staff at all levels, building trust between client and provider by delivering person-centered care and addressing competing priorities that is then reinforced by the setting, and addressing and minimizing client concerns related to privacy and confidentiality.[5-8] Studies also note that HCV telehealth is facilitated by the low burden of treatment, fewer monitoring requirements and increased efficacy of direct-acting antivirals (DAAs), as compared with previous modes of treatment.[6,9] These characteristics of DAAs make expanding HCV treatment beyond a non-traditional healthcare setting more feasible.[6]

This Toolkit aims to serve as a practical guide to the implementation of HCV telehealth as a client-centered approach. It is intended to support both the non-traditional healthcare setting interested in providing HCV treatment via telehealth and the telehealth agency itself. Using standardized role descriptions, we illustrate some of the various types of partnerships and settings in which HCV telehealth can be successfully implemented, as well as best practices and minimum requirements for implementation. Each distinct framework for HCV telehealth implementation can be expanded to other difficult to reach populations. The frameworks are extremely flexible and can be adapted or combined to fit various settings, as needed.

Hepatitis C Telehealth Frameworks

Tele-Harm Reduction

Tele-harm reduction is a telehealth enhanced harm reduction intervention delivered within a harm reduction-oriented non-traditional healthcare setting.

Facilitated Telehealth with Onsite Clinician

The facilitated telehealth model utilizes a case manager to identify persons with HCV in substance use disorder treatment programs, connect them to an HCV provider through onsite telehealth and provide support services to address competing priorities. An onsite clinician evaluates clients' health outcomes by obtaining vitals, performing physical examinations and monitoring adherence for substance use disorder treatment.

Facilitated Telehealth without Onsite Clinician

The facilitated telehealth model utilizes a case manager to identify persons with HCV in substance use disorder treatment programs, connect them to an HCV provider through onsite telehealth and provide support services to address competing priorities. Without an onsite clinician, the care coordinator is responsible for managing additional responsibilities, such as obtaining vitals, performing physical examinations, drawing blood and monitoring attendance. Care coordinator responsibilities depend on the discipline and training of each individual care coordinator.

Roles, Responsibilities & Settings

Many key roles in telehealth are flexible, and potentially interchangeable. Successful implementation of HCV telehealth requires flexibility to optimize available resources, and does not always follow a designated framework. The roles listed below can be filled by other staff who are available and qualified. For example, a nurse or qualified navigator could also fill the role of care coordinator. Individuals responsible for key steps across the HCV treatment cascade in three distinct telehealth frameworks are outlined in **Table 1** on Page 6.

Care Coordinator

Care coordinators assist clinical staff and clients across the HCV care continuum. They provide client education related to HCV treatment and telehealth; address clients' competing priorities; arrange telehealth appointments; support linkage to care and appropriate social services; facilitate communication between clinician and client; provide technology support, as needed; and assist clinical staff pre- and post-telehealth visit. Depending on education and clinical ability, Care Coordinators may also administer rapid HCV tests and conduct phlebotomy. Common interchangeable names for Care Coordinators include (Nurse) Care Managers, Community Health Workers and Client Navigators, among others.

Hepatitis C Peer Navigator

HCV peer navigators commonly work in harm reduction settings. They are individuals with lived experience, meaning they have previously had or are currently living with HCV, and can therefore play a crucial role in client education and adherence. HCV peer navigators provide referral to support services, share results with clients and provide health education. HCV peer navigators may also conduct HCV testing, assist the client with telehealth technology support, and remind clients of upcoming appointments with their telehealth provider.

Non-traditional Healthcare Setting

Traditional healthcare settings in which a client typically receives routine medical care, including preventive check-ups, include hospitals, clinics and community health centers, among others. In contrast, non-traditional healthcare settings include locations a client would not typically visit for routine medical care. Examples include syringe service and harm reduction programs and substance use disorder treatment programs, including mobile clinics. Although they do not solely relate to drug user health, prisons, jails and homeless shelters are other non-traditional healthcare settings.

