Integration of Comprehensive HIV Medical Care with Addiction Services

Intervention Implementation Guide

HRSA
Ryan White HIV/AIDS Program

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This publication lists non-federal resources in order to provide additional information to those considering replication. The views and content in these resources have not been formally approved by HHS or HRSA. Neither HHS nor HRSA endorses the products or services of the listed resources.

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Integration of Comprehensive HIV Medical Care with Addiction Services

Ending the HIV Epidemic in the U.S. Pillar: Treat & Respond

HIV Care Continuum Stage: Retention in HIV medical care; achievement and maintenance of viral suppression

Priority Population: People who inject drugs (PWID)

Setting: Hospital or hospital-based clinic

This guide examines the Integration of Comprehensive HIV Medical Care with Addiction Services intervention, which was launched by the Cooper Health System's Early Intervention Program Expanded Care Center (CEEC) in Camden, New Jersey. The program was initially funded through the New Jersey Division of HIV, STD, and TB Programs. In addition, CEEC receives funding from the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) Part A and Part C and allocated some of these resources to be added to this project. It is currently funded through third-party payer reimbursements such as Medicare, Medicaid, and private insurances (program income), as well as Substance Abuse and Mental Health Services Administration (SAMHSA) funding, and 340B pharmacy services program income.

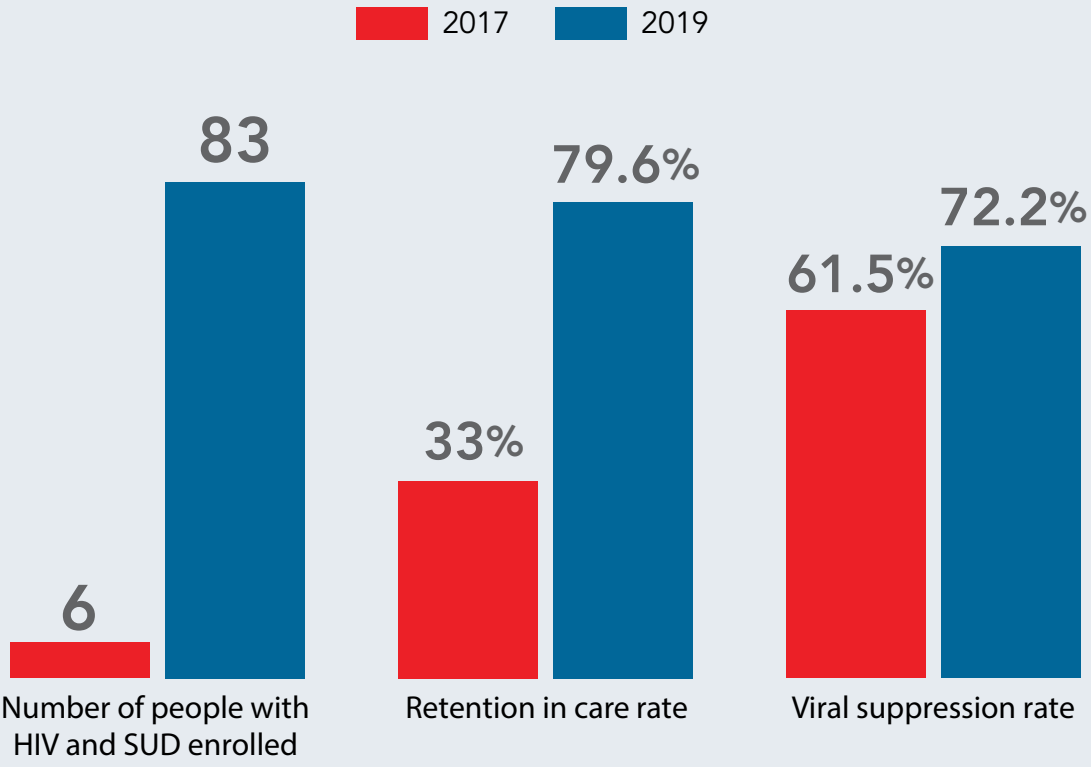
The CEEC identified an outbreak of new HIV infections among persons who use substances and experienced many challenges linking people with HIV and substance use disorder (SUD) to external agencies that offered addiction treatment. In response, the CEEC sought to improve access to addiction medicine services by integrating these services within their existing HIV program, to improve rates of viral suppression and retention in care among people with HIV and SUD.

This intervention integrates comprehensive HIV medical care with addiction services and medication protocols for SUD, as a treatment model for people with HIV and SUD. These services were implemented at the individual and system-level, to provide a "one-stop shop" for HIV primary care, wraparound services, and addiction medicine services.

This guide includes key components of the Integration of Comprehensive HIV Medical Care with Addiction Services intervention, outlines the capacity required by organizations/clinics to conduct this work, and includes replication steps to support others in their implementation efforts. Finding replicable interventions that meet Ending the HIV Epidemic in the U.S. (EHE) initiative goals and support clients along the HIV care continuum are key to future programmatic and client success in HIV care.[1]

Achievements

Over a three-year period, from 2017 to 2019, the intervention enrolled an increasing number of people with HIV and SUD in their addiction medicine services. By the end of 2019, 83 patients were enrolled, up from six people in 2017. For all clients with HIV and SUD, retention in care increased from 33 percent in 2017 to 79.6 percent in 2019; viral suppression increased from 61.5 percent in 2018 to 72.2 percent in 2019.



About SPNS

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services (HHS), is the primary federal agency for improving healthcare to people who are geographically isolated, economically or medically vulnerable. The Ryan White HIV/AIDS Program (RWHAP) Part F: Special Projects of National Significance (SPNS) Program is administered by HRSA's HIV/AIDS Bureau (HAB). The RWHAP SPNS Program supports the development of innovative models of HIV care and treatment in order to quickly respond to emerging needs of clients served by RWHAP. RWHAP SPNS advances knowledge and skills in the delivery of healthcare and support services for people with HIV who have not been successfully maintained in care. Through its demonstration projects, RWHAP SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models while promoting the dissemination and replication of successful interventions.

