Special Projects of National Significance (SPNS) Program
(Ryan White HIV Program Part F)

A Presentation for the Division of State HIV/AIDS Programs

August 30, 2017

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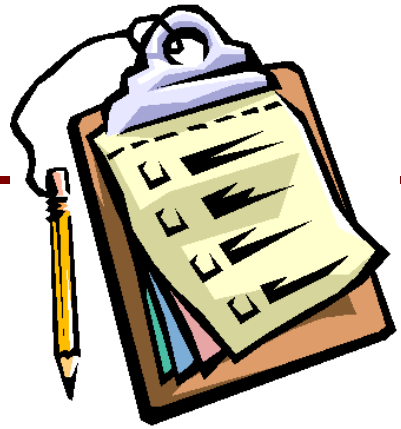
HIV/AIDS Bureau

Today's Agenda



- Opening Questions
- Background on SPNS
- The HIV Care Continuum
- Deeper Dive on Recent SPNS Initiatives and Learnings
- Brainstorm About SPNS Replication
- Review SPNS Resources

Opening Questions

- What do you know (or have heard of) about SPNS?
- Is there an issue related to HIV care that you've thought "I need an innovative answer for that"?
- Have you ever reviewed findings from a SPNS demonstration? What was it?
- Have you used findings from a demonstration project (any kind) for anything in particular?

The Special Projects of National Significance Program HIV/AIDS Bureau

- **Authorized under Part F of the Ryan White HIV/AIDS Program, Section 2691**
- **What SPNS Does:**
  - **Supports development of innovative models of HIV care** to quickly respond to the emerging needs of clients served by the Ryan White HIV/AIDS Program
  - **Evaluates effectiveness of the models'** design, implementation, utilization, cost, and health-related outcomes
  - **Promotes dissemination and replication** of successful models
  - **Supports special programs to develop standard electronic client information data systems** to improve grantee- and client-level data reporting to HHS

SPNS Initiatives

- **9 Initiatives**
- **70 Awardees in 16 states and Puerto Rico**
- **Multiple sub-awardees and partners**
- **7 Cooperative Agreements with Evaluation and Technical Assistance Centers/Providers**
- **Usually Multi-Year (most often 3-4 years)**
- **Awardees selected by objective review process**
  - Each site produces an Intervention Manual to foster replication

SPNS Focus

Identifying Models to Improve Continuum of Care Outcomes

Spread successful models into the HIV and health care system

Current SPNS Initiatives

- Health Information Technology
- Multiply Diagnosed Homeless & Medical Home
- Transgender Women of Color
- Culturally-Appropriate Latino
- Curing Hepatitis
- Workforce Development
- Social Media
- Housing Data Integration
- Dissemination of Effective Interventions

Health Information Technology

→ Demonstrate how the enhancement of health information technology (HIT) systems can integrate and use relevant measures of HIV treatment, surveillance, and laboratory testing

GA, MA, NY State,

Paterson, NJ, and VA

Ending in various stages through March 2018

Multiply Diagnosed Homeless and Medical Home

Building and maintaining sustainable links to care among mental health, substance use disorder treatment, emergency housing, and HIV primary care providers.

Ending August 2017

***AJPH* supplement coming out in Spring 2018**

Demonstration Sites in:

- **Dallas, TX**
- **San Francisco, CA**
- **Pasadena, CA**
- **Portland, OR**
- **San Diego, CA**
- **Houston, TX**
- **Gainesville, FL**
- **Tri-County Area, NC**
- **New Haven, CT**

→ Boston University & Boston Healthcare for the Homeless, ETAC

Transgender Women of Color

Innovative interventions designed to improve timely entry, access to, and retention into quality HIV primary care for transgender women of color.

Demonstration sites in:

- **Albany, NY**
- **Freemont, CA**
- **Los Angeles, CA**
- **New York, NY**
- **Oakland, CA**
- **Chicago, IL**
- **San Francisco, CA**

UCSF Center for Transgender Health, ETAC

Ending August 2017

Culturally-Appropriate Latino

Demonstration and evaluation of culturally-specific service delivery models rooted in transnational approaches.

Sites in: New York City, Philadelphia, Chapel Hill, NC, Chicago, Dallas, TX, and Los Angeles, CA.

ETAC: UCSF Center for AIDS Studies

Ending in August 2018

Hepatitis C (HCV) Initiatives, 2017 & 2018

- **Jurisdictional Approach to Curing Hepatitis C among People of Color Living with HIV**
  - Up to $650,000 per year for 3 years
  - 3 RWHAP Part A (New York City; Hartford ; Philadelphia)
  - National Alliance of State and Territorial AIDS Directors (NASTAD) awarded to serve as TA provider to selected RWHAP Part B subrecipients (Louisiana; North Carolina)
- **AIDS Education and Training Center Program (AETCs)**
  - Support provider training and develop a HIV/HCV curriculum around coinfection
- **Evaluation and Technical Assistance Center**

Workforce Development (a.k.a. Practice Transformation)

- Multi-site demonstration and evaluation of system-level changes in staffing structures and protocols to improve health outcomes
- Focus on Practice Transformative Models (PTMs) for the delivery of HIV treatment and comprehensive care services
- 15 sites in areas with shortages of HIV primary care physicians and increasing demand for access to quality HIV services

Participating communities: Chicago, Cleveland, Corpus Christi & Longview, TX, Kissimmee, Coral Gables, & W. Palm Beach, FL, New York City, Puerto Rico, San Diego, and Washington, DC,

Electronic and Social Media

Demonstration and evaluation of innovative electronic and social media methods to identify, link, and retain hard-to-reach youth and young adults ages 13-34

Demo sites in Corpus Christi, TX, Los Angeles, New York City, Philadelphia, Chicago, Cleveland, Hershey, PA, San Francisco, Winston-Salem, NC, St. Louis, MO