Telehealth Provider

The individual clinician (e.g., MD, DO, NP, PA) affiliated with the telehealth agency responsible for conducting clinical visits via telehealth. Example telehealth providers include clinicians experienced in providing HCV treatment, such as gastroenterologists and liver specialists; primary care and infectious disease providers; and addiction medicine specialists, among others.

In the table below, each column relates to one of the three HCV telehealth frameworks described above. Headings for each row represent key milestones across the HCV treatment continuum. At the intersection of a framework and milestone is the person or agency responsible for the activity.

Table 1. Hepatitis C Telehealth Key Activities, Roles and Responsibilities

	Tele-Harm Reduction	Facilitated Telehealth with Onsite Clinician	Facilitated Telehealth without Onsite Clinician
Preparation and Screening			
HCV Screening	HCV Peer Navigator affiliated with Non-traditional Healthcare Setting	Non-traditional Healthcare Setting clinical staff	Non-traditional Healthcare Setting clinical staff
Laboratory testing	Care Coordinator affiliated with Non-traditional Healthcare Setting	Care Coordinator*	Care Coordinator affiliated with Telehealth Provider agency
Telehealth Implementation			
Care coordination	HCV Peer Navigator affiliated with Non-traditional Healthcare Setting	Care Coordinator*	Care Coordinator affiliated with Telehealth Provider agency
Baseline (initial) medical evaluation	Telehealth Provider	Telehealth Provider, in collaboration with clinician affiliated with Non-traditional Healthcare Setting	Telehealth Provider
Order HCV medication	Telehealth Provider	Telehealth Provider	Telehealth Provider
Treatment initiation clinical visit	Telehealth Provider	Telehealth Provider	Telehealth Provider
Track HCV medication refill/adherence	Non-traditional Healthcare Setting clinical staff	Non-traditional Healthcare Setting clinical staff	Non-traditional Healthcare Setting clinical staff
On-treatment monitoring visit(s)	Telehealth Provider	Telehealth Provider	Telehealth Provider
End-of-treatment visit	Telehealth Provider	Telehealth Provider	Telehealth Provider
SVR12 visit	Telehealth Provider	Telehealth Provider	Telehealth Provider
Post-treatment Follow-up			
Follow-up for potential reinfection	Non-traditional Healthcare Setting staff	Care Coordinator*	Care Coordinator affiliated with Non-traditional Healthcare Setting

** In Facilitated Telehealth with an Onsite Clinician, the Care Coordinator can be affiliated with either Non-traditional Healthcare Setting or Telehealth Agency*

Frameworks

Tele-Harm Reduction: Community-based Harm Reduction Agency Setting

Description: A non-traditional healthcare setting, in this case a community-based harm reduction agency, is partnering with an academic medical center. The harm reduction agency conducts outreach, syringe exchange, HCV testing and education. An **HCV Peer Navigator** at the harm reduction agency is responsible for delivering positive HCV RNA results and medication to the client via outreach; assessing treatment readiness; coordinating medical forms and insurance; coordinating pre-treatment bloodwork; and supporting the client with technology to facilitate telehealth visits, as needed. The **Telehealth Provider** affiliated with the academic medical center is responsible for pre-treatment evaluation, ordering/approving medication and subsequent visits via telehealth. A **Care Coordinator** affiliated with the non-traditional healthcare setting assists with laboratory testing. In addition, the academic medical center has primary care and liver specialists available, as needed.

Key Considerations: This example requires an established relationship between the two partner organizations as well as a qualified HCV Peer Navigator with lived experience able to contact and engage clients. Clients served in this setting need to have access to a working phone; if they do not have one the HCV Peer Navigator will need to provide access to one at the time of the telehealth visits.

Pro: Clients do not have to travel to a setting other than the harm reduction agency they are already frequenting.

Con: Some non-traditional healthcare settings struggle with insufficient resources, including staff, capacity to perform phlebotomy, availability of tests and existing agreements with telehealth providers, among others.

