Ryan White HIV/AIDS Program (RWHAP) Part B Coverage of Treatment & Services in Syringe Services Programs (SSPs)

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This fact sheet outlines key considerations for RWHAP Part B recipients[1] as they support the delivery of and access to core medical and support services within and/or in combination with local SSPs to serve the needs of persons who inject drugs (PWID) living with HIV. It also provides a summary of Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) guidance as well as other federal and local policies related to the provision of services in SSPs.

Key Considerations for the Provision of RWHAP Part B Services in SSPs to PWID Living with HIV

HIV disproportionately affects PWID

PWID account for nearly 9% of newly HIV diagnosed individuals in the United States, while 7% of all PWID are estimated to be HIV-positive. Current HIV incidence rates predict that one in 23 women and one in 36 men who inject drugs will be diagnosed with HIV within their lifetimes with 40% of these individuals being White, 38% Black/African American, and 19% Hispanic/ Latinx. Only 57% of PWID reported having been tested for HIV within the past 12 months. This underscores the need for increased HIV testing among PWID to ensure early identification of people living with HIV and timely linkage to necessary care and services. Rates of linkage to care, retention in care, and viral load suppression among PWID living with HIV are also low. Because SSPs serve PWID, they provide a unique opportunity to reach PWID and address these gaps across the HIV care continuum.

PWID face barriers to optimal health outcomes

PWID are disproportionately affected by various social and economic factors that can limit access to health care broadly, and HIV care specifically. An HIV Surveillance Special Report released by the Centers for Disease Control & Prevention (CDC) showed that 81% of PWID living with HIV have incomes at or below the federal poverty level (FPL). In addition, the report showed that within the past 12 months, 56% report having

[1] The fact sheet is designed for RWHAP Part Bs and ADAPs but is relevant to other RWHAP Parts as well.

experienced homelessness, 24% have been incarcerated, and 16% have been uninsured. All four of these factors represent significant barriers for PWID to achieving optimal health outcomes. For example, PWID living with HIV who experience homelessness may display significantly higher rates of serious mental illness, diabetes, and heart disease, among other health conditions. Similarly, justice-involved PWID living with HIV face additional related challenges and have unique service needs. Furthermore, the high rates of poverty and lack of health insurance among PWID living with HIV limit access to treatment as well as other necessary resources such as food, housing, and transportation. PWID may also be deterred from accessing care due to difficulty navigating the healthcare system, stigma surrounding substance use, and fear of incarceration. Finally, PWID living with HIV are at a significant risk of contracting hepatitis C (HCV)— approximately 75% of PWID living with HIV in the United States are also infected with HCV.

The disproportionate burden of comorbidities, as well as social and structural barriers, make accessing and continuously utilizing health care extremely difficult for PWID, including those living with HIV. As the need for attention, services, and resources for PWID has increased over the past several decades, SSPs have also broadened the scope of their services for PWID. There is a diverse range of SSP program structures, types, and locations that can provide varying levels of care for PWID. This range is inclusive of programs from very low threshold outreach, that consists of delivery of safer injection equipment and referrals, to very comprehensive programs couched within local public health clinics or hospitals, that offer intensive case management, referrals, infectious disease testing, etc., with a variety of programs operating on this spectrum. These SSP models and service delivery types have distinct benefits and potential limitations for PWID and each service type is supported empirically and should be implemented based on community need.

SSPs improve health outcomes for PWID living with HIV

SSPs have historically been considered an integral part of the prevention effort for HIV and HCV among PWID by providing sterile injection materials. However, improving access to and coordination of medical and support services can make SSPs important health care access points for PWID. Since SSPs incorporate a nonjudgmental approach to working with PWID, expanding SSP services to include HIV testing and referral to treatment allows for PWID to access HIV prevention interventions without facing stigma, discrimination, or fear of arrest.

Research has suggested that SSPs are most effective at addressing the HIV epidemic when they offer four key services[2]: (1) medication-assisted treatment (MAT), (2) HIV and HCV screening and treatment, (3) HIV pre-exposure prophylaxis (PrEP), and (4)

[2] Please note the HHS required components for SSPs for federal funding to be used available here.

behavioral health services. Longitudinal analyses have shown that people with opioid dependency living with HIV who are prescribed and achieve maintenance on MAT (i.e., methadone, buprenorphine, naltrexone) are significantly more likely to initiate antiretroviral therapy and to achieve viral suppression than those not retained on MAT. Additional studies have also shown that adding MAT and PrEP to SSP services is not only cost-effective, but cost-saving when compared to SSPs that only offer syringe and naloxone distribution.