Funding Source

The featured intervention was initially funded through the New Jersey Division of HIV, STD, and TB Programs. In addition, CEEC receives funding from the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) Part A and Part C and allocated some of these resources to be added to this project. It is currently funded through third-party payer reimbursements such as Medicare, Medicaid, and private insurances (program income), as well as Substance Abuse and Mental Health Services Administration (SAMHSA) funding, and 340B pharmacy services program income.

To learn more about the RWHAP, visit: **ryanwhite.hrsa.gov**

Getting Started

This table provides a general overview of the Integration of Comprehensive HIV Medical Care with Addiction Services intervention so readers can assess the necessary steps required for replication. This intervention facilitates engagement in HIV care and treatment, addiction treatment and viral suppression for people with HIV and SUD.

INTERVENTION AT-A-GLANCE	
Step 1	**Conduct Community Needs and Resource Assessments** Assess current trends of injection drug use (including overdose, demand for treatment of SUD, and drug-related incarceration rates), and the number of new HIV infections attributed to injection or other drug use in your community. Assess existing services for, and unmet needs of, people who inject drugs (PWID) with HIV, SUD, and co-occurring mental health disorders, and assess your service offerings and strengths.
Step 2	**Bring Stakeholders Together** Identify key external and internal stakeholders (such as county jails and health departments, community-based organizations, syringe service programs, emergency department physicians and hospitalists, Addiction Medicine and Infectious Disease Consult Services) who can refer clients with SUD who have a new HIV diagnosis, or have fallen out of care; and enable trauma-informed care and wraparound services in a stigma-free, "one-stop-shop" for people with HIV, SUD and co-occurring mental health disorders. Coordinate meetings with internal and external stakeholders to provide details on the intervention and secure buy-in. Identify a contact person from each organization to enable linkage to services.
Step 3	**Develop Internal Infrastructure** Develop an internal infrastructure to support coordinated HIV, SUD, and mental health care. Set up communication structures and systems for providing integrated services. Establish policies and procedures for all addiction services, including client agreements. Revisit and update policies and procedures, as needed.
Step 4	**Develop and Maintain a Data Management and Sharing System** Develop and maintain a data management and sharing system to improve data coordination and sharing between medical and nonmedical providers, and continuously monitor outcomes (enrollment in addiction medicine services, retention in care, and viral suppression).

Step 5 	**Establish a Multi-disciplinary Staffing Model and Build Staff Capacity** Provide ongoing training for existing staff who have new roles and responsibilities, and for new team members, including trauma-informed care, education on HIV and hepatitis C virus (HCV) screening, harm reduction, outreach, and prescribing medication for opioid use disorder (MOUD).
Step 6 	**Identify and Engage New Clients** Work with partners and across systems to identify and engage new clients and re-engage people with HIV who are lost to care. Secure buy-in for and implement health system-wide "opt-out" HIV and HCV screening and provide HIV counseling and testing services at the local jail. Provide contact information for navigators who will meet new clients immediately and encourage them to engage or re-engage in HIV care.
Step 7 	**Assess Client Needs with Screening Tools** Assess client needs with the proper screening tools to ensure they receive appropriate HIV care and treatment, primary care, addiction treatment, mental health care, medical and non-medical case management, social and other services, based based on their individual needs.
Step 8 	**Maintain Partnerships** Maintain partnerships with county jails and health departments, community-based agencies, social service providers, mental health and addiction treatment services, and harm reduction programs to ensure that referrals can be made when more intensive services are needed, and that people with HIV, SUD and co-occurring mental health disorders are connected to these needed services.

RESOURCE ASSESSMENT CHECKLIST

Prior to implementing the intervention, organizations should walk through the following Resource Assessment (or Readiness) Checklist to assess their ability to conduct this work. If organizations do not have the recommended readiness, they are encouraged to develop their capacity so that they can successfully implement this intervention. Questions to consider include:

- ❑ Does your organization have experience working with people with HIV, SUD, and mental health disorders, and helping to support their medical and social service needs?
- ❑ Is the staff trained in providing integrated and trauma-informed care for HIV, mental health, and SUD?
- ❑ Is the staff culturally responsive, compassionate, and interested in working with PWID with HIV?
- ❑ Is your organization able to either offer or partner with others to provide clients with integrated, comprehensive HIV medical care with addiction services and medication protocols for SUD at a "one-stop shop"?
- ❑ Can you provide or partner with others to offer mental health care, harm reduction services, medical and non-medical case management, chronic disease self-management, and care coordination for complex clients and for clients transitioning from jail to community medical care?
- ❑ Does your organization offer housing services and, if not, are you able to partner with an organization that does?
- ❑ Does your organization have a mobile outreach van and clinical staff who can devote time to ensure care is brought to clients? If not, is there a local harm reduction organization or a county health department that provides mobile access with whom you could partner?
- ❑ Does your organization or a partner organization have a low-barrier adherence program or other activities, such as walk-in services?
- ❑ Does your organization have navigators on staff, or are you able to hire individuals to perform outreach, care plan development, and navigation support services?
- ❑ Are you able to safely and securely store buprenorphine treatment?