Facilitated Telehealth with Onsite Clinician: Substance Use Disorder Treatment Setting

Description: In this example, a **Care Coordinator** and **Telehealth Provider** are both affiliated with the same non-traditional healthcare setting (i.e., substance use disorder treatment program) and there is an outside partnership with the Telehealth Provider agency to conduct HCV treatment. The **Care Coordinator** is responsible for facilitating telehealth visits, clients and staff engagement and client interactions with the **Telehealth Provider**. The **Telehealth Provider** is responsible for obtaining vitals and conducting a physical exam prior to or at the time of the initial telehealth visit.

In this example, HCV treatment may be conducted entirely while the client is at the substance use disorder treatment program. Due to higher rates of housing instability among PWUD, there may be frequent changes in venues where individuals are housed. Continuing the example above, if the client had an initial telehealth visit while at the substance use disorder treatment program, then left to return to their shelter placement indicating an interest to continue to pursue treatment, the **Care Coordinator** would be responsible for facilitating subsequent telehealth visits with the **Telehealth Provider** from the client's shelter placement.

Key Considerations: This example requires flexibility and ongoing communication among all staff interacting with the client. The Care Coordinator needs to be able to work with clients once they leave the substance use disorder treatment program.

Pro: Highly flexible telehealth model that can be adapted to suit the unique needs of each client. The Care Coordinator can be affiliated with either the Telehealth Provider agency or a non-traditional healthcare setting.

Con: Frequent changes in venues where individuals are housed is common in this framework.

Facilitated Telehealth without an Onsite Clinician: In-patient Detox/Rehab Setting

Description: A non-traditional healthcare setting (i.e., in-patient detox/rehab facility) is partnering with a telehealth provider (i.e., primary care provider). Clinical staff at the in-patient detox/rehab facility conduct onsite phlebotomy, and are responsible for conducting blood work upon enrollment. Clients identified to have positive HCV RNA are referred to a **Care Coordinator** affiliated with the Telehealth Provider agency; they are responsible for obtaining consent, assessing treatment readiness and insurance status. Pre-treatment bloodwork is conducted by the **Care Coordinator** affiliated with the Telehealth Provider agency. Staff affiliated with the in-patient detox/rehab facility and the **Care Coordinator** affiliated with the Telehealth Provider agency are jointly responsible for coordinating telehealth visits for the client.

Depending on a client's length of stay in the in-patient facility, their HCV treatment may be initiated and even completed while residing in the facility. If the client leaves the in-patient facility prior to completing HCV treatment, they can (and should) maintain contact with the **Care Coordinator** affiliated with the Telehealth Provider agency for the remainder of treatment and follow-up via telehealth.

Key Considerations: This model requires an established relationship between a Telehealth Agency and a non-traditional healthcare setting.

Pro: The **Care Coordinator** affiliated with the Telehealth Provider agency delivers person-centered care by linking clients to an HCV provider onsite and addressing competing priorities. The Care Coordinator may have the capacity to obtain vitals, perform physical examinations, draw blood, and monitor adherence. Clients are able to start HCV treatment while onsite in this example.

Con: There is no clinician onsite to collaborate with the Telehealth Provider and the majority of care coordination is done remotely.

Billing Considerations

Many billing considerations for telehealth are complex, and guidance is continually changing in line with the healthcare landscape. Below are answers to frequently asked questions related to billing as well as key resources and contact information, should you need additional support.

Q: Can a client have more than one primary care provider (PCP)?
A: No, each client is allowed only one PCP. Therefore, specialists can bill via telehealth more freely.

Q: Is billing dictated by each client's individual insurance plan?
A: Yes.

Q: Are billable telehealth visits allowable if/when services are also available onsite?
A: Services available onsite may also be offered via telehealth, where appropriate. For example, therapy and medication monitoring may be conducted via telehealth while a physical exam may not. This may differ by plan. Services provided in OASAS Article 32 programs are billed at a flat rate, and may not be billed again separately.