Potential role of RWHAP Part B funds in SSPs

RWHAP recipients can play an important role in addressing the HIV epidemic within the PWID population by funding RWHAP-allowable services within stand-alone SSPs and those within organizations. This is particularly relevant in suburban and rural areas where there tend to be fewer SSPs with less capacity to provide various necessary related services (e.g., HIV and HCV testing and linkage to care, distribution of overdose prevention medications, and/or MAT). This resource presents selected RWHAP service categories that support SSP program designs. The reader should not assume that every SSP will be eligible to use RWHAP funds in every setting; rather, NASTAD has included a range of potential mechanisms to support SSP services with RWHAP funds in a variety of settings.

While the focus of the document is on the use of RWHAP Part B funds, the same expenditure rules apply to the use of RWHAP program income and ADAP rebates to support and/or fund SSPs.

Policy considerations for using RWHAP Part B funds in SSPs

The Consolidated Appropriation Act of 2016 permits the use of federal funds from the Department of Health and Human Services (HHS) to support SSPs, with the exception of paying for sterile needles or syringes or other drug preparation equipment[3]. The HHS Implementation Guidance to Support Certain Components of Syringe Services Programs outlines the requirements for programs directly funded by HHS interested in implementing or expanding SSPs for PWID. HRSA has provided additional clarification for recipients on the use of HRSA funding (including RWHAP funding) to support SSPs.

As outlined in the HHS Implementation Guidance, the key requirements to use federal funding to support SSPs in providing allowable RWHAP Part B core medical and support services to RWHAP-eligible clients include:

[3] Since there is a prohibition on using any federal funds on injection equipment, jurisdictions must use alternative funding to purchase and distribute syringes and other injection equipment. This can include a variety of state or local funding (e.g., state or local taxes, state or local legislative allocations) or private/non-profit foundation sponsorship or resources.

(1) Having an "Determination of Need" from CDC that approves their use of HHS funding to support SSPs in the relevant geographic area (except for the purchase of syringes/needles or other drug preparation equipment)
(2) Presenting a certification to the HRSA HAB project officer in the form of a letter signed by the health officer from the state, local, territorial, or tribal health department that such program is in accordance with applicable law
(3) Obtaining prior and continued approval from the jurisdiction's HRSA HAB project officer regarding the intended use of funding to support RWHAP Part B core medical and support services costs

RWHAP recipients should ensure that they are working closely with HRSA HAB and in compliance with federal and state/local policy in obtaining approval for and implementing SSPs in their jurisdiction. All activities that are funded with RWHAP grant funds are subject to the terms and conditions incorporated or referenced in the recipient's federal funding. All RWHAP funded activities must fall under RWHAP service category definitions and must be delivered to individuals who are RWHAP eligible (i.e., living with HIV[4], low-income as defined by the recipient).

Treatment and Care for People Living with HIV (PLWH) Accessing SSPs: RWHAP Service-Specific Information

RWHAP Part B core and support services that benefit PWID living with HIV

There are thirty RWHAP service categories that RWHAP Part B recipients can fund to diagnose HIV infection, link and retain PLWH in care, and provide HIV treatment, including for PWID living with HIV[5]. The following are select RWHAP service categories that can be particularly beneficial to meeting the needs of PWID living with HIV. These are not exhaustive, however, and should be taken under consideration in the broader context of individual jurisdictions' and clients' needs. Please refer to HRSA HAB PCN 16-02 for the complete list of RWHAP service categories and their definitions.

- **Early Intervention Services (EIS):** Early Intervention Services includes four required components that can encompass a variety of programming to address the needs of PLWH who are unaware of their status or have been recently diagnosed, including PWIDs. As per PCN 16-02, the required four components are: "(1) Targeted HIV testing…and referrals for HIV care and treatment services if clients are found to be HIV-infected…; (2) Referral services to improve HIV care and treatment services at key points of entry; (3) Access and linkage to HIV care and treatment services such

[4] To serve HIV-negative clients, with some exceptions within Early Intervention Services (EIS) and Outreach Services, SSPs would need to identify other funding sources outside of RWHAP.
[5] RWHAP Part B funds can be used to fund relevant positions under RWHAP service categories at the SSPs to support the provision of services to address the needs of the PWID living with HIV they serve.

as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Use Care; and (4) Outreach Services and Health Education/Risk Reduction related to HIV diagnosis." PWIDs, including those living with HIV, can have reduced access to testing and care services because of real or perceived stigma and economic barriers. By supporting SSPs' capacity to provide EIS, RWHAP Part B recipients can promote the identification, referral, and linkage of PWID living with HIV into care and other supportive services. RWHAP Part B recipients might also leverage EIS as part of broader Data to Care (D2C) activities geared towards linking and re-engaging individuals who are out of care.

