



# What's Going on @ SPNS



AN UPDATE FROM THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION,  
HIV/AIDS BUREAU, SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

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## ■ Helping Providers Implement Key SPNS Findings through the IHIP Project

Ongoing efforts to develop and evaluate new models of HIV care have been broadly successful. To further promote and support widespread replication and implementation of innovative models within the health care community, the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) is sharing findings and best practices from its Special Projects of National Significance (SPNS) program through the creation of training manuals, curriculum, and Webinars.

Leading-edge models of HIV care developed through the evaluation of SPNS demonstration projects will be disseminated through the Integrating HIV Innovative Practices (IHIP) project. The goal of IHIP is to enable Ryan White HIV/AIDS Program providers, as well as other health care providers, to take proven SPNS innovations and put them into practice within their own clinics and practices—thus improving access, engagement, and retention in care for the vulnerable populations living with HIV/AIDS. Ultimately, the result will be healthier communities.

“We need to be more effective in the dissemination and spread of effective models,” says SPNS Branch Chief Adan Cajina. “The objective is to raise the visibility of the SPNS program to a level comparable with the U.S. Centers for Disease Control and Prevention’s (CDC’s) Diffusion of Effective Behavioral Interventions (DEBI) project.”

SPNS demonstration project grantees have investigated the best ways to promote new service delivery models to care for specific patient populations—as well as overcoming providers’ operational challenges in implementing effective systems for linkage and retention, health information exchanges, and improving the HIV continuity of care along the treatment cascade. IHIP will synthesize and share those findings through the development of standard toolkits that providers can use to build capacity and improve access to and retention in HIV primary care. Common products in the toolkits will include a training manual, curriculum, and Webinars. The idea is that Ryan White HIV/AIDS Program grantees and other providers can use these resources to expand their capacity to effectively deliver new models of evidence-based HIV care.

“SPNS dissemination has been captured throughout the years mostly in monographs or scientific peer review journals. Very seldom has it been sustained beyond that package of products,” says Cajina.

“Through the Webinars and other IHIP products, not only do we expect to reach a larger audience, but we also expect to transform the lessons learned into practical training materials that will show our community of HIV providers how to implement successful interventions within their programs,” explains Cajina. “IHIP provides hands-on information for varying groups of providers—not only clinicians, but also nurses, case managers, staff members, peer navigators, and so on.”

As an example, one of the first IHIP initiatives generated the following resources:

- A **Training Manual** with step-by-step guidance and a synthesis of best practices across the most successful SPNS grantee sites.
- **Curriculum** modules, including elements such as exercises, handouts, and ready-to-use PowerPoint slides, to train staff and assist with buy-in, as well as to educate patients.

- A **Monograph** that summarizes specific grantee case studies.
- Training **Webinars**, featuring clinical and grantee experts, that provide a more interactive experience.

Training manuals are designed to be comprehensive resources. For example, the training manual for the Integration of Buprenorphine into HIV Primary Care Settings initiative provides guidance on everything from how to secure a U.S. Drug Enforcement Administration number to information about prescribing buprenorphine and tips for monitoring symptoms.

Curriculum modules are organized to accommodate the busy schedules of HIV clinic and agency staff. Each module may be taught as a standalone session, which takes between 20 and 60 minutes to complete (although 60-minute sessions may be broken into two 30-minute modules) and includes teacher instruction, guided group discussion, group activities, and group evaluation components. Most modules come with an associated PowerPoint presentation, as well as detailed discussion and activity guides. Handouts are provided for most of the modules.

All materials (including archived Webinars) are available on [the TARGET Center Web site](#). In addition, a Web badge for the IHIP program is available; providers can copy provided coding to place the IHIP icon on their own sites to demonstrate their support for IHIP products and help drive traffic to these resources.

It is important to note that select AIDS Education and Training Centers (AETCs) will be contributing to the development of some IHIP toolkits. The SPNS mission is to initiate innovative approaches to HIV care and treatment, and the AETC mission is to provide training and education. Thus, these IHIP collaborations represent an exciting opportunity for the Division of Training and Capacity Development, which houses the SPNS and AETC programs, to better coordinate the effort to disseminate critical information.