Q: Is an initial, in-person visit required prior to initiating telehealth?
A: For OASAS programs, initial, in-person visits are not currently required in most situations, however this may change after the federal public health emergency ends.

Q: Can a client be enrolled in two outpatient or opioid treatment programs at a time?
A: No, each client can be enrolled in a single outpatient or opioid treatment program at a time.

Q: Can a PA or NP conducting telehealth bill as a specialist?
A: Billing depends on discipline. Physician Assistants operate under a clinician's license and services are billed under the clinician. Nurse Practitioners operate under their own license, and are able to bill for services as a specialist.

Q: Are facility fees, or the portion of the billing rate associated with brick and mortar costs, allowable for telehealth?
A: Facility fees are currently allowable for telehealth, however this may change after the federal public health emergency ends.

Q: Do telehealth providers need to be credentialed by each non-traditional healthcare site they work with?
A: No, telehealth providers are acting as outside specialists when providing services and do not need to be credentialed. However, a contractual agreement or approval is typical in this situation. Regulations differ for clinicians working in and providing telehealth services to Article 28 facilities, in which case they must be credentialed by both the originating and distant site.

Billing Resources

New York State Medicaid Update (2021): Comprehensive Guidance Regarding Use of Telehealth, including Telephonic Services

New York State Office of Addiction Services and Supports (OASAS) Ambulatory Patient Groups Clinical and Medical Billing Guidance (January 2022)

Telehealth Standards for OASAS Designated Providers (draft, effective August 2021)

Centers for Medicare & Medicaid Services Healthcare Provider Taxonomy: Provides a list of providers and suppliers who are eligible to apply for enrollment in the Medicare program, with the appropriate Healthcare Provider Taxonomy Codes.

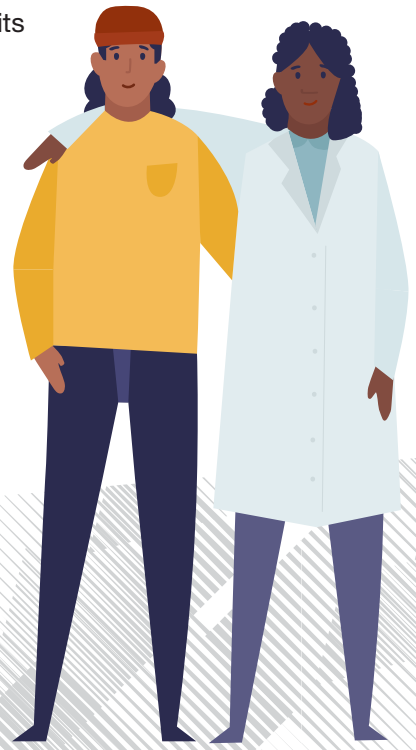
New York State Department of Health Policy and Billing Guidance (2011)

New York State Medicaid update on expanded coverage of telehealth coverage (2019)

Contact telehealth.policy@health.ny.gov and picm@oasas.ny.gov with additional billing questions, including those related to Medicaid.

Electronic Health Record (EHR)/Protected health information (PHI) Considerations

- A shared electronic health record (EHR) between the telehealth provider and telehealth agency will facilitate HCV telehealth but is **not** required.
- The telehealth agency will need to obtain written consent from the client prior to sending PHI to the telehealth provider
- If the telehealth provider and the telehealth agency do not share an EHR or have EHR interoperability, a workflow needs to be established so that protected health information (PHI) can be scanned/faxed between agencies or sent via encrypted email.
- Obtaining remote access to another agency's electronic health records will require a formal agreement between agencies and might require credentialing of the telehealth provider at the telehealth agency
- Telehealth software needs to be HIPAA compliant; staff need to be trained in its use
- Release of information should be in accordance with 42 CRF, Part 2: If any records indicating that a person is currently using substances or has a history of substance use or substance use disorder are to be shared, a 42 CFR, Part 2 consent is required.



Additional Resources

The Center for Connected Health Policy: Non-profit, non-partisan organization working to maximize telehealth's ability to improve health outcomes, care delivery and cost effectiveness.

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