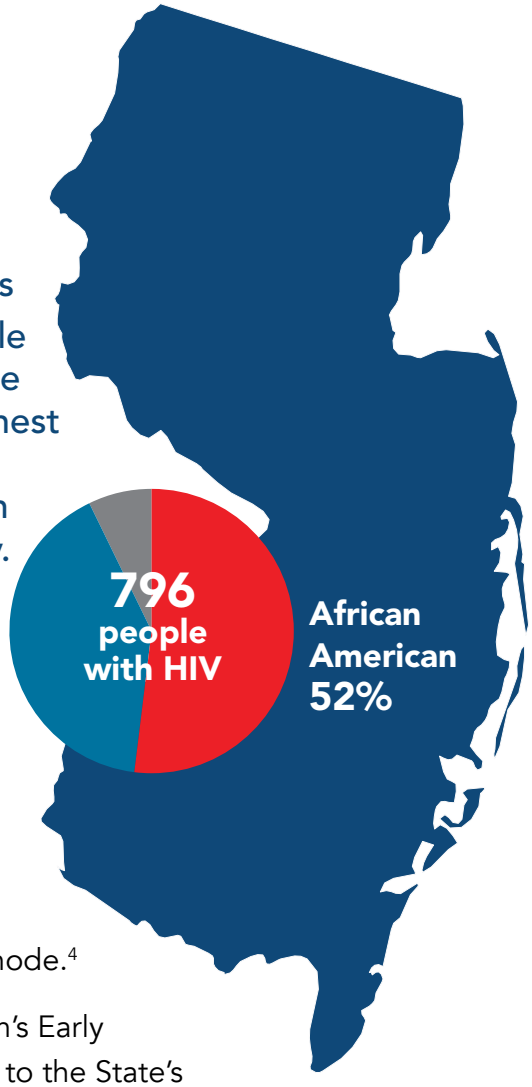
Setting the Stage

In New Jersey (as of 2021) there were:

- 38,470 people with HIV
- 5,600 people exposed to HIV through injection drug use
- 844 people exposed to HIV through male-to-male sex *and* injection drug use[2]

In recent years, New Jersey was one of the top 10 U.S. States for new HIV diagnosis, reporting 805 new cases among adults and adolescents.[3] In 2020, New Jersey's RWHAP served 15,139 clients, accounting for 40 percent of state residents with HIV. Most were low-income (61.6 percent were living at or under 100 percent of the Federal Poverty Level), and the majority were Black/African American (53.1 percent)or Hispanic/Latinx (31 percent). Of New Jersey's 8,574 adult male RWHAP clients, 10.4 percent reported injection drug use as their transmission mode, and 1.5 percent reported male-to-male sex *and* injection drug use. Of New Jersey's 4,777 adult female RWHAP clients, 10.7 percent reported injection drug use as their transmission mode.[4]

Camden has **796** people with HIV, the second highest number of HIV cases in New Jersey.



Camden City, New Jersey, is home to the Cooper Health System's Early Intervention Program (EIP) Expanded Care Center (CEEC)—and to the State's second highest number of HIV cases. As of June 30, 2021, a majority of the 796 people with HIV in Camden were African American/Black (52 percent) or Hispanic (41 percent). Overall, 20 percent of people with HIV in Camden (19 percent of whom were male and 24 percent of whom were female) reported injection drug use (or injection drug use and male-to-male sex) as their risk for HIV transmission.[5]

The current U.S. opioid crisis has had many consequences. The crisis threatens to reverse a long-standing downward trend in HIV infections among PWID. Opioid use disorder

(OUD) worsens HIV treatment outcomes and survival. According to the National HIV Surveillance System (NHSS), PWID with HIV are less likely than other people with HIV to be linked to care within a month of their diagnosis, less likely to be retained in care, and less likely to achieve viral suppression within six months of diagnosis (except for those who reported male-to-male sexual contact *and* injection drug use as HIV risk factors).[6]

People with HIV who inject drugs often have comorbidities, including mental health disorders, chronic HCV infection, sexually transmitted infections (STIs), skin abscesses, soft tissue infections, and endocarditis, calling for multidisciplinary care. In addition, they often encounter stigma in healthcare settings, leading people to delay or avoid health care, or seek it only in settings where they are more comfortable.[7,8] Studies have found that integrating HIV care and treatment with addiction treatment, mental health care, and social support services in a stigma-free setting improves HIV clinical outcomes among people with SUD.[9,10]

New Jersey relies on traditional clinic structures rather than integrated care, so it was not equipped to serve people with HIV and SUD under one roof. In the city of Camden, new HIV diagnoses jumped from 22 to 47 annual cases between 2014 and 2019, as did the proportion of PWID diagnosed with HIV: from 9 percent in 2014 to 32 percent in 2019. PWID in Camden were more likely to visit the emergency department than non-injectors with HIV (83 percent versus 51 percent), and more likely to be hospitalized (56 percent vs. 8 percent).[11]

In 2017, the CEEC faced a large increase in opioid use and overdoses. More people with SUD, many of whom also had mental health disorders, were coming to the clinic and physicians in Camden's emergency departments were seeing more opioid overdoses. The local community-based organizations that the CEEC works closely with were reporting an increase in the number of people presenting for SUD counseling, and CEEC staff who were working in the jail full-time doing HIV screening and assessments noticed that there were many people being incarcerated because of these challenges. Based on this information, the CEEC decided that integrating SUD services for people with HIV was an unmet need that required addressing.

As the negative impacts of the opioid crisis were being felt throughout the community, the CEEC drew from its long-standing relationships with county health department officials, jail staff, community-based organizations, SSP, hospital and health systems and nurses providing care for people with HIV in southern New Jersey. These key partners knew that the CEEC was a resource for people with HIV and SUD, and they connected CEEC navigators to newly diagnosed individuals with SUD, and people with HIV and SUD who had fallen out of care.

Description of Intervention Model

CHALLENGE ACCEPTED

The Challenge: Create a safe place for delivering stigma-free, trauma-informed and integrated HIV, addiction medicine and behavioral health services under a single roof.

The Integration of Comprehensive HIV Medical Care with Addiction Services intervention is a clinic-based "one-stop shop." The intervention provides multidisciplinary, stigma-free services for people with HIV, SUD, and mental health disorders, based on their individual challenges and needs. These services include HIV care and treatment, addiction treatment and MOUD, mental health care, primary care, medical and non-medical case management, chronic disease self-management, and help with housing, insurance, and other social issues. The eligibility criteria include:

- Individuals with a new diagnosis of HIV, SUD, and other co-occurring conditions, including mental health disorders and HCV, and
- People with HIV and SUD who are not currently engaged in HIV treatment.

The intervention staff are committed to improving the health and well-being of people with, or affected by, HIV through high-quality, compassionate medical care and support services, community education, and early detection, regardless of ability to pay. Staff develop trusting relationships with their clients and are available to meet their individual medical and social service needs.