- **Medical Case Management:** Medical Case Management can be a critical means of identifying and removing barriers to medical care and ensuring adherence to prescribed treatment. It is found to significantly increase linkage to services and treatment adherence among PLWH. SSPs often conduct harm-reduction-based medical case management coordinated with other public health systems and providers. Bolstering current SSP services with RWHAP Part B funds could significantly increase access to medical case management for PWID living with HIV as they access needed services in an environment in which they are already receiving assistance and are familiar.

- **Mental Health Services:** Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. People with substance use disorders, including those living with HIV, also display higher rates of co-occurring mental health conditions. Coping with co-occurring mental health conditions has been found to significantly impact treatment adherence, and ongoing psychological distress is associated with poor long-term health outcomes for PLWH. SSPs can provide access to mental health services for clients who inject drugs and are living with HIV, either through onsite counseling or referrals to services.

- **Outpatient/Ambulatory Health Services:** Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a healthcare provider in an outpatient medical setting. Services may include medical history taking, testing and examinations, treatment and management of physical and behavioral health conditions, risk assessment and risk reduction counseling, therapeutic counseling, preventive care and screening, prescription and management of medication therapy, treatment adherence, education and counseling on health and prevention issues, and referrals to HIV specialists. These services can occur within, or in conjunction with, SSPs. Funding these services in

SSPs that reach populations that have been underserved in traditional medical care settings may improve the health outcomes of PWID living with HIV.

- **Substance Use Outpatient Care:** Substance Use Outpatient Care includes screening, assessment, and diagnosis of drug or alcohol use disorders, as well as treatment of substance use disorders (e.g., pretreatment/recovery readiness programs, harm reduction, behavioral health counseling, outpatient treatment and counseling, MAT, neuro-psychiatric pharmaceuticals, and relapse safety planning). The provision of MAT has been strongly associated with better HIV treatment outcomes and higher rates of viral load suppression. Additionally, MAT has been shown to improve HIV treatment outcomes for the unstably housed. SSPs can be co-located with outpatient substance use services or can be linked with outpatient substance use care.

- **Food Bank/Home Delivered Meals:** Food Bank/Home Delivered Meals includes the provision of actual food items, hot meals, or a voucher program to purchase food. Both PLWH and individuals using substances exhibit higher rates of food insecurity and issues related to poor diet. Food insecurity increases psychological distress, decreases treatment adherence, and diminishes positive health outcomes for PLWH. Often, SSPs already provide supplemental food and hygiene products and make referrals to food banks. Expanding the capacity of these services to meet this need will ultimately improve the quality of life and overall health of PWIDs living with HIV.

- **Health Education/Risk Reduction:** Health Education/Risk Reduction provides critical information to clients living with HIV on how to reduce the risk of HIV transmission. This can include: strategies to reduce transmission such as PrEP for clients' sexual and injection partners and treatment as prevention; health care coverage options (e.g., Medicaid coverage, Medicare coverage); health literacy; and treatment adherence counselling. These types of services are often provided in SSP settings, particularly education related to safer injection practices and casework related to health care and social service access.

- **Housing Services:** Housing Services provide transitional, short-term, or emergency housing assistance to enable clients to gain or maintain medical care and treatment. PWIDs living with HIV are disproportionately impacted by homelessness and homelessness, in turn, negatively affects rates of viral load suppression.

- **Medical Transportation:** Medical Transportation Services is the provision of nonemergency transportation that enables clients to access or be retained in core medical and support services. PWID living with HIV can greatly benefit from

receiving transportation services to outpatient substance use treatment programs, including MAT or behavioral health services that may be co-located with SSPs.

- **Non-Medical Case Management:** Non-Medical Case Management provides guidance and assistance to clients in accessing medical, social, community, legal, financial, and other needed services. It may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, pharmaceutical manufacturers' patient assistance programs (PAPs) or cost-sharing assistance programs (CAPs), other state or local health care and supportive services, or health insurance plans. SSPs often provide extensive case management and referrals within the SSP setting to assist clients in accessing necessary services. Support for this sort of case management could be funded for RWHAP-eligible PLWH using RWHAP resources.

- **Outreach Services:** Outreach Services include the provision of: (1) identification of PLWH who do not know their HIV status and/or (2) linkage or reengagement in care for PWLH who know their status. Outreach services must be conducted in places where there is a high probability that individuals are infected with HIV and/or are engaging in behaviors that increase risk of HIV infection. SSPs provide outreach services to PWIDs, related to both HIV and hepatitis. RWHAP Part B funding can be used to expand outreach services (e.g., dedicated staff) for PWIDs living with HIV and those living with HIV/hepatitis-coinfection. RWHAP Part B recipients might also leverage Outreach Services as part of broader D2C activities.

