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MAJOR ARTICLE

Peer-Assisted Telemedicine for Hepatitis C in People Who Use Drugs: A Randomized Controlled Trial

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Background. Hepatitis C virus (HCV) elimination requires treating people who use drugs (PWUD), yet <10% of PWUD in the United States access HCV treatment; access is especially limited in rural communities.

Methods. We randomized PWUD with HCV viremia and past 90-day injection drug or nonprescribed opioid use in 7 rural Oregon counties to peer-assisted telemedicine HCV treatment (TeleHCV) versus peer-assisted referral to local providers (enhanced usual care [EUC]). Peers supported screening and pretreatment laboratory evaluation for all participants and facilitated telemedicine visits, medication delivery, and adherence for TeleHCV participants. Generalized linear models estimated group differences in HCV viral clearance (primary outcome) and HCV treatment initiation and completion (secondary outcomes).

Results. Of the 203 randomized participants (100 TeleHCV, 103 EUC), most were male (62%), White (88%), with recent houselessness (70%), and used methamphetamines (88%) or fentanyl/heroin (58%) in the past 30 days. Eighty-five of 100 TeleHCV participants (85%) initiated treatment versus 13 of 103 (12%) EUC participants (relative risk [RR], 6.7 [95% confidence interval {CI}, 4.0–11.3]; $P < .001$). Sixty-three of 100 (63%) TeleHCV participants versus 16 of 103 (16%) EUC participants achieved viral clearance 12 weeks after anticipated treatment completion date (RR, 4.1 [95% CI: 2.5–6.5]; $P < .001$).

Conclusions. The Peer TeleHCV treatment model substantially increased HCV treatment initiation and viral clearance compared to EUC. Replication in other rural and low-resource settings could further World Health Organization HCV elimination goals by expanding and decentralizing treatment access for PWUD.

Clinical Trials Registration. NCT04798521.

Keywords. hepatitis C virus; injection drug use; peer support; telemedicine; rural.

An estimated 57.8 million people live with hepatitis C virus (HCV) globally, with >287 000 HCV-associated deaths annually and disproportionate burden in rural areas [1]. In the United States (US), an estimated 2.4 million people have chronic HCV, leading to >14 000 deaths each year [2]. Rising HCV incidence and prevalence in the US are fueled by the opioid crisis, inadequate access to medications for opioid use disorder, and HCV prevention and treatment among people who use drugs (PWUD) [2–5]. HCV prevalence and acute HCV infection rates are highest in rural areas [6] due to travel distances and low treatment adoption among rural providers [7, 8]. Aligned with the World Health Organization strategic plan to eliminate HCV by 2030, the Biden administration proposes a national elimination plan predicted to save 24 000 lives and $13.3 billion in health expenditures over 10 years [9, 10]. However, new approaches are needed to achieve elimination in key hard-to-reach populations, such as rural PWUD.

Most interventions to increase HCV treatment among rural PWUD were developed for urban settings or have limited efficacy. Many rural states use telementoring for HCV treatment through the Extension for Community Healthcare Outcomes (ECHO) model, but attributable treatment gains are modest [11]. Observational studies of telemedicine HCV treatment demonstrate enhanced treatment initiation in mostly urban settings [12–14]. Integrated models of HCV and substance use disorder (SUD) care increase screening and treatment initiation in randomized studies, but are untested in rural environments where they are difficult to scale [14].

Peer support specialists ("peers") are trusted by PWUD for navigating health systems and mitigating stigma, bringing lived experiences and skills that can facilitate personal connections and foster hope [15]. Several studies show promise in the use of peers to help PWUD navigate the HCV care cascade [16–18]. Single-center observational studies of peer interventions demonstrate high rates of linkage to care, treatment initiation, and cure in urban settings. One small, single-center,

Received 22 July 2024; editorial decision 27 July 2024; published online 17 December 2024

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https://doi.org/10.1093/cid/ciae520

urban randomized trial of peer interventions focused on surrogate HCV outcomes and demonstrated a small improvement in linkage to care but not treatment initiation [18]. No randomized trials test peer interventions for HCV cure in rural areas, peer-assisted telemedicine, or HCV elimination strategies in rural areas [14, 19].

The Peer TeleHCV trial compared peer-assisted HCV screening and telemedicine treatment (TeleHCV) versus enhanced referral to local resources (enhanced usual care [EUC]) to achieve HCV viral clearance among rural PWUD.