The intervention is grounded in the following values and strategies:

- *Client-centered.* Intervention staff develop care plans for each client, which are based on their needs for HIV and primary care, behavioral health care, MOUD, and social services, and provides medical and non-medical case management. Care plans are revised to address arising challenges and needs, to positively affect linkage, engagement, and retention in care.
- *Trauma-informed and welcoming.* The intervention provides appropriate,

coordinated, and continuous multidisciplinary care. Services are trauma-informed and based on each client's acuity and identified needs, and delivered in a safe, welcoming, and stigma-free space.

- *Harm reduction.* The intervention provides non-judgmental and non-coercive services to meet clients "where they are at," and assist them in minimizing risks in their environment and activities.
- *Team-based.* Service delivery relies on collaboration and close communication between its providers and care teams.

In 2012, the Cooper Center took the lead on forming a multistakeholder committee, called SAFEPAT (Strategic Alignment for Effective Prevention and Treatment), a collaboration of prevention and treatment services, to assure coordinated healthcare practices and a healthy community to address important health and social issues among people with HIV. SAFEPAT brought together county health department officials, community-based organizations, SSPs, hospital and health systems and nurses providing care for people with HIV in southern New Jersey. SAFEPAT has provided a foundation for the intervention. It created and continuously updates a Memorandum of Understanding with information about all the services that its membership provides, as well as the hours they are offered, and contact information for each agency's point person. Through SAFEPAT, there is statewide awareness of the intervention as a resource for people with HIV, SUD and mental health disorders who need to be connected to care.

SAFEPAT still meets and has addressed syphilis, COVID-19, mpox, and other arising public health challenges.

> *"SAFEPAT is instrumental for helping us communicate from one service provider to another, and extremely effective in putting us all together when there is a health care crisis. In the opioid crisis, we used it to work as a unified front."*
>
> –Pamela Gorman,
> Administrative Director at Cooper University Hospital and Intervention Program Coordinator

Intervention Steps:

The stigma that people with HIV, PWID, and people with mental health disorders often experience in traditional healthcare settings can discourage them from seeking or remaining in care. To improve engagement and re-engagement in care, retention in care, and viral suppression, the intervention uses navigators to immediately connect with clients, and has created a safe and welcoming place where clients can receive HIV services, addiction medicine, and behavioral health services that meet their individual needs, under a single roof.

1 Assess community needs and identify key stakeholders

In southern New Jersey, SAFEPAT, a multistakeholder committee led by Cooper, focuses on key health and social issues among people with HIV. When the area was hit with a significant increase in opioid use and overdoses in 2017, SAFEPAT provided a forum to collectively address the opioid crisis.

- SAFEPAT's stakeholders were already dealing with the opioid crisis, and they recognized that it needed to be addressed.
- Together, they identified a need to integrate HIV medical care with addiction services.
- The CEEC expanded its services and ensured, through SAFEPAT, that it was known as a statewide resource for connecting people with SUD to HIV care.
- SAFEPAT efforts were reported at a larger statewide HIV Planning Group meeting to disseminate information about outbreaks and responses to them.

2 Develop infrastructure to support multidisciplinary care

Providing multidisciplinary care requires staff training, teamwork, and constant communication. To facilitate these processes, the CEEC instituted staff orientation and ongoing trainings, multidisciplinary teams, and regular meetings. The CEEC also developed a data management and sharing system, and adequate funding to support a data team to input and analyze information.

- All staff members undergo training during an on-line and in-person orientation, with additional training required for clinical and non-clinical staff members which is provided by the Northeast/Caribbean Regional AIDS Education Training Center (AETC).
- Three multidisciplinary teams support the clinic's doctors and clients; they meet during daily morning huddles.
- A shared office, which houses the clinical psychologist, the addiction specialist, and the infectious disease specialist, facilitates conversations about client needs and challenges.
- Each week, a multidisciplinary team case conference is held.

- Each month, the addiction medicine team meets.
- The CEEC's data management and sharing system integrates CAREWare with EPIC. It is used to improve retention in care, to augment verbal communication between medical and non-medical staff about client needs, for documentation, and to generate reports.

3 Client identification and navigation

People with a new diagnosis of HIV and SUD, and people with HIV and SUD who have fallen out of care, are identified through the intervention's testing program and its relationships with the jail, community-based organizations, and a system-wide opt-out HIV and HCV testing model at inpatient and outpatient healthcare settings. Intervention navigators are the point people for all external partners who contact them when they identify new clients with HIV and SUD.

- Navigators meet with new clients in the community, at the hospital, in the jail, or at the clinic, usually on the same day they are diagnosed or identified.
- Navigators begin building trusting relationships with new clients and encourage them to enter or re-enter care.
- Navigators invite new clients to make an appointment at the clinic, or to just drop by and visit the navigator.
- Following the client's lead, navigators continue to meet with clients, either at the clinic or in other settings, until they feel ready to schedule an appointment at the clinic.
- Navigators are on-site during the client's clinic visits, and work to ensure that their needs are met.
- Navigators are available any time the client has emergent issues or challenges. Each time clients come to the clinic, navigators ask them if any particular needs have arisen; if so, clients are connected with the providers and services to address them.

4 Intake assessment

At their first clinic visit, clients perform a self-administered intake assessment for SUD and mental health disorders on a tablet, and a non-medical case manager performs an acuity assessment to identify additional needs. Some of the information that is collected in the acuity assessment triggers an automatic offer of medical case management (such as being newly diagnosed or out of care for over a year, nonadherence to antiretroviral therapy (ART) and/or a high viral load). During the intake, intervention staff collect demographic and contact information, an initial medical assessment, and a psychosocial assessment. The assessment includes questions about the client's living arrangement, including whether it is

safe and stable, insurance coverage, and substance use and mental health. After clients complete their self-assessment, their questions and concerns are addressed. Their care plan is based on the results of their assessments. A client often requires multiple services, and interaction with navigators, medical and non-medical case managers, psychotherapists, addiction medicine and HIV primary care providers.

- Navigators and clinical psychologists are available to meet with clients during their first appointment. Any emergent needs are addressed.
- Labs are drawn, and a Nurse Navigator checks vital signs and assesses new clients for immediate medical care needs, and connection with a medical provider during the same visit, when needed, or within one week.