UCLA School of Medicine is ETAC

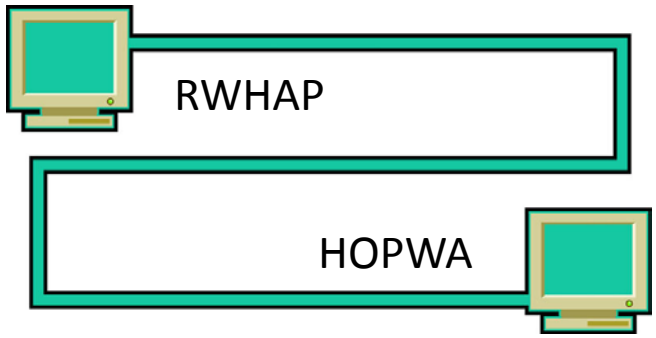
Housing and Data Integration

Promotes HIV Care and Housing Coordination through Data Integration to Improve Health Outcomes along the HIV Care Continuum

In partnership with the Department of Housing and Urban Development

5 sites in Hartford, CT; Seattle, WA; W. Palm Beach, FL; Kansas City, MO; and Honolulu, HI

RAND Corporation is ETAC



Dissemination of Effective Interventions

Disseminates four adapted linkage and retention interventions from prior SPNS and SMAIF funded initiatives:

- *Enhancing links for persons being released from jails;*
- *Buprenorphine Treatment in HIV Primary Care;*
- *Outreach and Interventions for Underserved Populations;*
- *Use of Peers in Retention and Re-engagement*

12 performance sites implement one of these interventions adapted for replication

AIDS United and **Boston University School of Public Health** hold **Cooperative Agreements** to implement this with the various subcontracting performance sites

New Hepatitis C Initiatives, This Fall

- **Curing Hepatitis C Among People of Color Living With HIV**
  - Funds two (2) recipients up to $2,500,000 each per year for 3 years
  - Recipients expected to subaward and work with clinical sites
  - Improve coordination with SAMHSA-funded SUD treatment providers to deliver behavioral health and SUD treatment support to achieve treatment completion and prevent HCV infection and re-infection
  - Enhance state, local, and tribal health department surveillance systems to increase their capacity to monitor acute and chronic coinfections of HIV and HCV
- **AIDS Education Training Center Program (AETCs)**
  - Train providers through the use of a curriculum and provider competencies developed by AETC NCRC
  - Collaboration with Regional AETCs
- **1 Evaluation and Technical Assistance Provider**

New SPNS & SMAIF Funded Project, this Fall

HRSA-17-113, and -114

Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services

To support the design, implementation, and evaluation of innovative interventions that coordinate HIV care and treatment, housing, and employment services

Up to 10 Demonstration Sites and 1 ETAP

More Questions

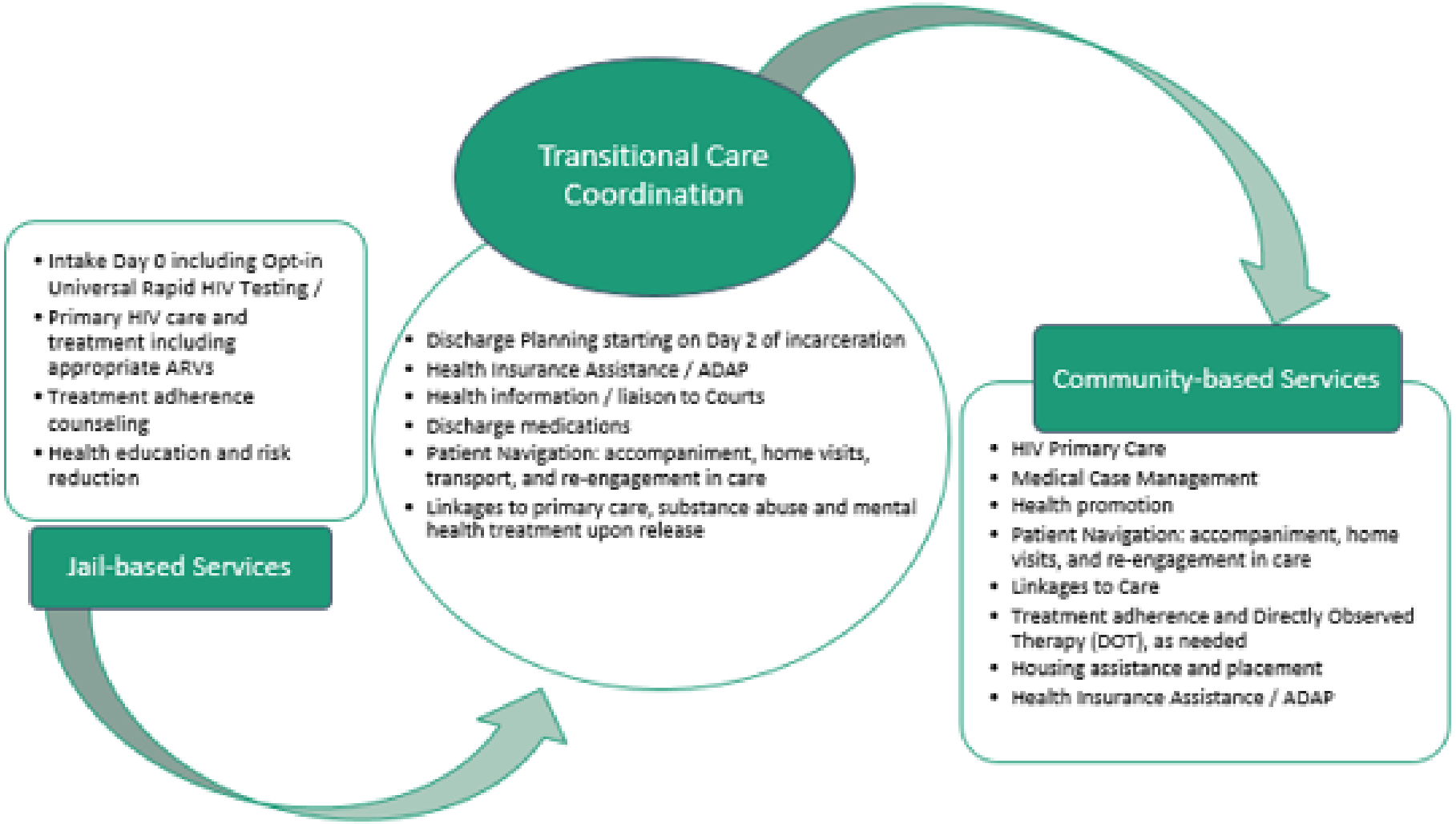
- What gaps in the HIV care continuum is your jurisdiction addressing?
- What innovations have you tried to address them, and how did that work?
- Is there anything about current or upcoming SPNS Initiatives that intrigues you?