METHODS

Participants and Setting

Peers recruited PWUD in 7 rural Oregon with high rates of HCV and opioid overdose. Participants were eligible for inclusion if they were 18 years or older, lived in the study area, had injected drugs or used nonprescribed opioids within 90 days of screening, and had a detectable HCV RNA level >15 IU/mL. We excluded those who were pregnant or breastfeeding, health insurance ineligible, or had decompensated cirrhosis (defined as Child-Turcotte-Pugh score of ≥7) [20]. Recruitment occurred through rural syringe service programs, outreach sites (eg, parks, encampments, or shelters), and participant referrals (snowball sampling) [21].

Study Design and Oversight

The Peer TeleHCV trial was an open-label, unblinded, randomized controlled trial conducted in 7 rural Oregon counties, previously described (protocol version updated 17 October 2022, Supplementary Appendix) in concordance with the 2013 Standard Protocol Items: Recommendations for Interventional Trials (SPIRIT) guidelines [22].

The trial was designed and overseen by a committee including representatives of the Oregon Health Authority, academic research team, and data and safety monitoring board (see Supplementary Appendix) and funded by the National Institute on Drug Abuse Rural Opioid Initiative (UH3DA044831). The Oregon Health & Science University institutional review board approved the study protocol (version 16) and provided oversight.

Study Interventions

Prerandomization

Peers performed eligibility prescreening and rapid HCV antibody testing (OraSure HCV). For those meeting initial inclusion criteria with a reactive HCV antibody or self-report, peers facilitated pretreatment evaluation at local laboratories by standing order (Supplementary Table 2), transportation, navigation of health system stigma, and advocacy in managing phlebotomy challenges. Participants meeting final inclusion criteria were randomly allocated in a 1:1 ratio using centralized random number assignment through Research Electronic Data Capture (REDCap) to receive either peer-assisted telemedicine with a study clinician (TeleHCV) or referral to local HCV navigator and treatment services (EUC) [23]. Study interventions diverged at the point of randomization; no allocation concealment was necessary. Additional details concerning pretreatment laboratory evaluation and liver disease assessment included in Supplementary Tables 3–5.

TeleHCV (Intervention)

Peers assisted with insurance enrollment; telemedicine visits, including bringing communication devices (phone, laptop, or tablet) to participants; medication delivery and storage; adherence support, including follow-up outreach to locate participants with unstable housing or phone access; and services such as offering harm reduction tools, linkage to SUD treatment, and temporary housing. The TeleHCV clinical team—2 internal medicine physicians, a physician assistant, and a clinical pharmacist—provided culturally sensitive telemedicine care from an urban academic medical center, following standard documentation and clinical practice guidelines. The TeleHCV clinical team offered same-day unscheduled appointments, direct communication with peers to discuss patient concerns, and 4-week adherence follow-up calls.

Enhanced Usual Care (Control)

Peers provided referral to local services, including handoff to other local peers, a list of local HCV prescribers, and referral to the local managed care organization care coordinator.

Study Assessment and Compensation

Baseline research visits were conducted by peers and research assistants at screening and randomization, with follow-up visits at 1, 3, 6, and 9 months. Baseline surveys assessed sociodemographic characteristics, medical care history, barriers to HCV treatment, substance use history and route of administration, level of engagement with SUD treatment and harm reduction services, perceived stigma related to drug use, and HCV and HIV treatment history. Follow-up surveys assessed medication initiation, adherence, and changes in SUD treatment and use, and harm reduction service engagement. Participants were compensated equally in both arms ($15–$40) for participation in study assessments and laboratory completion; no compensation was provided for treatment initiation in either group.

Detailed study assessments, reimbursement schedule, and follow-up timeline are described in Supplementary Figures 1 and 2 and the published study protocol [22].

Outcomes

The primary outcome was HCV viral clearance. This was defined as undetectable HCV RNA at 12 weeks after treatment completion for those who initiated treatment (sustained

virologic response at 12 weeks [SVR_{12}]), and as undetectable HCV RNA at 9 months postrandomization for those who did not initiate. This outcome was chosen to allow intention-to-treat analysis of all participants exposed to each intervention and accounts for background spontaneous HCV clearance among noninitiators. Secondary outcomes included initiation and completion of direct-acting antiviral (DAA) treatment. Treatment initiation was defined as confirmed fill of DAA prescription and self-reported initiation. Treatment completion was defined as confirmed fill of full DAA regimen and self-reported adherence of >90% pills taken. A qualitative analysis and additional a priori secondary outcomes—including harm reduction behaviors, substance use, and SUD treatment—were assessed and will be reported elsewhere.