5 Second appointment

A week after their first visit, clients meet with a physician and start ART. Staff are available to meet emergent needs.

- Navigators and clinical psychologists are available to meet with clients during their second appointment.
- Follow-up with case management or a clinical psychologist is provided, if needed.

6 Follow-up care

A third visit is scheduled four weeks later, and other visits are scheduled according to each client's needs and as they emerge. To avoid overwhelming clients, appointments with the multidisciplinary team are intentionally staggered. This also reduces the length of appointments for clients (which can easily take up to two hours).

- Each time clients visit the clinic, navigators and other providers check with clients to see if any new needs have arisen; if so, they are connected to a medical case manager who coordinates care with relevant service providers.
- Most services are provided within the clinic; however, the clinic has resources for transportation and other external services, if needed, that are not covered by insurance.

7 Walk-in services

Intervention staff offer daily open sessions and weekly walk-in addiction medicine services (in addition to scheduled appointments) to provide low-threshold access to buprenorphine.

- Program teams use walkie-talkies to let people know when the doctor is ready to see them.
- While they wait, walk-in clients can go into the conference room where donations are kept, and help themselves to clothing, shoes, and

other items including coupons that can be redeemed at the grocery store, fast food restaurants, or the lobby café.

8 **Retention in care**

During the intake process, clients are asked to give their consent to being contacted by a care outreach worker if they miss two scheduled appointments and the clinic is unable to reach them. The care outreach worker will try to contact them by phone and via mail (letters come in unmarked envelopes), or by visiting them at home. Care outreach workers provide assistance with attending medical visits and help remove any barriers to care clients are experiencing.

- Clients with a gap of more than six months between appointments are identified by scanning the Ryan White CAREWare database. Clinic staff manually scan their charts for contact information and last appointment status.
- Information on clients who have missed appointments or have not visited the clinic for more than six months is uploaded to a gap database, which is distributed to outreach, case management and screen/identify/linkage to care and clinical staff, who focus on contacting and re-engaging these clients.

Meetings

The intervention relies on close communication between staff members, both verbally and through its data management and sharing system, to ensure that clients are getting the services they need. The clinic established teams which are assigned to a doctor and consist of a navigator, a clinical psychologist, a medical case manager, a nonmedical case manager, and a nurse. At morning huddles, the clinic teams meet to discuss clients who have appointments that day, to identify new clients, and address challenges clients are experiencing to ensure they get connected with the appropriate resources.

To support the clinic's multidisciplinary care model, the clinical psychologist, the addiction specialist, and the infectious disease specialist share an office, where they can have sidebar conversations about their clients' needs. This close collaboration has attracted doctors, residents, and fellows to the program.

Every Thursday, a multidisciplinary team case conference takes place, where doctors present cases and ask other team members to provide feedback on challenges. Each month, the addiction medicine team meet to talk about services and any needs to be addressed.

STAFFING REQUIREMENTS & CONSIDERATIONS FOR REPLICATION

Staffing/Organizational Capacity

The minimum staff requirements and competencies needed to successfully implement the intervention include the positions listed below. All staff undergo annual Core Training, including on HIV Disease and Health Literacy for Public Health Professionals.

Administration
Administration consists of a Medical Director who is a physician, an Administrative Director, a Business Manager, a Patient Access Supervisor (who handles registration, discharge, and oversees the Insurance Specialist), a Support Services Supervisor for the case management staff, and a Prevention Supervisor, who oversees outreach, navigation, and pre-exposure prophylaxis (PrEP) Counselors.

Staff

- *Clinical Services Representatives:* Cover front desk registration and discharge.
- *Insurance Specialist:* Works to find coverage for clients who are uninsured. Certified Medical Assistants and Registered Nurses provide care.
- *Medical Care Coordinators and Health Coaches:* Provide daily medical and non-medical case management services and support group therapy sessions.
- *Navigators:* Serve as the point people for community partners and clients and are trained in motivational interviewing, social networks strategies, and Antiretroviral Treatment and Access to Services Training.
- *Clinical Psychologists:* Are available for daily assessments and psychotherapy.
- *Clinical Pharmacist and a Pharmacy Liaison:* Supported by the 340B program (for more information, see: **https://www.hrsa.gov/opa**).
- *Clinical Providers:* The CEEC is staffed by doctors who are Board-Certified in Infectious Diseases, Addiction Medicine, and Internal Medicine or Primary Care.
- *Advanced Practice Nurse:* Specializes in HIV and pre-exposure prophylaxis (PrEP) and provides weekly to biweekly medical care appointments.
- *Physician Assistant:* Focused on Primary Care, Hormonal Therapy, and PrEP. who provides weekly to biweekly medical care appointments.
- *Licensed Certified Drug and Alcohol Counselor:* Provides daily individual counseling and weekly group therapy sessions.
- *Patient Education Coordinator/Research Coordinator:* Coordinates patient education and research.
- *PrEP Counselor:* Provides counseling on the use of PrEP.

Data Management Team

The CEEC harnessed the power of data management for generating reports, tracking demographic information, sharing client needs, improving retention in and documenting intervention outcomes, such as retention in care and viral suppression among people with HIV and SUD. It used specialists to integrate electronic health record data identifying people with HIV and SUD from EPIC into CAREWare, the electronic health and social support services information system for HRSA's RWHAP recipients and providers (for more information, see: **https://targethiv.org/library/topics/careware#tabs-0-middle-bottom-2**).

The CEEC relies on a data management team which consists of:

- *Quality Assurance Supervisor:* Oversees data collection, needs assessments, and abstract preparation.
- *Data Analyst:* Manages information technology management across multiple software platforms.
- *Clinical Data Coordinator:* Drills down on performance measurement data and drives quality improvement initiatives.
- *Data Specialist:* Collects and enters data on medical care services and consumer surveys.