- **Referral for Health Care and Support Services:** Referral for Health Care and Support Services directs clients to needed core medical and support services in person, over the telephone, or through written communication. Referrals from health care providers or case managers are not included—they are instead reported through the appropriate Outpatient/Ambulatory Care or Medical and Non-Medical Case Management categories—yet referrals from SSPs may be eligible. Many SSPs already provide referrals and linkages to important services and programs, such as mental health services and substance use treatment, and additional funding from RWHAP Part B programs could increase their capacity to make these critical referrals for PLWH.

RWHAP Part B-allowable administrative costs within SSPs

The RWHAP legislation allows a limited amount of the grant award for the administrative costs of RWHAP services[6]. For SSPs funded through RWHAP Part B, allowable administrative funds can help support, for example, the cost of staff, the maintenance of data systems to capture service utilization and client health outcomes for RWHAP eligible clients, and the purchase and/or upgrade of data systems that allow SSPs to monitor their delivery of services to their RWHAP eligible clients. Administrative funds can also be used, within established limits, for minor Alterations and Renovations (A&R), work that changes the interior arrangements or other physical characteristics of an existing facility or installed equipment so that it can be used more effectively for its currently designated purpose or adapted to an alternative use to meet a programmatic requirement. This may be particularly helpful to SSPs that lack resources to bolster the physical space and/or equipment they utilize in delivering RWHAP services to PWID living with HIV. RWHAP Part B programs must demonstrate that any minor A&R funded using RWHAP Part B dollars benefits RWHAP-eligible clients.

RWHAP Part B-funded trainings related to SSPs

Evidence suggests that provider discrimination and lack of physician education about substance use act as barriers to care for PWID living with HIV. Cultural competency trainings would help to address these barriers and reduce stigma surrounding drug use by educating providers on infectious disease risks related to drug use and HIV risk reduction strategies for PWIDs. AIDS Education and Training Centers (AETCs) can provide training and support to local providers to enhance capacity in serving PWID living with HIV. Jurisdictions should consider increasing the partnership with their local AETCs (e.g., contributing RWHAP Part B funds) to further support cultural competency in serving PWID living with HIV, including engaging with SSPs.

In addition to building capacity related to servicing PWID living with HIV, RWHAP Part B recipients may also choose to use administration funds to increase understanding of the impact of trauma for PWID living with HIV served by SSPs through technical assistance, development of materials, or trainings. Individuals exposed to various types of past and current trauma, such as childhood sexual and physical abuse, intimate partner violence, physical assault, or psychological abuse, often experience negative physical, mental, behavioral, and social consequences. There is a growing body of evidence that PLWH are

[6] RWHAP Part B Recipients (i.e. states/territories) are allowed to use up to 10% of RWHAP Part B funding for the payment of administrative costs in any grant year, with a total of 15% used for the combination of administration, planning, and evaluation activities. Separately, the lesser of five-percent of the total grant or $3,000,000 may be used to fund CQM activities. The cost caps do not apply to rebate funds, but the costs must still be related to RWHAP allowable services.

exposed to high levels of trauma during childhood and adulthood, at rates much greater than those experienced by the general population. Among PLWH, experiences of trauma are associated with poor mental health, increased engagement in HIV high-risk transmission behaviors (e.g., injection drug use) and diminished adherence to HIV care and treatment.

Conclusion

The disproportionate burden of comorbidities, as well as social and structural barriers, can make accessing and continuously utilizing health care extremely difficult for PWID, including those living with HIV. SSPs are effective providers of services for PWID living with HIV, and these services can be supported and strengthened by RWHAP Part B services. **NASTAD encourages RWHAP Part B programs to consider creating and/or strengthening partnerships with SSPs and drug user health programs in their state or jurisdiction to improve outcomes for PWID and increase the capacity to provide these vital services.**

Resources:

- NASTAD (National Alliance of State & Territorial AIDS Directors) www.NASTAD.org
  - NASTAD – Health Care Access
  - ADAP Formulary Coverage of Substance Use Treatment
  - Ryan White HIV/AIDS Program Part B and ADAP Uses of Rebate Funds
  - The Intersection of Hepatitis, HIV, and the Opioid Crisis: The Need for a Comprehensive Response
- HRSA HIV/AIDS Bureau
- HRSA TARGET Center – technical assistance for the Ryan White community
- The Foundation for AIDS Research (amfAR) – Opioid & Health Indicators Database
- HHS - Preventing HIV And Hepatitis Among People Who Inject Drugs And Their Partners
- HRSA-Specific Implementation Guidance to Support Certain Components of Syringe Services Programs (2016)
- Ryan White HIV/AIDS Treatment Modernization Act (2009)

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