Statistical Analyses

To estimate power, we assumed a baseline HCV viral clearance rate of 44% among EUC participants. This was based on pilot data showing 19% of known HCV-positive individuals from a similar sample had previously received HCV treatment and a predicted spontaneous clearance of 25% over 36-week follow-up [24]. A sample size of 200 provided 80% power to detect a 19% difference in HCV viral clearance between groups, which was deemed clinically relevant.

We used univariate statistics to describe participant characteristics overall and by study arm. The primary outcome, cumulative incidence of HCV viral clearance, was modeled and compared between study arms using the modified Poisson approach under intent-to-treat principles [25]. Interactions between randomized group and sex and ethnicity were tested, and results are reported overall and stratified by these variables. Analyses by race were not conducted due to small sample of non-White participants. Missing HCV viral clearance laboratory data were assumed not at random and imputed as HCV detected. Sensitivity analyses were conducted treating missing data as HCV not detected, missing completely at random (ie, a complete case analysis), and missing at random (ie, using a multiple imputation model with baseline characteristics, treatment initiation, and treatment completion as predictors of missingness). Secondary outcomes of treatment initiation and completion were analyzed using the same strategy. Among the subset of participants who initiated treatment, we conducted additional analyses of treatment completion and HCV viral clearance. All analyses were completed using R v.4.2.1 with the "geepack" and "mice" packages.

RESULTS

From 17 July 2020 to 12 December 2022, 774 individuals were screened, 227 had detectable HCV RNA, 221 were eligible, and 203 participants were randomized. One hundred were assigned to TeleHCV and 103 to EUC (Figure 1). Baseline characteristics were well balanced between groups (Table 1). Among all participants, the mean age was 42 years (standard deviation [SD], 11 years), 62% were male, 88% were White and 5% Hispanic, and 69.5% reported experiencing houselessness in the previous 6 months. Sixty-two percent reported using non-prescribed opioids (including 52% heroin and 33% fentanyl) and 88% methamphetamine at least once in the past 30 days; 58% used both opioids and methamphetamine. Eighty-two percent reported past 30-day injection drug use, with 15% of those sharing syringes at least once. Fifty-four percent of participants had a lifetime history of at least 1 opioid overdose.

Treatment Initiation

Eighty-five percent (85/100) of participants randomized to the TeleHCV arm initiated treatment compared to 13% (13/103) of EUC (relative risk [RR], 6.73 [95% confidence interval {CI}, 4.02–11.30]; $P < .001$) (Table 2). All were prescribed pangenotypic DAA regimens: 80 of 98 (82%) received glecaprevir/pibrentasvir and the remaining received sofosbuvir/velpatasvir.

Treatment Completion

Forty-six percent (46/100) of participants in the TeleHCV arm and 9% (9/103) of EUC (RR, 5.30 [95% CI: 2.70–10.20]; $P < .001$) achieved treatment completion (Table 2). Among treatment initiators, completion rates were similar between arms: 46 of 85 (54%) in the TeleHCV group versus 9 of 13 (69%) in the EUC group (RR, 0.78 [95% CI: .52–1.18]; $P = .24$) [26]. Of the 43 participants who initiated but did not complete treatment, 20 provided reasons for discontinuing. Reasons cited were lost or unable to obtain medications (10/20), return to substance use (3/20), incarceration (2/20), side effects (2/20), personal reasons (2/20), disruption related to coronavirus disease 2019 (COVID-19) infection (1/20).

Viral Clearance

Sixty-three percent (63/100) of TeleHCV participants achieved HCV viral clearance 12 weeks following treatment completion or mock treatment completion (for participants who did not initiate) compared to 16% (16/103) of EUC participants (RR, 4.06 [95% CI: 2.52–6.52]; $P < .001$). Treatment effects were not significantly modified by sex ($P = .44$) or ethnicity ($P = .89$), and due to small sample size, analyses stratified by race were not conducted (Table 2, Figure 2). Sensitivity analyses of missing HCV viral clearance laboratory data (10/100 missing in TeleHCV [10%] vs 19/103 missing in EUC [18%]) did not substantially change results (RR, 2.15–4.06 under different assumptions about missing data, all statistically significant; Supplementary Figure 3, Supplementary Table 1).