Staff Characteristics

Core competencies include:

- Cultural responsiveness, compassion, and empathy
- Willingness to work with people with SUD and co-occurring mental health disorders
- Familiarity with HIV, SUD, mental health, harm-reduction, and trauma-informed care
- Communication skills, humility, and teamwork

Replication Tips for Intervention Procedures and Client Engagement

Successful replication of the Integration of Comprehensive HIV Medical Care with Addiction Services intervention involves the following:

Assessment. Organizations should assess 1) current availability of and access to services and care for PWID with HIV, 2) the services that your organization and its community partners can offer, 3) medical, behavioral health, addiction treatment, and social service needs of clients with HIV, SUD, and co-occurring medical and mental health disorders.

Collaboration. A single organization cannot do it alone. It is essential to develop and maintain relationships with partners. Identify key stakeholders who will facilitate implementation of interventions and work with them to develop systems that will enhance referrals, linkage to, and retention in care. For example, the CEEC relies on system-wide, opt-out HIV and HCV testing across inpatient and outpatient settings for referrals. To implement this process, the CEEC recognized that they needed leadership from the health system, the laboratory, and health informatics at the table. Once the order for HIV and HCV screening was implemented via automated best practice alerts, the number of monthly HIV and HCV tests increased from 300 to 1,300.

Trauma-informed approach. The impact and enormity of trauma on PWID and people who have a history of incarceration is significant. As such, an important piece of replicating this intervention is ensuring that leadership and all staff are devoted to delivering trauma-informed care, and that team members receive training in a trauma-informed approach to service delivery.

Routinize assessments and tools. Engage clients in a tablet-based self-assessment to empower them and identify their needs. Replicating organizations can go online to access screening and assessment tools and acuity scales that work for their organization or adapt them according to their needs.

Hire the right people. All staff members should be non-judgemental, approach their work with empathy, be team players, and be open to learning from, and listening to, clients and each other. Seek people with strong interpersonal skills, who are easily able to connect with clients, and ensure they feel welcomed and safe at the clinic. Hire navigators who know the community and its resources and are comfortable working at the jail and other settings that clients frequent.

Share resources and information. Hold regularly scheduled and informal meetings to update staff and partners.

Develop a robust data management and sharing system. Get adequate funding to support a data team who will input and analyze your data and facilitate process improvement. The CEEC's data management and sharing system has enabled the program to improve retention in care and viral suppression among people with HIV and SUD, and to monitor these important outcomes, reducing the number of clients who did not have an appointment for six months from 15 percent to 10 percent in just three months.[12]

Securing Buy-in

The CEEC was able to secure buy-in for its Integration of Comprehensive HIV Medical Care with Addiction Services intervention because it had long-standing partnerships with the jail, county health departments, healthcare and hospital entities, Syringe Service Programs, and community-based organizations providing services for people with SUD. It was able to take a leadership role in SAFEPAT, using it as a venue to collectively address the opioid crisis in Southern New Jersey, by building on the common recognition of the impact and severity of the crisis among stakeholders.

The following strategies may help to secure buy-in for the Integration of Comprehensive HIV Medical Care with Addiction Services intervention:

- ***Highlight the need the intervention seeks to address, and your capacity to address it as a resource for your community.*** The intervention is treating clients who are not thriving elsewhere, or who drain system resources and provider time through frequent utilization of costly healthcare access (such as ER visits) and are less likely to achieve viral suppression than people with HIV who do not have SUD; therefore, it fills a gap that other entities are failing to meet or are ill-equipped to meet.

- ***Ensure all key players are at the table, including formal partners and community stakeholders, hospital and health system representatives, jail health and re-entry programs, Syringe Service Programs, referral agencies, and clients.*** Discuss client needs and available resources. Establish a common understanding of how you will link clients into care and what services will be provided for them.

- ***Employ a collaborative approach to intervention planning and implementation and maintain communication through regular meetings to keep partners and other stakeholders informed and involved.*** For example, the CEEC has a Community Advisory Board, which includes people with and/or affected by HIV, and people who provide services for the HIV community. The Board meets on a monthly basis.

Overcoming Implementation Challenges

Despite successful implementation of the intervention, some challenges were experienced but were overcome by:

- ***Delivering trauma-informed care.*** As the intervention successfully linked more clients with HIV, SUD, and mental health disorders into–or back into–care, there were service disruptions, often resulting from situations that were triggering for clients who had experienced trauma. This led to staff-wide training on providing trauma-informed care. The intervention staff built on their training to create a rapid behavioral response team, which proactively identified clients experiencing trauma-related challenges and de-escalated situations before they got out of hand, by helping people calm themselves.
- ***Expanding staff capacity through training.*** As the intervention increased the scope of its services, it needed to build staff capacity and enable multidisciplinary care by providing a thorough orientation and ongoing training, including cross-training, for all staff members. Orientation training is provided online and during in-person sessions through the RWHAP's AETC, the Centers for Disease Control and Prevention (CDC), and Rutgers University.
- ***Adjusting to evolving circumstances.*** Although the opioid crisis was the catalyst for this intervention, most intervention clients who have SUD are polysubstance users. Intervention staff found that stimulant use and risk behavior through sexual contact are the predominant ways that clients are acquiring HIV. In response, the intervention implemented services for stimulant use disorder.
- ***Expanding services.*** As the clinic expanded the scope of its services to include addiction medicine services and MOUD, it developed policies, procedures and client agreements to successfully implement them.

The CEEC has had clients enrolled in the program for 30 years. They feel welcome at the clinic's stigma-free environment, and reluctant to go elsewhere for services, so the CEEC has added staff and services to meet their needs.

"When people make that connection with people that are a part of your staff, they keep coming back. They don't even want to go anywhere else. This is why we have so many services at the clinic. People wouldn't go to other providers, so we just kept adding everything."

–Pamela Gorman, Early Intervention Program and Infectious Diseases, at Cooper University Health Care and the Integration of Comprehensive HIV Medical Care with Addiction Services intervention Program Director

Promoting Sustainability

The Integration of Comprehensive HIV Medical Care with Addiction Services intervention emerged from a strong, ongoing multi-stakeholder collaboration, and mutual dedication to addressing the opioid crisis. The intervention has improved retention in care and viral suppression among people with HIV and SUD, providing a foundation for sustainability. This work has been sustained and expanded and is being replicated. It is funded through third-party payer reimbursements such as Medicare, Medicaid and private insurances (program income), the New Jersey Division of HIV, STD, and TB Programs, and 340B pharmacy services program income. In addition, CEEC receives funding from HRSA's RWHAP Part A and Part C and allocates some of these resources to be added to this project. SAMHSA also provides funding for the intervention.