Deep Dives into SPNS Projects

- NYC Transitional Health Care SPNS Jails Project
- SPNS Systems Linkages Initiative
- SPNS HIT Capacity Initiatives
- SPNS Homeless Initiative
- SPNS Transgender Women of Color

Rikers Island

HIV Continuum of Care Model



Rikers Island Transitional Health Care

- **From Rikers Island to Community Health Centers**
- **HIV Population**:
  - 3,000 self report living with HIV on admission
- **Discharge Plans:**
  - 2,400 discharge plans/year address primary care and:
    - behavioral health treatment (52%)
    - housing (29%)
- **Linkages to Care:**
  - 1,750 released to the community with a plan
  - **74% (1,300) met with community health provider**

Rikers Island SPNS Project Outcomes

434 Participants were enrolled at Baseline

- **Compared with baseline, among those seen at 6 months (n = 243):**
  - More were taking ART medications (92.6% vs 55.6%)
  - More had improved ART adherence (93.2% vs 80.7%)
  - Fewer emergency department visits (0.20 vs 0.60 visits)
  - Fewer were unstably housed (4.15% vs 22.4%) and
  - Fewer experienced food insecurity (1.67% vs 20.7%)

Teixeira PA, Jordan AO, Zaller N, Shah D, & Venters H. Health Outcomes for HIV-Infected Persons Released From the New York City Jail System With a Transitional Care-Coordination Plan. *American Journal of Public Health*, February 2015; 105 (2): 351-357. Link to the PubMed Abstract

Resources for this intervention may be found in IHIP on TARGET IHIP under Jail Linkage Programs

Systems Linkages and Access to Care, 2011-2016

Website link: https://hab.hrsa.gov/about-ryan-white-hivaids-program/spns-systems-linkages-and-access

- **Five Year Initiative** (September 2011 to August 2016)
- **6 States** (Louisiana, Massachusetts, New York, North Carolina, Virginia, and Wisconsin)
- **Systems Linkages** are the enhancement of existing – or implementation of new collaborative relationships or partnerships among Ryan White HIV/AIDS Program and other, non-traditional HIV organizations
- **Use of IHI Collaborative Model** (like in previous HAB Cross Parts Initiatives)
- **HIT data systems linkage & re-engagement interventions** (OOC lists)
- **Data system integration** (testing, surveillance, and care & treatment)
- **Community linkage interventions** (Disease Intervention Specialists & State Bridge Counselors, Patient Navigation, Correctional Care Coordination, Enhanced testing/linkage, Social Networks, etc.)

SPNS Systems Linkages 2011-2016 Louisiana Department of Health

Louisiana Department of Health					
Strategy Name	**Strategy Description**	**Testing**	**Linkage**	**Retention**	**Suppression**
Video Conferencing	HIV-positive offenders at Louisiana Department of Corrections facilities and parish jails who are soon-to-be discharged will be connected to medical case managers via video conferencing to facilitate their linkage to HIV care providers and support services upon release.		◆	◆	◆
LaPHIE Expansion	The LaPHIE data system will be used at both public and private hospitals to identify newly diagnosed HIV-positive individuals who have never been in care or known positives who have fallen out of care and facilitate their linkage to HIV medical providers.		◆	◆	

Website link: https://careacttarget.org/library/replication-resources-spns-systems-linkages-and-access-care

SPNS Systems Linkages 2011-2016 Massachusetts Department of Health

Massachusetts Department of Health					
Strategy Name	Strategy Description	Testing	Linkage	Retention	Suppression
Nurse-Peer Teams	Deployment of linkage and retention teams comprised of nurses and HIV+ peers.		◆	◆	◆
Surveillance Data Communications	Communication between MDPH HIV Surveillance Program and pilot sites regarding patient laboratory data.		◆	◆	◆

[Website link: https://careacttarget.org/library/replication-resources-spns-systems-linkages-and-access-care](https://careacttarget.org/library/replication-resources-spns-systems-linkages-and-access-care)

SPNS Systems Linkages 2011-2016
North Carolina Department of Health

North Carolina Department of Health					
Strategy Name	**Strategy Description**	**Testing**	**Linkage**	**Retention**	**Suppression**
Retention - Regional Bridge Counselors	Develop the capacity of the regional bridge counselors and medical clinic staff (collectively referred to as 'retention staff') to re-engage and retain PLWH in HIV care.			◆	◆
State Bridge Counseling	State Bridge Counselors (SBCs) will work to ensure rapid linkage to care for all newly diagnosed PLWH within their respective regions. They will also work to locate and link out-of-care patients who have been out of care for 12 months or longer.		◆		◆
Clinic-Based HIV Testing	Individuals who accompany an HIV-positive patient to a clinic appointment will be offered free and confidential rapid HIV testing at the clinic.	◆			

[Website link: https://careacttarget.org/library/replication-resources-spns-systems-linkages-and-access-care](https://careacttarget.org/library/replication-resources-spns-systems-linkages-and-access-care)

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SPNS Systems Linkages 2011-2016
Virginia Department of Health

Virginia Department of Health

Strategy Name	Strategy Description	Testing	Linkage	Retention	Suppression
Active Referral	Develop an active, bi-directional referral process for use by those providing HIV testing through VDH funding sources. This process will assist newly-diagnosed persons with rapid and effective linkage into HIV care.		◆	◆	
Care Coordination	Implement a centrally managed care coordination model to facilitate coordinated treatment, care, and support services for HIV-positive inmates released from state correctional facilities.		◆	◆	
Mental Health Services	Establish a referral and service network for mental health in each of the pilot regions of the state to include active referrals for those living with HIV and having mental health and/or substance use issues.			◆	◆
Patient Navigation	Establish a model of patient navigation in each of the two pilot regions which includes a specific protocol for assisting clients into care and maintaining them in the care system which uses motivational interviewing techniques to increase client independence over time.		◆	◆	◆