Among participants initiating treatment, viral clearance at the SVR_{12} timepoint was comparable: 74% were cured in the TeleHCV arm (63/85) versus 77% in EUC (10/13) (RR, 0.96 [95% CI: .67–1.33]; $P = .82$). Across both arms, 85% of those who completed treatment, compared with 59% of those who

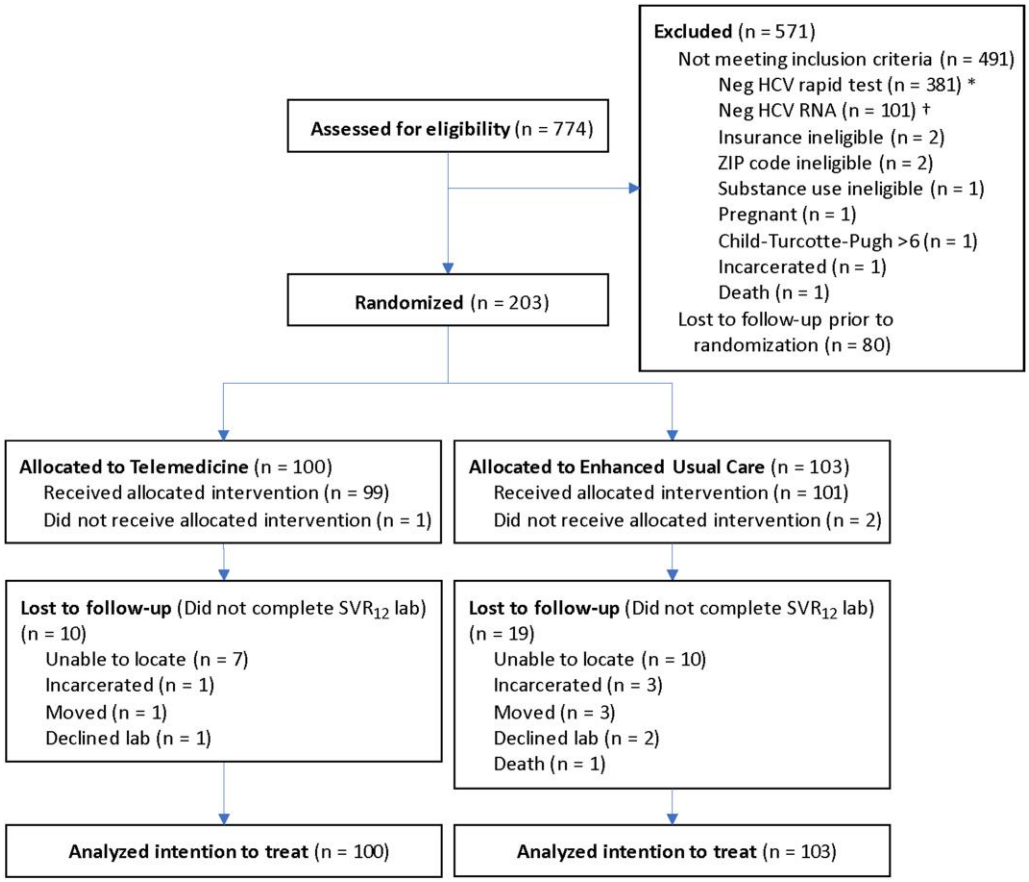

Figure 1. Enrollment and randomization of participants. Details regarding the enrollment flow and eligibility assessment are provided in the Supplementary Materials. *Negative hepatitis C virus (HCV) rapid test: nonreactive hepatitis C antibody by OraQuick HCV platform. †Negative HCV RNA: undetectable HCV RNA by polymerase chain reaction. Abbreviations: HCV, hepatitis C virus; Neg, negative; SVR_{12}, sustained virologic response at 12 weeks.

did not, achieved viral clearance. Five percent of noninitiators spontaneously cleared, all in EUC (Figure 3).

Among those who initiated treatment and completed viral clearance laboratory tests (n = 90), the mean time between last dose taken and viral clearance lab draw was 122 days (SD, 101 days). Mean time between last dose and viral clearance was longer among initiators who did not achieve viral clearance compared to those who did, although the difference was not statistically significant (151 vs 115 days, $P = .37$). Among those who did not complete treatment but achieved viral clearance, 24 of 27 filled their first DAA prescription and reported a median adherence of 80% (interquartile range, 50%–99%) at the first follow-up timepoint. The most common reasons for failure to achieve viral clearance in TeleHCV were treatment failure or reinfection in 22 of 37 (59%), laboratory noncompletion in 10 of 37 (27%), and noninitiation of DAAs in 5 of 37 (14%). Most common reasons for nonclearance in EUC were noninitiation of DAAs in 65 of 87 (75%), laboratory noncompletion in 19 of 87 (22%), and treatment failure or reinfection in 3 of 87 (3%).