## Current and Upcoming IHIP Projects

### *Buprenorphine in Primary Care Settings*

One SPNS initiative that is currently featured as part of the IHIP library is Integration of Buprenorphine into HIV Primary Care Settings. Addiction to opioids—including heroin and many prescription pain medications—is a persistent problem in the United States. According to a 2010 Substance Abuse and Mental Health Services Administration (SAMHSA) national study, abuse of pain relievers ranked second (after marijuana) among illicit drug users in the previous year. Heroin ranked fifth.<sup>1</sup>

The problem of opioid addiction is especially problematic for people living with HIV/AIDS (PLWHA). HIV-positive patients with substance use disorders have benefitted less from treatment

than their non-substance-using peers.<sup>2</sup> That's partly because opioid-dependent patients are less likely to be prescribed HIV antiretroviral (ARV) medications, and when they receive ARVs are more likely to be involved in early discontinuation.<sup>2,3</sup> In addition, substance use is associated with increased sexual risk behaviors, increased HIV risk, and poorer health outcomes, and it contributes to destabilizing conditions, such as homelessness and mental illness.<sup>4</sup>

The link between injection drug abuse (IDU) and HIV infection is particularly strong. Since the epidemic began, IDU, either directly or via sexual contact with an IDU partner, has accounted for one-third of the estimated AIDS cases, and it accounted for 18 percent of new HIV infections in 2010.<sup>5</sup>

Thus, treatment to reduce dependency is an important part of improving health outcomes for PLWHA and reducing the incidence of HIV infection. For decades, methadone has been the primary—and until recently, one of the only—medical treatments for opiate addiction in the United States. Treatment with methadone is highly regulated and the number of clinics providing opioid treatment programs nationwide has generally been limited. As a result, people have often gone untreated. In 2009, about 6.4 million people who needed required treatment went without it.<sup>1</sup>

In October 2002, the U.S. Food and Drug Administration (FDA) approved buprenorphine (Subutex and Suboxone) for the treatment of opioid dependence in a primary care setting. And in September 2004, the SPNS program designed the Buprenorphine Initiative to determine the effectiveness of integrating buprenorphine opioid abuse treatment into HIV primary care settings—something that had never been studied before. The initiative funded 10 model demonstration programs and one evaluation and support site. Overall, the initiative treated more than 300 HIV-positive opioid-dependent patients with Suboxone tablets (Suboxone film was not yet available).<sup>6</sup>

The promise of opioid treatment within the context of Ryan White HIV/AIDS Program sites is that it helps diminish opportunities for miscommunication between health care providers and substance abuse counselors because HIV and addiction therapy are co-located. Also, the propensity for drug-drug interactions with HIV medications is lower with buprenorphine treatment than it is with methadone.<sup>7</sup> Patients and providers were overwhelmingly satisfied with SPNS initiated treatments and results. In general, the Buprenorphine Initiative:

- Allowed for integration—rather than fragmentation—of services, resulting in improved retention in care.
- Allowed initiation of ARVs among patients not previously on treatment.

- Improved drug and HIV treatment outcomes, particularly among those not previously on ARVs.
- Improved CD4 counts among patients participating in the project.
- Resulted in decreased heroin and other opioid use.
- Increased social stability.
- Decreased HIV transmission risk behaviors.
- Decreased stigma associated with substance abuse treatment.
- Improved mental and physical health-related quality of life.<sup>8-14</sup>

Several best practices from the Buprenorphine Initiative emerged. Providers found it useful to:

- **Screen for opiate abuse.** Many patients hide their opiate abuse from their physicians because of stigma or legal concerns, among other reasons. To uncover opiate abuse that may have gone unnoticed, one site began regularly administering an instrument called the Global Assessment of Individual Need (GAIN), which evaluates patients for depression, substance abuse, and mental illness.
- **Develop a team approach.** Several important roles emerged that can be performed by existing personnel already performing similar functions. Existing staff, however, should receive special training to perform those unique roles. All sites stressed the importance of having a care coordinator, or “glue person,” to serve as the face of the program within the clinic and the primary point of contact for issues related to buprenorphine.
- **Identify a physician mentor.** Grantees accessed the SAMHSA-funded Physician Clinical Support System for Buprenorphine, a free nationwide program linking physicians interested in integrating buprenorphine into their practices with mentors for support.
- **Provide pharmacy care linkages.** Grantees noted that onsite availability of a pharmacy and laboratory facilitated implementation, but were not prerequisites for success. Before transferring prescriptions to a community pharmacy, however, several grantees found it helpful to tour a pharmacy to observe buprenorphine protocols.
- **Secure buy-in.** SPNS grantee staff gave updates and case study presentations at monthly clinic staff

meetings. They advertised the program by putting up flyers around the clinics and at affiliated partner sites. Clinic outreach workers assisted with word-of-mouth advertising and education about the program in the community. Patients who had successfully undergone buprenorphine induction were encouraged to speak to new patients about any fears they might have.