SPNS Systems Linkages 2011-2016
Wisconsin Department of Health

Wisconsin Department of Health					
Strategy Name	**Strategy Description**	**Testing**	**Linkage**	**Retention**	**Suppression**
Linkage to Care Specialists	Employ a LTCS to improve linkage and retention to HIV medical care among the newly diagnosed, new to care, post-incarcerated, and out of care.		◆	◆	◆
Social Networks Testing	Enlist newly and previously diagnosed HIV-positive and high-risk HIV negative recruiters on an ongoing basis and provide HIV counseling, testing and referral to people in their networks.	◆			

[Website link: https://careacttarget.org/library/replication-resources-spns-systems-linkages-and-access-care](https://careacttarget.org/library/replication-resources-spns-systems-linkages-and-access-care)

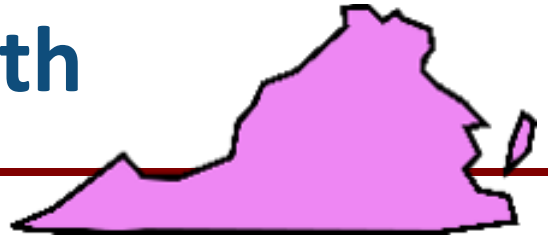
SPNS HIT Capacity Building Initiative for the HIV Care Continuum

2014 to 2017

- **4 States and 1 TGA (MA, NY, VA, GA & Paterson, NJ)**
- **GA's project** was a LaPHIE replication
- **General Findings:**
  - It's complicated!
  - This is a developmental process, constantly evolving
  - You're at the mercy of the general HIT system and environment
  - You can make advances, and providers are eager to help

Detailed Findings and Papers to be available beginning in first half of 2018

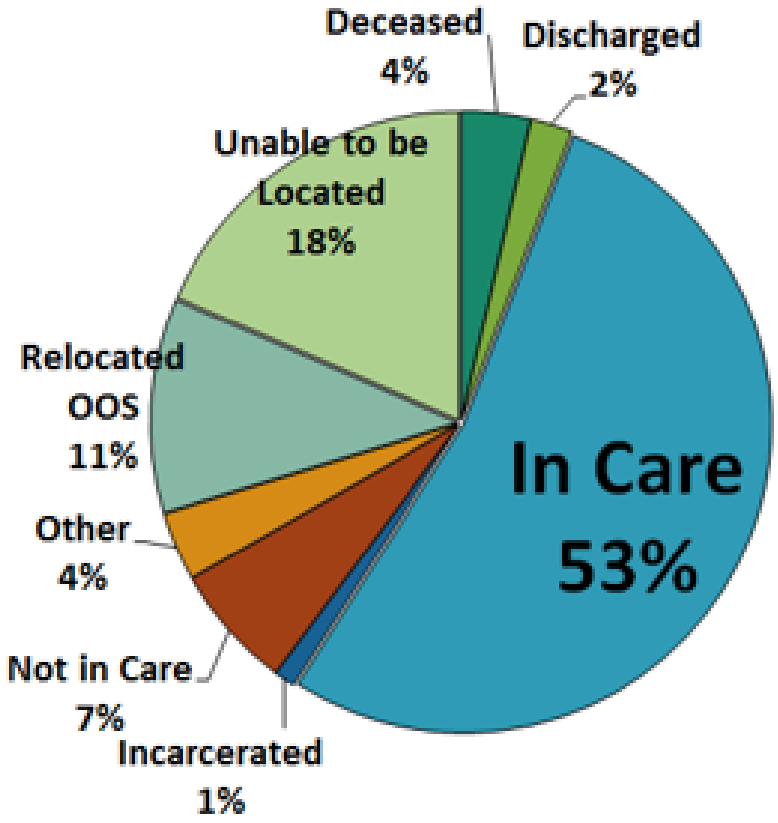
Virginia Department of Health



Three HIT Project Components:

- **Care Markers Database (CMDB):** Developed and expanded VA's HIV CMDB to integrate all available HIV data across VDH's Division of Disease Prevention
- **e2Virginia:** Developed an integrated HIV care and prevention data collection system and implemented with all RWHAPs
- **Data-to-Care:** Linked HIV surveillance, e2VA, and "Black Box" matching to identify persons out of care (OOC) and re-engage them into the care system; included bidirectional feedback of data between participating agencies and VDH

Data to Care Outcomes
Virginia Department of Health



N=277

Out-of-care: Evidence of a care marker within one 12-month period, but none in the following 12 month period

Data reported to the Virginia Department of Health as of 11/16/2016

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Georgia Public Health Information Exchange Project, 2012-2017

- **Data to care project modeled after LaPHIE which alerted providers to PLWH who were out of care**
  - GA Dept. of Health helped pass an amended law in July 2014 which allows communication of surveillance data to health care providers
- **An out of care (OOC) watch list and health information exchange (HIE) system was created to identify patients who are OOC (>15 months)**
- **Healthcare providers are alerted in near/real-time when OOC patients are seen so action can be taken to link or re-engage them in HIV care**

Pilot results to date

Clinical Site	OOC Alerts Sent	Number Linked to Care
Fulton County	18	4 (22%)
Grady Memorial	90	58 (64%)
St. Joseph's Mercy Care	29	9 (31%)