Adverse events were rare. There were 5 reported deaths in the follow-up period, most due to overdose (3 in TeleHCV and 1 in EUC; Supplementary Table 2).

DISCUSSION

In this randomized controlled trial, rural PWUD with HCV offered peer-assisted telemedicine HCV treatment were 4 times more likely to achieve viral clearance at 6 months after randomization than those with peer-assisted referral to local treatment resources. Our findings suggest that a peer-assisted telemedicine treatment model offers a powerful new tool for rural communities and policy makers working to eliminate HCV.

This is the first randomized trial to compare telemedicine HCV approaches to enhanced usual care and the first to evaluate a scalable intervention to engage, test, and cure rural PWUD living with HCV. It thus directly responds to calls for systems science telemedicine approaches to bridge gaps in care for PWUD in rural communities [14, 27]. It is also the first randomized comparison of a peer-assisted treatment approach

Table 1. Characteristics of Participants at Baseline

Characteristic	Overall (n = 203)	TeleHCV (n = 100)	EUC (n = 103)
Age, y, mean (SD)	41.59 (11)	40.99 (11)	42.17 (11)
Sex			
Female	77 (38)	42 (42)	35 (34)
Male	126 (62)	58 (58)	68 (66)
Race			
Native American	14 (7)	5 (5)	9 (9)
Black	2 (1)	1 (1)	1 (1)
Multiracial	5 (2)	2 (2)	3 (3)
Other	3 (2)	3 (3)	0 (0)
White	179 (88)	89 (89)	90 (87)
Health insurance	199 (98)	99 (99)	100 (97)
Houseless in past 6 mo	141 (70)	67 (67)	74 (72)
FIB-4 score, mean (SD)	0.90 (0.57)	0.86 (0.48)	0.94 (0.64)
Past 30-d drug use			
Any opioids	126 (62)	70 (70)	56 (54)
Fentanyl/heroin[a]	117 (58)	63 (63)	54 (52)
Methamphetamine	179 (88)	90 (90)	89 (86)
Polysubstance use (opioids and methamphetamine)	117 (58)	66 (66)	51 (50)
Injected drugs in past 30 d	167 (82)	87 (87)	80 (78)
Shared needles	30 (15)	13 (13)	17 (17)
Medications for opioid use disorder[b]	23 (11)	14 (14)	9 (9)
Buprenorphine	13 (66)	7 (7)	6 (5.8)
Methadone	11 (5.4)	8 (8)	3 (3)
Lifetime history of overdose	110 (54)	58 (58)	52 (51)

Data are presented as No. (%) unless otherwise indicated.

Abbreviations: EUC, enhanced usual care; FIB-4, Fibrosis-4 Index for Liver Fibrosis; SD, standard deviation; TeleHCV, peer-assisted telemedicine hepatitis C virus treatment.

[a]Fentanyl/heroin use was self-reported with limited point-of-care drug testing to differentiate fentanyl and heroin use; fentanyl and heroin characteristics were assessed independently but combined here.

[b]One of 12 individuals in TeleHCV group reported using both methadone and buprenorphine.

Table 2. Study Outcomes

Primary and Secondary Outcomes	TeleHCV (n = 100)	EUC (n = 103)	Relative Risk (95% CI)	*P* Value
Viral clearance[a] (primary outcome)	63 (63)	16/103 (16)	4.06 (2.52–6.52)	<.001
Sex				
Male (n = 126)	36 (62)	9 (13)	4.69 (2.27–8.90)	<.001
Female (n = 77)	27 (64)	7 (20)	3.21 (1.60–6.47)	<.001
Ethnicity				
Hispanic (n = 11)	2 (50)	1 (14)	3.50 (.45–27.52)	.234
Non-Hispanic (n = 190)	61 (64)	15 (16)	4.07 (2.45–6.63)	<.001
Race				
Native American (n = 14)[b]	3 (60)	0	NA	
Black (n = 2)[b]	0	0	NA	
Mixed race (n = 5)[b]	1 (50)	0	NA	
Other (n = 3)[b]	0	0	NA	
White (n = 179)[b]	59 (66)	16 (18)	NA	
HCV treatment initiation	85 (86)	13/103 (13)	6.73 (4.02–11.30)	<.001
HCV treatment completion	46 (46)	9/103 (9)	5.30 (2.70–10.20)	<.001

Data are presented as No. (%) unless otherwise indicated.

Abbreviation: CI, confidence interval; EUC, enhanced usual care; HCV, hepatitis C virus; NA, not applicable; TeleHCV, peer-assisted telemedicine hepatitis C virus treatment.