- **Prepare people for treatment.** Useful pre-treatment steps included completing a comprehensive health history, identifying any comorbidities, conducting a medication review, ensuring access to buprenorphine, performing appropriate lab work and toxicology screenings, providing patient education and counseling, and asking patients to sign an adherence contract. Supplying “kick packs” to patients to help with withdrawal symptoms, managing patient expectations, and maintaining detailed Suboxone prescribing records were also helpful. One SPNS grantee used a [Suboxone Treatment Record](#), which can be accessed on the IHIP Web site.
- **Guide patients through treatment phases.** The SPNS Buprenorphine grantees followed patient protocols for induction and stabilization, which can be accessed at [http://buprenorphine.samhsa.gov/Bup\\_Guidelines.pdf](http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf). In most cases, patients entered the maintenance phase of treatment—which occurs when a patient has been sustained on a steady dose of buprenorphine—within the first 2 weeks.

### *Hard-to-Reach Populations*

An IHIP toolkit that summarizes findings from several SPNS interventions on Engaging Hard-to-Reach Populations is also currently available. A tremendous need exists to engage hard-to-reach HIV-infected populations in HIV/AIDS care. According to the CDC, many PLWHA are not in care and 20 percent of HIV-positive people in the United States are unaware of their serostatus.<sup>15</sup> Numerous factors prevent PLWHA from engaging in care or prompt them to fall out of care shortly after starting it. These factors include food and housing insecurity, poverty, substance abuse disorders, mental illness, and other psychosocial and economic determinants.<sup>16</sup> In addition, limited educational attainment and a history of incarceration can interfere with access to care because it makes obtaining and maintaining employment and health insurance difficult.<sup>17</sup> Finally, the social stigma still associated with HIV inhibits many PLWHA from seeking testing or care, and low levels

of health literacy mean that many PLWHA fail to understand why being in treatment is so important for them.

It's important to note that HIV/AIDS tends to disproportionately affect ethnic and racial minorities within the United States. Those groups account for nearly 70 percent of the approximately 50,000 new HIV infections incurred every year; well over one-half of all PLWHA nationwide;<sup>18</sup> and the majority of all HIV/AIDS deaths since the start of the epidemic.<sup>19</sup>

Several of the most successful interventions for engaging these hard-to-reach populations are presented in the IHIP toolkit. For example:

- **Traditional Street/Social Outreach.** Providers recruit volunteers or entry-level personnel to perform outreach (which in some cases may involve actual testing) to targeted populations. The outreach workers often are close in age to the targeted populations and share a similar ethnic, racial, cultural, and linguistic background, so they are able to develop rapport quickly. The outreach workers may even have successfully engaged in care themselves through the clinic.<sup>20</sup>
- **Motivational Interviewing (MI).** Providers use culturally and linguistically competent counseling to encourage PLWHA to examine their own motivations regarding testing and care.<sup>21</sup> Based on the Trans Theoretical Model (TTM) of change, which explains and even predicts a person's ability to make proposed behavior changes,<sup>22,23</sup> MI techniques build trust and help PLWHA feel comfortable.
- **Health System Navigation/Enhanced Case Management.** Providers help PLWHA manage the care that they receive at various agencies. Patients often are assigned a nonclinical staff person with skill sets similar to those of case managers, outreach workers, and/or peer advocates. This service “connector” staff person provides intensive help to clients for a predetermined time, and then follows up at regular intervals.
- **HIV Interventions in Jails.** Providers partner with a local jail to identify, engage, and reengage PLWHA in care. To protect privacy and provide anonymity, HIV testing in the jail facility often is offered during the intake process or during group HIV education activities.
- **In-Reach.** Providers conduct extensive “in-reach” efforts to identify and reengage PLWHA lost to care—within their clinics, as well as other facili-

ties. In general, contact with clients is initiated by a nonclinical staff person who has experience working with patient records, knows how to quickly identify clients who have fallen out of care, and has a strong understanding of Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules.