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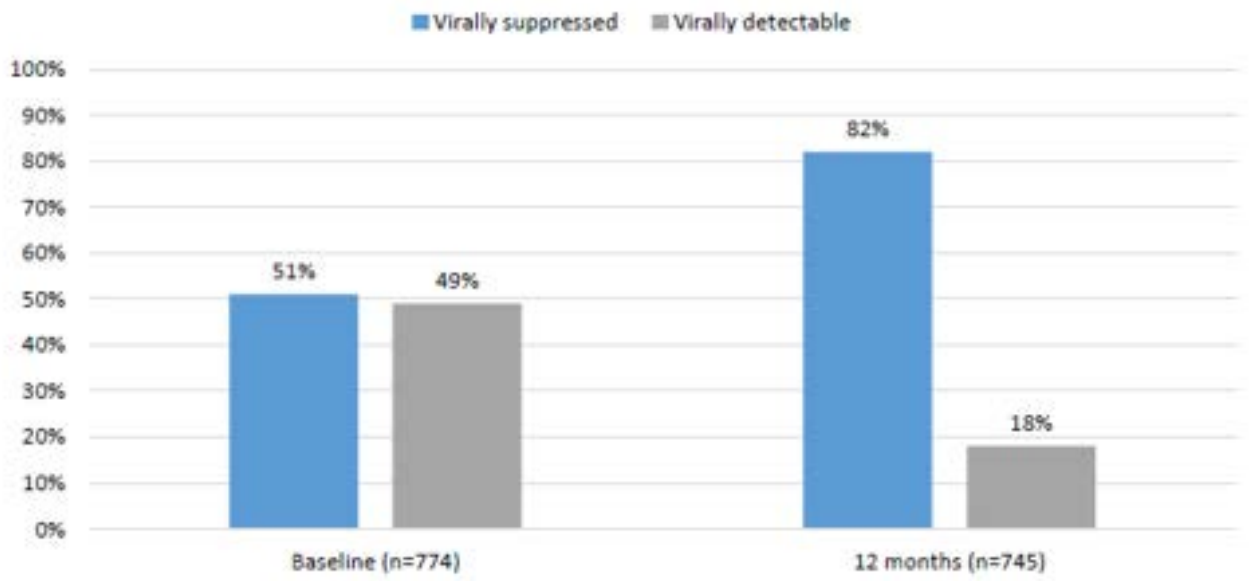
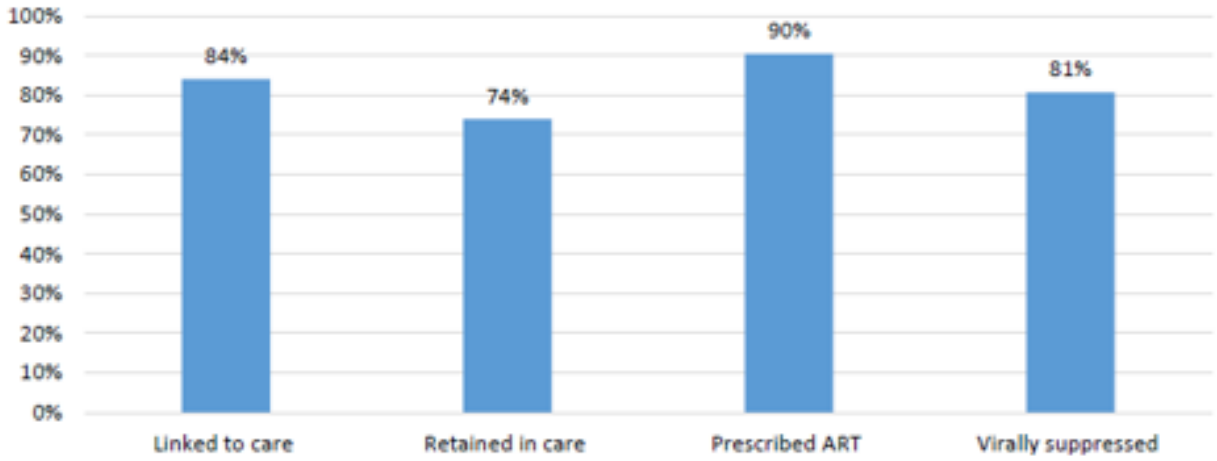
Changes in Viral Suppression Homeless Initiative



* Lowest VRL Prior to Enrollment (<200 copies/mL), 180 days prior to enrollment to 30 days post enrollment
** Lowest VRL Load (<200 copies/mL) first 12 months** 30 to 395 days post enrollment

HIV Care Continuum, Homeless Initiative

HIV Care Continuum (N = 334)