[a]Viral clearance defined as an undetectable HCV RNA at 12 weeks post–treatment completion, or 12 weeks after mock treatment completion date for participants not initiating treatment within 6 months of randomization.

[b]Due to small sample sizes and zero cells, results were unable to be stratified by race.

to achieve viral clearance, the primary outcome necessary for HCV elimination [14, 18]. These results align with high viral clearance rates seen in prior observational single-center evaluations of peer HCV treatment navigation and confirm the effectiveness of a peer-assisted telemedicine approach [16, 17]. Importantly, low viral clearance rates in the peer-assisted EUC group suggest that peer navigation alone—previously shown to be successful in urban areas—must be paired with low-barrier treatment models like telemedicine to effectively drive viral clearance in rural areas [7, 11]. The peer-assisted telemedicine approach bypassed infrastructure barriers to remote care in rural communities, even during the COVID-19 pandemic—a time of broad healthcare system disruption [4, 27]. PWUD often have limited access to cell phones or internet required for telemedicine visits, even in communities with excellent internet access [28]. In addition to provision of harm reduction supplies and adherence support associated with viral clearance in prior studies, peers brought communication devices directly to PWUD for remote visits (eg, in parks, homelessness encampments), greatly facilitating treatment initiation in the TeleHCV arm [17, 29].

Overall, viral clearance rates across groups were lower than SVR_{12} rates in some past HCV treatment interventions for PWUD [13, 30–32]. The TeleHCV viral clearance outcome, however, includes all participants randomized to the intervention, including noninitiators. This is a study strength, as it accounts for treatment initiation, spontaneous clearance, and reinfection among PWUD, which more accurately reflects population-level impact than studies measuring SVR_{12} among initiators, alone. In addition, treatment completion and viral clearance rates 12 weeks after treatment completion among those taking at least 1 day of therapy were also slightly lower than SVR_{12} rates reported in some studies [30, 33, 34]. This may reflect the complexity of our study population, with high rates of injection and methamphetamine use, houselessness, and low use of medications for opioid use disorder, all of which are associated with lower cure rates [30]. These are precisely the hard-to-reach, highly vulnerable populations that must be cured to achieve HCV elimination. The long mean SVR_{12} viral clearance lab completion timeframe among initiators may have increased the possibility of early reinfection detection, which cannot be separated from treatment failure in this study. This is supported by a not statistically significant trend toward a longer delay in HCV RNA results among treatment initiators with persistent viremia in our study. In a global meta-analysis, reinfection occurred at a rate of 6.2 per 100 person-years among recent people who inject drugs. Reinfection tended to occur early

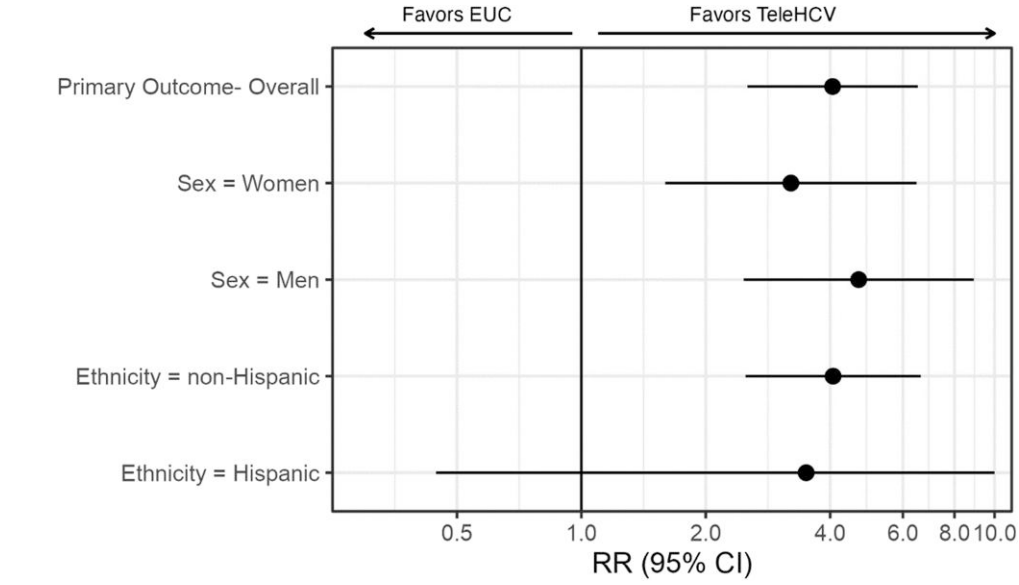

Figure 2. Primary outcome and subgroup-specific estimates, with 95% confidence intervals (confidence interval ranges truncated at 10). Abbreviations: CI, confidence interval; EUC, enhanced usual care; RR, relative risk; TeleHCV, peer-assisted telemedicine hepatitis C virus treatment.