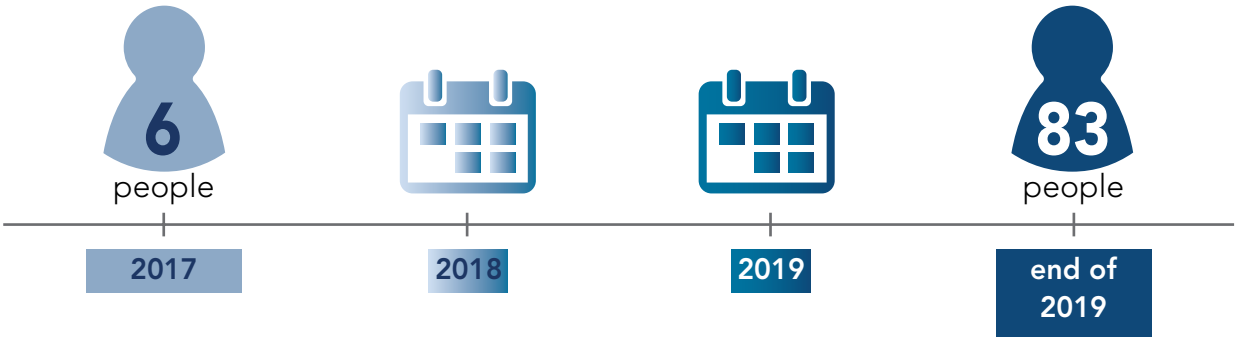
The important components of the intervention's sustainability include its strong partnerships, the clinic's data management and sharing system, staff selection criteria and cross-training, and the development of an intake system that can rapidly assess and address client needs as a "one-stop shop."

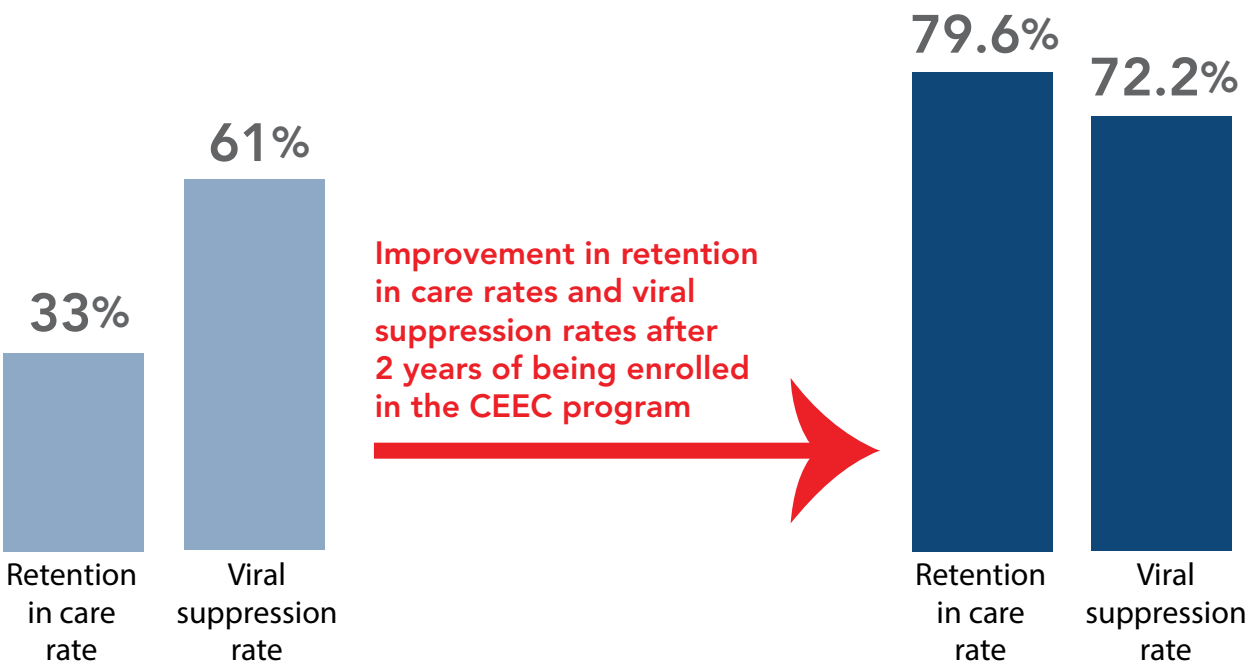
Outcomes related to sustainability and expansion have included:

- Identification of program navigators as "go-to" people for client referrals
- Routinizing intake processes for client self-assessment and acuity assessments
- Integrated, team-based, wraparound care
- Trauma-informed care
- Development of data management and sharing system that integrates data from electronic health records into CAREWare for generating reports and monitoring client needs and outcomes

INTEGRATION OF COMPREHENSIVE HIV MEDICAL CARE WITH ADDICTION SERVICES: BY THE NUMBERS

Number of people with HIV and SUD enrolled in CEEC:

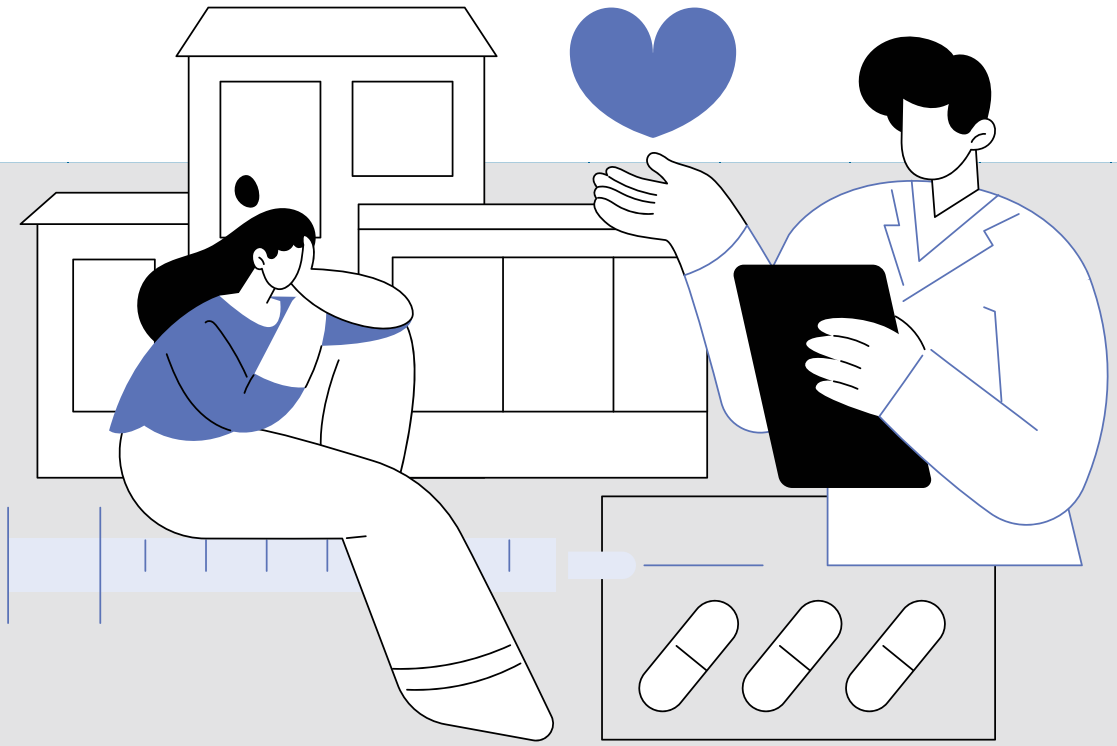




Conclusion

The Integration of Comprehensive HIV Medical Care with Addiction Services intervention is a comprehensive, promising intervention for engaging and re-engaging people with HIV and SUD, many with co-occurring mental health disorders, in care. The CEEC, through its partnerships with a range of stakeholders, has become a resource for people with HIV who have SUD in Southern New Jersey.

The intervention's adept navigators, acuity and assessment systems, data management and sharing system, staff training and teamwork drive delivery of wraparound and trauma-informed care. Providing integrated HIV and addiction medicine services has been the most successful approach for treatment and support of people with HIV and SUD. This intervention has reached people who often experience stigma related to HIV, substance use, and mental health disorders. The intervention was shown to increase engagement of people with HIV and SUD in care and significantly improve retention in care and viral suppression.



OTHER AVAILABLE RESOURCES

Integration of Comprehensive HIV Medical Care with Addiction Services Resources

Integration of Comprehensive HIV Medical Care with Addiction Services:
https://targethiv.org/intervention/integration-comprehensive-hiv-medical-care-addiction-services?utm_source=bpURL

The Effect of Addiction Services on Viral Load Suppression in People with HIV with Substance Use Disorder:
https://targethiv.org/sites/default/files/RWNC2020/16136_Gorman.pdf

The Intersection of HRSA's Ryan White HIV/AIDS Program and the Opioid Epidemic:
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/opioid-executive-summary-report.pdf

Injection Drug Use and Healthcare Utilization in Patients Newly Diagnosed With HIV:
https://journals.lww.com/journaladdictionmedicine/Fulltext/2022/05000/Injection_Drug_Use_and_Healthcare_Utilization_in.13.aspx

Enhancing Trauma-Informed Care Through Collaboration and Routine Behavioral Health Screening:
https://ryanwhiteconference.hrsa.gov/wp-content/uploads/2022/08/2022-National-Ryan-White-Conference-Full-Program-508-081622.pdf

Additional Replication Resources

Integrating HIV Innovative Practices (IHIP):
https://targethiv.org/ihip

Best Practices Compilation:
https://targethiv.org/bestpractices/search

HIV Care Innovations:
https://targethiv.org/library/hiv-care-innovations-replication-resources

Integration of Buprenorphine into HIV Primary Care Settings: Tools from the Integrating HIV Innovative Practices Program:
https://targethiv.org/ihip/buprenorphine

Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care:
https://targethiv.org/deii/deii-buprenorphine

A to Z Interventions and Strategies:
https://www.cdc.gov/hiv/effective-interventions/a-to-z.html

Antiretroviral Treatment and Access to Services Training:
https://www.cdc.gov/hiv/effective-interventions/treat/artas/?Intervention%20Name=ARTAS

The New Jersey HIV Trauma Informed Care Project:
https://caiglobal.org/projects/new-jersey-hiv-trauma-informed-care-project/

Federal Statutes, Regulations, and Guidelines that Apply to Medication-assisted Treatment (MAT) for Practitioners and Opioid Treatment Programs (OTPs):
https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines#DATA-2000

Treating Substance Use Disorders Among People With HIV:
https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep20-06-04-007.pdf

Buprenorphine Quick Start Guide:
https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf

FAQ for Buprenorphine Waiver Applicants and Certified Practitioners:
https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner/buprenorphine-waiver-faqs

Treatment Improvement Protocol (TIP) 63: Medications for Opioid Use Disorder:
https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-02-01-002.pdf

Need Help Getting Started?

If you are interested in learning more about this intervention or other interventions featured through the Integrating HIV Innovative Practices project and want to see if you qualify for technical assistance, please email: **ihiphelpdesk@mayatech.com**

Subscribe to our Listserv

To receive notifications of when other evidence-informed and evidence-based intervention materials, trainings, webinars, and TA are available through the Integrating HIV Innovative Practices project, subscribe to our Listserv at: **https://targethiv.org/ihip**

Tell Us Your Replication Story!

Are you planning to implement this intervention? Have you already started or know someone who has? We want to hear from you. Please reach out to **SPNS@hrsa.gov** and let us know about your replication story.

Endnotes

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