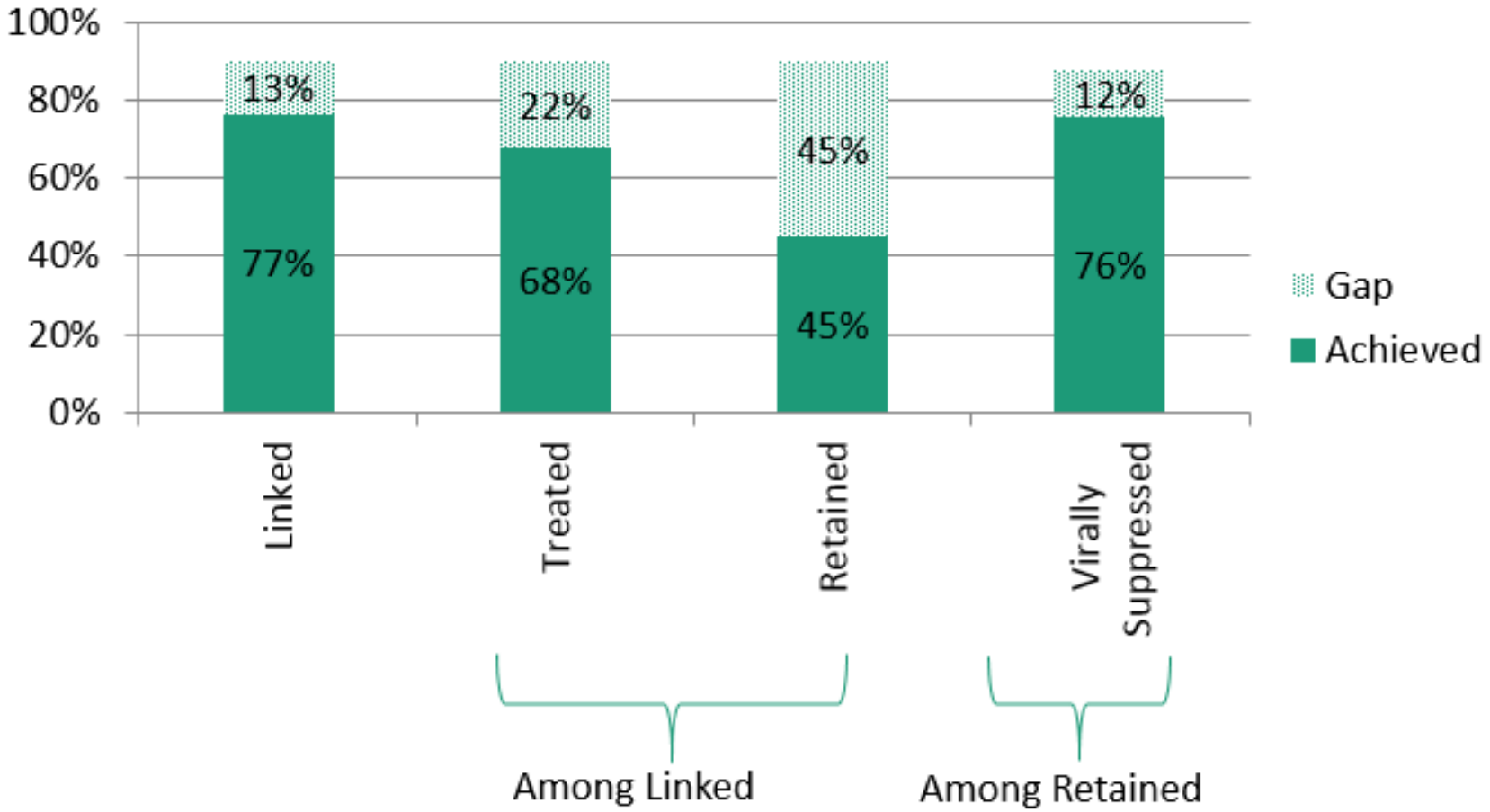


- **Linked to care:** Person out of care for at least 6 months or newly diagnosed at enrollment and connected in 90 days
- **Retention in care:** 2 HIV medical visits 90 days apart in 12 month period
- **Viral suppression (n=290):** At least 1 lab test in a 12 month period, <200 copies/mL

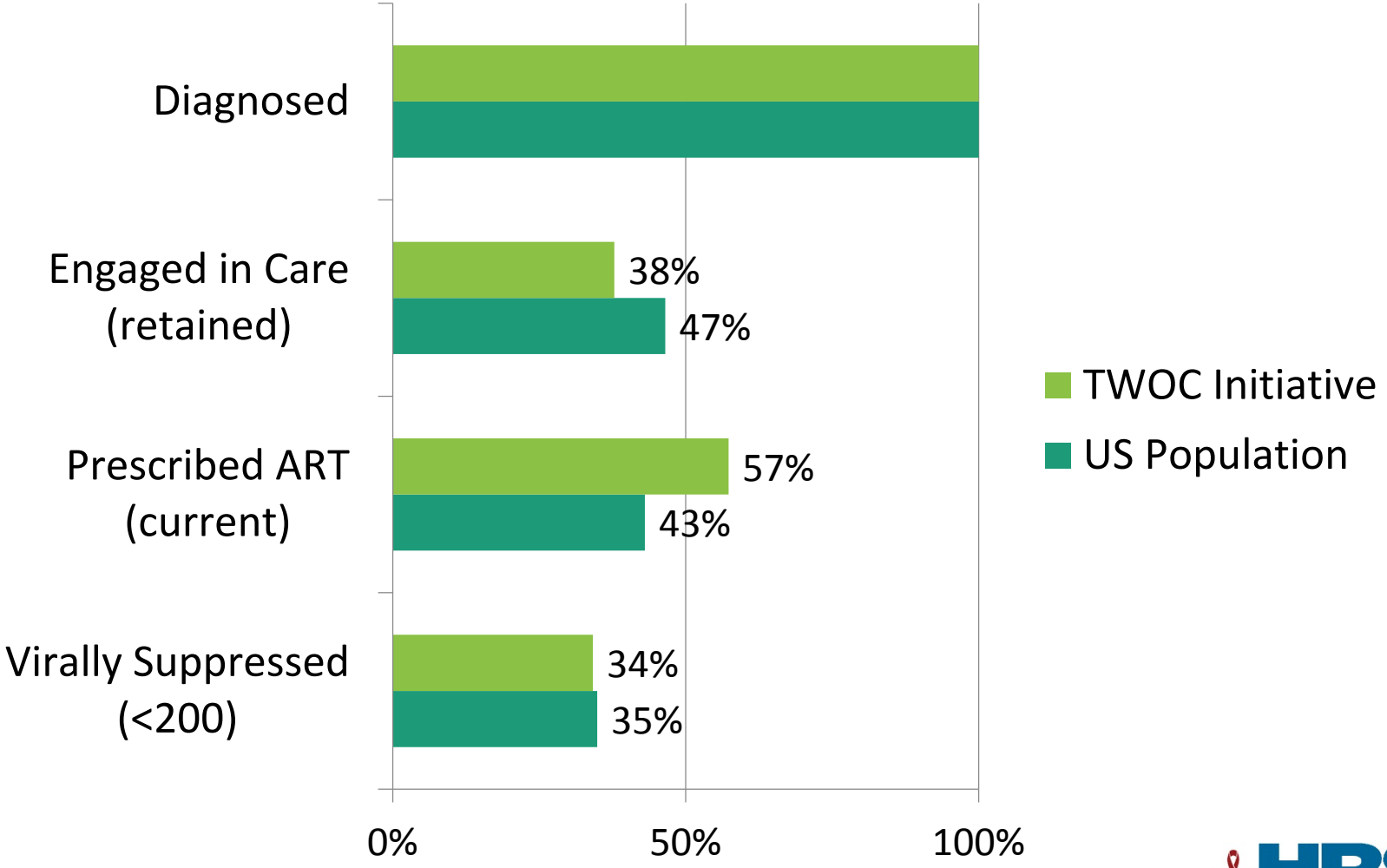
HRSA SPNS Initiative: Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations

www.cahpp.org/projects/medheart

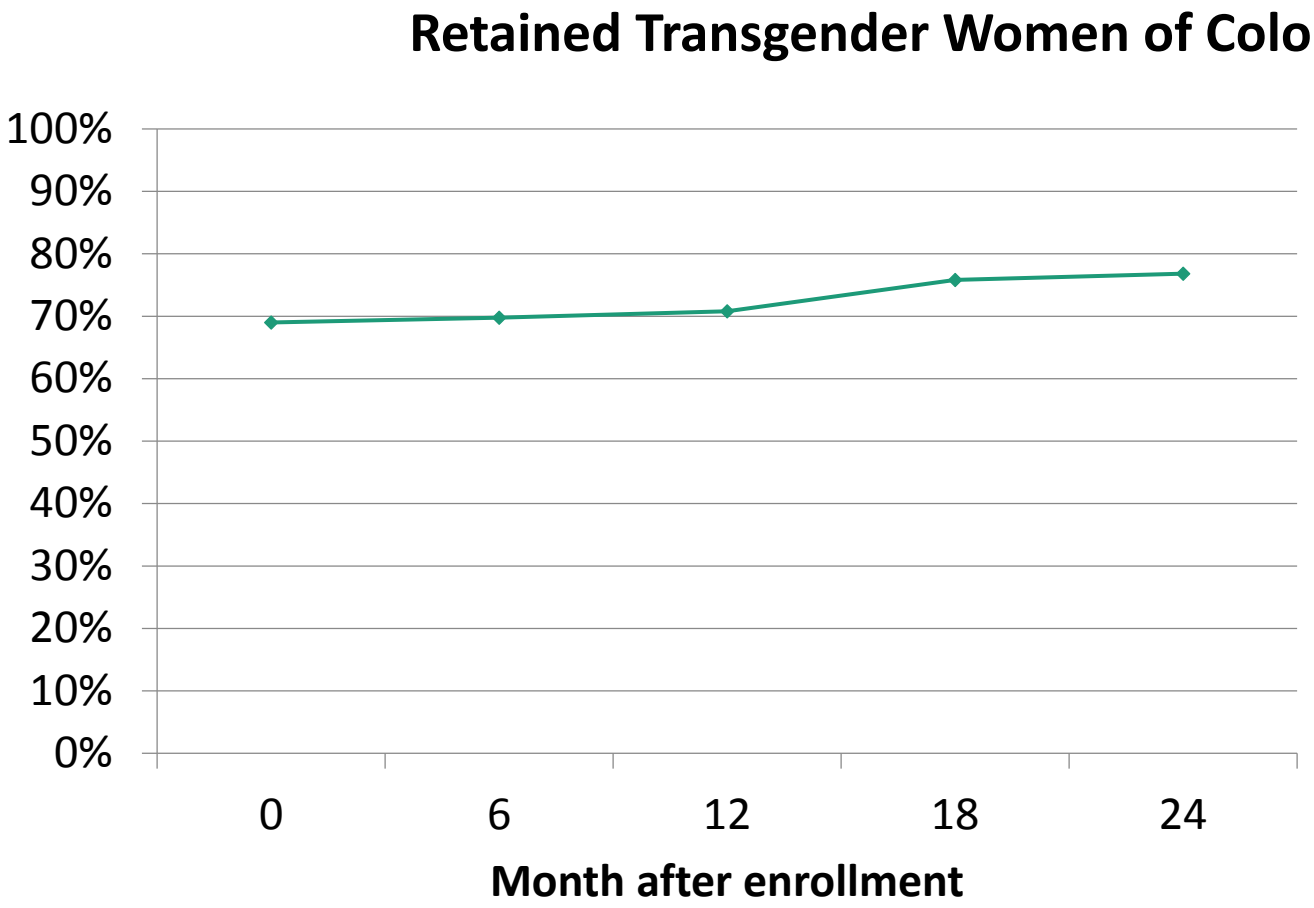
HIV Care Continuum Outcomes at 24 months – SPNS TWOC Initiative



HIV Care Continuum Outcomes Compared to U.S. Population Living with HIV



HIV Care Continuum Outcomes Over Time



n=860 (The number of participants in the SPNS Transgender Women of Color Initiative)

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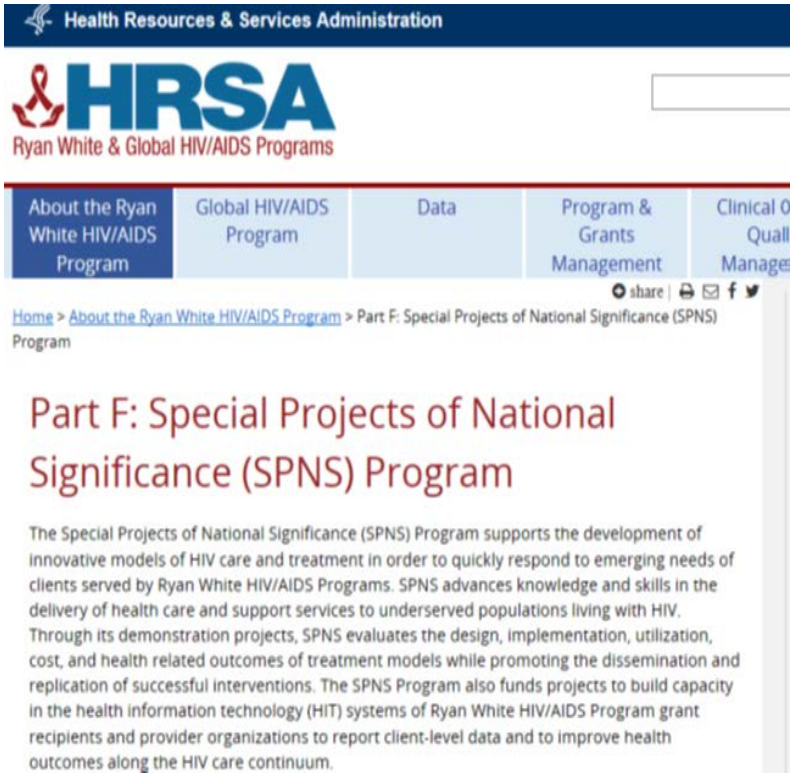
Pause for Clarifying Q & A

Final Questions for Discussion

- What is one idea for a SPNS replication that you'd like to take back to your jurisdiction?
- **How would you start the discussion about that?**
- What resources and help from the SPNS staff would you need in holding that discussion?