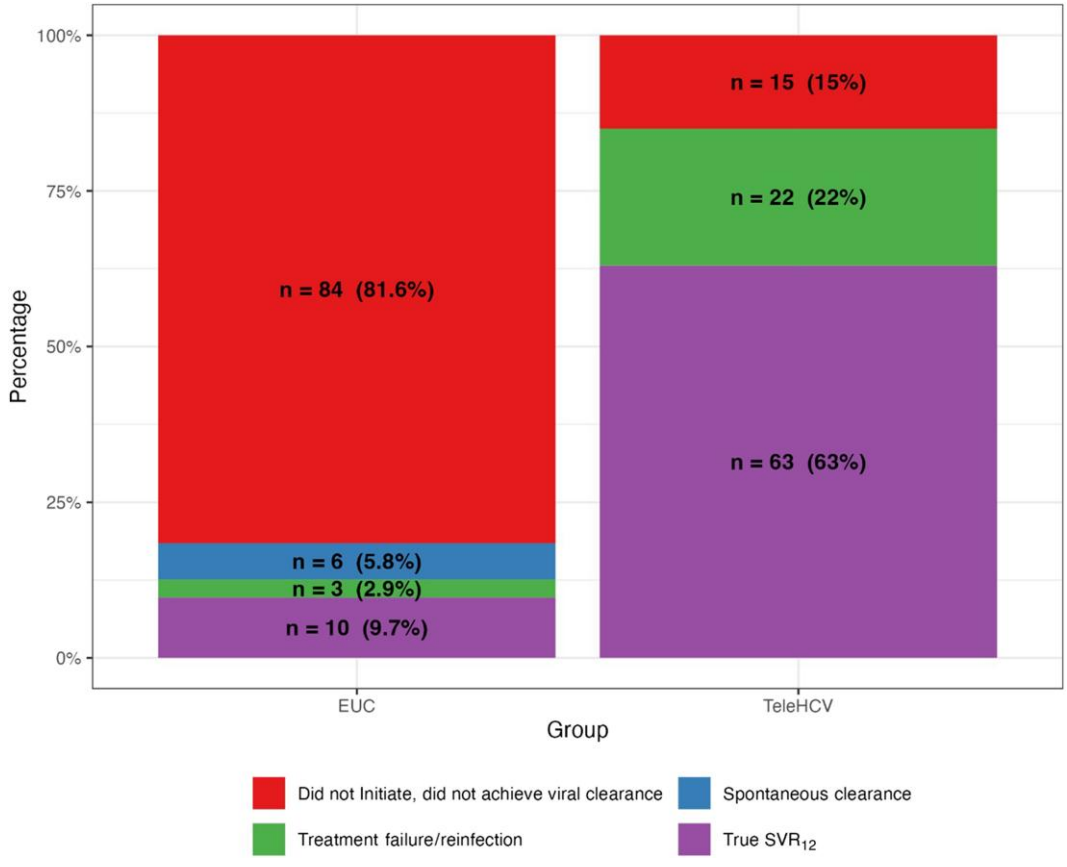

Figure 3. Hepatitis C virus (HCV) viral outcomes by initiation status. True SVR_{12} = initiated direct-acting antiviral therapy (DAA), undetectable HCV RNA at 12 weeks posttreatment; Treatment failure/reinfection = initiated DAA, detectable RNA at 12 weeks posttreatment; Spontaneous clearance = did not initiate DAA, undetectable RNA at 12 weeks posttreatment. Reinfection and treatment failure were not differentiated. Abbreviations: EUC, enhanced usual care; SVR_{12}, sustained virologic response at 12 weeks; TeleHCV, peer-assisted telemedicine hepatitis C virus treatment.

posttreatment completion [35], particularly among those using stimulants and experiencing houselessness [36].