- **Social Marketing/Social Networking Campaigns.** Providers employ traditional social marketing techniques to promote healthy behaviors, such as getting tested for HIV and engaging in treatment. This often involves reposting information on social networking sites in abbreviated form to encourage audiences to visit source sites.
- **Health Information Technology.** Several initiatives focused on using electronic data systems to facilitate the identification of people who are new to care or who have fallen out of care. For example, the Louisiana Public Health Information Exchange (LaPHIE) initiative used surveillance data from the Office of Public Health to generate point-of-care messages for providers.

### *Enhancing Linkages to HIV Care in Jail Settings*

An IHIP toolkit on Enhancing Linkages to HIV Primary Care and Services in Jail Settings will be available soon. More than 9 million people cycle through U.S. jails each year;<sup>24</sup> and a significant number of those inmates are PLWHA. In fact, the rate of AIDS among prison and jail inmates is about 2.4 times higher than among the general population.<sup>25</sup>

Populations disproportionately affected by HIV/AIDS also are overrepresented within correctional facilities. More than one-half of all incarcerated persons are African-American or Latino men and women.<sup>26,27</sup> Many incarcerated PLWHA have faced structural inequities and psychosocial issues in their lives, such as poverty, unstable housing, drug addiction, limited educational attainment, and under- and unemployment.<sup>28,29</sup> In addition to HIV, incarcerated PLWHA often have other undiagnosed and untreated diseases, including hepatitis C, tuberculosis (TB), mental illness, heart disease, and diabetes.<sup>28,30–31</sup>

Many PLWHA in jails are part of the 20 percent of HIV-positive people in the United States who do not know their serostatus. Others are aware that they are HIV-positive but have fallen out of care or were never engaged in care in the first place.<sup>30</sup>

The jail setting represents an opportunity to engage or reengage PLWHA. Receiving care during or shortly after release from incarceration can greatly reduce the chance that PLWHA will transmit the HIV virus to others within their communities. In

addition, studies have shown that linkage to HIV, mental health, and other health services can help reduce recidivism.<sup>32-34</sup>

A SPNS initiative to develop HIV service delivery interventions at 10 demonstration sites occurred from 2007 to 2012. Findings revealed that rapid HIV testing in jails is feasible, scalable, and results in early HIV diagnosis; and that planning for aftercare is cost-effective and results in significantly greater likelihood of HIV control.

Three variables were found to be highly predictive of achieving viral load suppression within 6 months of release. These variables are: having a meeting with an HIV provider, attending a first meeting with a case manager, and assessing the need for help with HIV-related medical services—all within 30 days of release from jail. These findings clearly support further development of case management programs for HIV-positive jail detainees.

Note that many of the participants have sustained part or all of their SPNS infrastructure and programming activities.

### *Oral Health Innovations*

An IHIP toolkit on Innovations in Oral Health Care will be available soon. Oral health problems may spread to other parts of the body and inflict great harm to the heart, brain, and other organs if not treated, particularly in PLWHA who have severely compromised immune systems.<sup>35</sup> In fact, oral health problems are often the first manifestations of HIV disease and can signal clinical progression.<sup>36,37</sup> In addition, more than 500 medications can cause xerostomia, or “dry mouth,” which can lead to dental decay, periodontal disease, and fungal infection.<sup>38-40</sup>

Despite the importance of oral health care, many PLWHA face barriers to accessing such care and consequently, have unmet oral health care needs. Ryan White HIV/AIDS Program consumers consistently identify oral health care as one of their top unmet needs.<sup>41</sup>

A SPNS initiative to support provision of comprehensive oral health care for PLWHA awarded grants to 15 urban and rural demonstration sites across the country, as well as an evaluation and assistance site. Results highlight several promising interventions with common strategies such as increasing access to transportation; involving case managers; educating community partners, project staff, and clients; reducing stigma; and delivering culturally competent, high-quality dental care.

Providers will soon have access to even more IHIP toolkits. Future IHIP projects may include The Hepatitis C Treatment Expansion Initiative, among others.

### *Conclusion*

The SPNS projects have identified many innovative models for addressing treatment and operational challenges. The IHIP project represents a unique opportunity to disseminate the “best of the best.” By providing comprehensive implementation guidance on the most successful models, IHIP will enable health care providers to more effectively translate research into practical reality, ultimately helping more people lead healthier lives.

### **For More Information about IHIP**

To access more information about the Integrating HIV Innovative Practices (IHIP) project, as well as the IHIP toolkits, visit <https://careacttarget.org/ihip>.

In addition, contact the following SPNS officers:

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