SPNS Dissemination – HAB Website

- **SPNS Section of HAB website**
  - SPNS Program Factsheet
  - SPNS Products: CyberSPNS Bulletins and topical reports
  - Current and Past initiatives: purpose, recipients and their demonstration projects, and journal articles (added when published)
  - Available at the following link: https://hab.hrsa.gov/about-ryan-white-hivaids-program/part-f-special-projects-national-significance-spns-program



SPNS Dissemination – Target Center

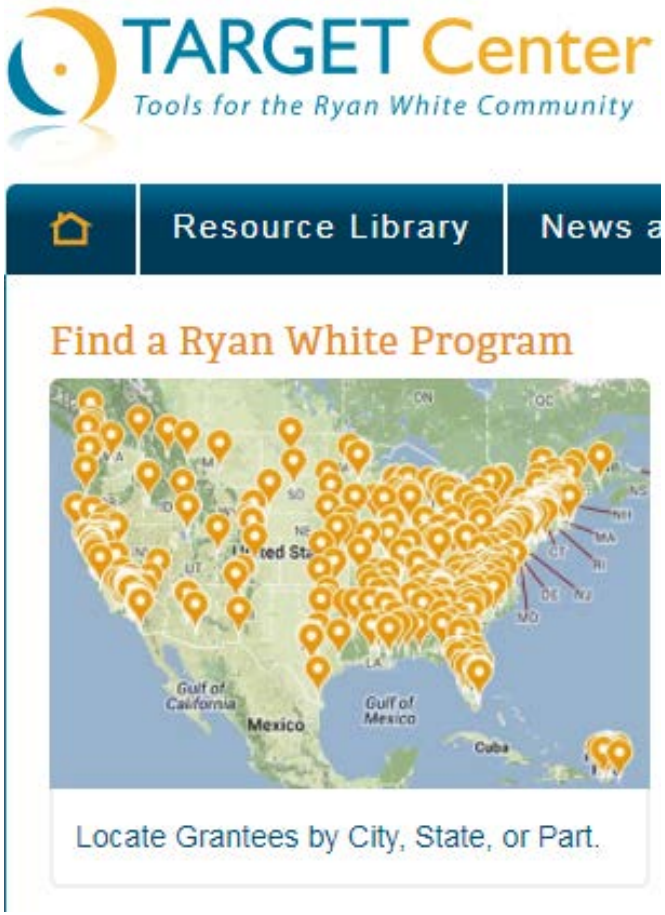
- **SPNS Content in TARGET Center website**
  - SPNS Past Initiatives Products
  - SPNS CyberSPNS Bulletins
  - SPNS Webcasts
  - SPNS Topical Reports
  - Available at the following link: https://www.careacttarget.org/
  - Use multiple keyword searches to find specific

    SPNS content. Example:

    SPNS Oral Health

    SPNS Jails

    SPNS Women of Color



SPNS Dissemination - iHiP

- **Training Materials and Replication of SPNS Interventions and Service Delivery Models**
  - Highlighting tested and proven SPNS funded HIV strategies
  - Practices outlined have demonstrated success and replicability across health care settings
  - Products: training manuals, curriculum, monographs, and webinar series
  - Available at the following link: https://careacttarget.org/ihip

How SPNS Can Support RWHAP Part B Recipients

- Use findings from SPNS initiatives and increase collaboration between DSHAP staff, RWHAP Part B recipients, and OTCD domestic staff
- Use the Integrated Plans to identify service gaps and/or population-based care continuum disparities
- Jointly brainstorm ideas

Two Approaches to Searching for SPNS Resources

- **Population Focus** - by population and care continuum disparity – OR

- **Service Delivery Model Focus** - by innovative service delivery models for specific treatment issues

Identifying Resources by Population Focus

- **Underserved, Uninsured, Underinsured, Marginalized Populations served by Past SPNS initiatives:**
  - Caribbean, US-Mexico Border, American Indian/Alaska Native, YMSM of Color, New Releasees from Jails, Women of Color

- **Populations Currently Under Demonstration (findings coming soon):**
  - Transgender Women of Color, Homeless and Multiply Diagnosed, Latino (Puerto Rican and Mexican), Youth (through social media)

Identifying Resources by Service Delivery Models

- **SPNS has Tested Innovative Service Delivery Models to Address Specific Treatment Issues**

- **Example: Buprenorphine Treatment Integration**
  - Training Manual
  - Curriculum
  - Monograph of Site Models
  - Webinars

- **All of these resources are available through iHIP on TARGET**

  Link to iHIP Target Center Page: www.careacttarget.org/ihip

Identifying Resources by Other Service Delivery Models

Other Innovative Service Delivery Models to Address Specific Treatment Issues:

- Outreach (Patient Navigation & Peer Models)
- Oral Health
- Prevention with Positives (clinical interventions)
- Electronic Networks of Care (HIT models like LaPHIE)
- Systems Linkages (Regional and Statewide community-level models)

All of these resources are available through TARGET and/or iHIP on TARGET

TARGET Search Tip: Use SPNS + Key Words in Your Search

Closing Questions and Discussion

Evaluation Survey

- Please use the following link to complete a short evaluation of this session
- The link may also be found on your agenda

https://www.surveymonkey.com/r/ARSV2017_SPNS

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Thank you for your attention and interest!