The most important impact of the Peer TeleHCV intervention on viral clearance was mediated by substantially higher treatment initiation rates, with roughly 6 times more participants initiating in the TeleHCV arm than EUC. Importantly, prior comparative studies of peer navigation showed increased linkage to care but not treatment initiation, adding credence to the importance of telemedicine treatment access for peer interventions [14, 37]. This difference in treatment initiation is particularly notable considering several key intervention features and local contextual factors. First, all participants completed full pretreatment evaluation labs prior to randomization. Laboratory evaluation can pose one of the largest barriers to treatment initiation for PWUD and other marginalized populations due to transportation, telecommunication, and phlebotomy challenges for those with a history of injection [38]. Peers drove most participants to laboratories (often multiple times due to incomplete blood draws associated with poor venous access), helped navigate health system stigma, and facilitated insurance enrollment, overcoming factors associated with decreased treatment initiation [7, 8]. Additionally, providers from all 7 counties participated in a parallel HCV ECHO program between 2017 and 2023 [39]. ECHO is a core tool to increase HCV treatment access in rural areas, but only 13% of EUC participants referred to local resources, including ECHO-involved providers, initiated treatment within 6 months [11]. While ECHO was not part of the study intervention, our data suggest that the Peer TeleHCV model may be an even more powerful tool for eliminating HCV among rural PWUD.

Study findings should be interpreted considering some limitations. First, while the demographic and geopolitical landscape of rural Oregon is similar to many low-density areas of the US, the effect size may not be generalizable to higher-density regions with relatively greater access to care. Second, while the Peer TeleHCV model proved resilient during the COVID-19 pandemic, it is possible that pandemic pressures on rural HCV treatment providers exceeded those on telemedicine providers, accounting for the low numbers of EUC subjects who initiated treatment. Third, outcomes relied partly on self-report to categorize treatment completion and adherence, which may overestimate adherence, while still correlating with SVR_{12} [40]. Finally, our study lacked deep sequencing RNA testing and follow-up reinfection surveillance, limiting our ability to assess baseline reinfection rate and differentiate from treatment failure.

The Peer TeleHCV study helps close a major gap in efforts to reach HCV elimination targets. These findings highlight the critical importance of engaging people with lived experience of substance use in implementing interventions affecting PWUD and suggest that policymakers prioritize funding for peer models. The findings also support shifts toward low-threshold, out-of-office models for PWUD disengaged from traditional care. The Peer TeleHCV model is scalable and applicable to most rural areas in the US and beyond. Nationwide implementation, however, requires investment on the level of the Biden administration's proposed elimination plan [9]. With federal support for expansion of models like peer-assisted telemedicine treatment, HCV elimination in the US is indeed possible.

Supplementary Data

Supplementary materials are available at *Clinical Infectious Diseases* online. Consisting of data provided by the authors to benefit the reader, the posted materials are not copyedited and are the sole responsibility of the authors, so questions or comments should be addressed to the corresponding author.

Notes

Author contributions. A. S.: Conceptualization, methodology, writing–original draft and editing, supervision. R. C.: Methodology, validation, formal analysis, writing–original draft and editing. G. L.: Conceptualization, methodology, investigation, data curation, writing–review and editing, project administration. M. C. H., H. C. S., J. B., and C. F.: Investigation, writing–review and editing. T. G.: Software, investigation, data curation, writing–review and editing, project administration. J. C.: Conceptualization, investigation, data curation, writing–review and editing, project administration. A. T.: Conceptualization, methodology, resources, writing–review and editing. J. M. L.: Conceptualization, resources, writing–review and editing. J. E. L.: Investigation, data curation, project administration. P. T. K.: Conceptualization, methodology, resources, writing–review and editing, project administration, funding acquisition. All authors had full access to all study data and procedural materials.

Acknowledgments. Oregon HOPE TeleHCV is a collaboration that includes participants, peers, clinical staff, program and state leaders, and researchers from Oregon Health & Science University, Oregon Health Authority, Comagine Health, HIV Alliance, Bay Area First Step, and the Oregon Washington Health Network. The project could not have launched or continued without the tireless efforts of the entire Oregon HOPE TeleHCV team, including Caiti Barrie, Sarann Bielavitz, Khaila Dahlberg, Rhody Elzaghal, Sean Farrell, Paul Gonzales, Joshua Haynes, Larry Howell, Maxine Howell, Kelly Jones, Lisa Kennedy, Karen Kidd, Sara McCrimmon, Jordan Shin, and Dane Zahner.

Financial support. This work was supported by the National Institute on Drug Abuse of the National Institutes of Health (cooperative agreement UH3DA044831).

Potential conflicts of interest. A. S. has participated in investigator-initiated research funded by Merck, AbbVie Pharmaceuticals, and the Gilead Focus Foundation not related to this manuscript. All other authors report no potential conflicts.

All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

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