

Ryan White Programs' Provision of Substance Use Treatment

Amanda Bowes and Magalie Lerman

NASTAD



AGENDA

- An overview of substance use treatment needs among people living with HIV (PLWH)
- Allowable uses of Ryan White Part B and ADAP funds to expand access to substance use treatment, including support of syringe service programs (SSPs)
- The impact of the Affordable Care Act (ACA) on RWHAP/ADAP provision of substance use treatment
- State examples
- Discussion

SUBSTANCE USE & PLWH

- Substance use disproportionately impacts PLWH:
 - Overall effectiveness of their HIV care and treatment
 - Broader health
 - Overdose and death from overdose

- Reasons for not seeking substance use treatment:
 - Inadequate screening
 - Stigma
 - Lack of available and adequate services

SUBSTANCE USE TREATMENT MEDICATIONS

- Allow individuals to manage addiction or dependency by reducing risk for overdose, cravings, and/or withdrawal.
- Fall into two categories:
 - Overdose prevention
 - Medication assisted treatment (MAT)
- Substance use treatment medications may require:
 - Close monitoring by prescribing provider
 - Laboratory testing
 - Access to broader substance use/mental health/psychosocial support services

OVERVIEW: ADAP

- ADAPs provide access to medications via:
 - **Full-pay medication program:** clients receive medications paid in full by ADAP with no coordination of insurance benefits.
 - **ADAP-funded insurance program:** clients have some type of coverage other than full-pay prescription ADAP (i.e., Qualified Health Plans, employer-sponsored coverage, Medicaid, and Medicare) and ADAP pays the premiums, deductibles, and/or co-payments/co-insurance.

OVERVIEW: ADAP

- The Ryan White HIV/AIDS Program Section 2616(c)(6) of the Public Health Service Act contains language that places the following requirements on ADAP formularies:
 - ADAP formularies must include at least one drug from each class of HIV antiretroviral medications;
 - ADAP funds may only be used to purchase medications approved by the Food and Drug Administration (FDA) or devices needed to administer them; they must be consistent with the Department of Health and Human Services' (HHS) Adolescent and Adult HIV/AIDS Treatment Guidelines; and all treatments and ancillary devices covered by the ADAP formulary, as well as all ADAP-funded services must be equitably available to all eligible/enrolled individuals within a given jurisdiction.

ADAP - SUBSTANCE USE TREATMENT

- As of December 31, 2015, 14 ADAPs covered one or more FDA-approved substance use treatment medications on their formularies (including MAT). Coverage data is available for individual medications.
 - Data available via the [National ADAP Formulary Database](#).
- ADAPs cannot cover or pay for the full breadth of costs associated with substance use treatment medication.

IMPACT OF THE ACA

- The Affordable Care Act (ACA) builds on the Mental Health Parity and Addiction Equity Act of 2008 by requiring coverage of mental health and substance use disorder benefits in individual/small group markets and expanding parity requirements overall.
 - For ADAP clients enrolled in QHPs both on- and off-ACA Marketplace, this represents a huge opportunity for expansive and comprehensive care.

RYAN WHITE PART B – SUBSTANCE USE

- Per HRSA Policy Notice 10-02, outpatient and residential substance use treatment are considered a core medical and supportive service, respectively, under the Ryan White HIV/AIDS Program.
 - **Allowable RW-Funded Outpatient Services:** pre-treatment/recovery readiness programs; harm reduction; mental health counseling to reduce depression, anxiety, and other disorders associated with substance use; outpatient drug-free treatment and counseling; opiate MAT (e.g., methadone); neuro-psychiatric pharmaceuticals; and relapse prevention

FEDERAL FUNDING FOR SSPs

- Relaxation of the federal ban on syringe exchange in the 2016 omnibus allows funding for operational aspects of SSPs (i.e., not to purchase sterile needles, syringes, or other supplies for the purpose of injecting drugs).

HRSA FUNDING FOR SSPs

- In May 2016, HRSA released [guidance](#) on federal funding to support SSPs. Highlights include:
 - Applications require health department support.
 - In order to reallocate funds, documentation of the CDC Jurisdictional Eligibility Finding as well as a letter signed by the state health officer which states that SSP operation is lawful.
 - All FY2016 federal notices of awards (FOAs) can potentially be used for SSP and future FOAs will include whether or not SSP can be funded.
 - Ryan White HIV Program funds can be used for SSP as long as the SSP is comprehensive and serves people living with HIV.
 - Federally Qualified Health Centers (FQHC) are well positioned to repurpose HRSA funding for SSP activities

STATE EXAMPLES

Drug User Health for the HIV Population



Todd Grove Healthcare Access Unit Supervisor
STI/HIV/Viral Hepatitis Branch
December 13, 2016

- Colorado submitted a “Determination of Need” application to CDC, and was determined to be at-risk/ currently experiencing increase in HV and HIV due to drug use
- Senate Bill 15-053 expands access to the life-saving drug Naloxone
- The chief medical officer of the Department of Public Health will issue standing orders for Naloxone to be dispensed by pharmacies and harm reduction organization employees and volunteers upon application
- Can also be written to family and friends, individuals, or to emergency personnel -including police and fire



- Colorado Legislature allowed for use of monies formerly earmarked for ADAP only (from tobacco master settlement agreement) to be utilized for biological interventions
 - PrEP
 - nPEP
 - STI test and treat
 - Comprehensive injector health programs - includes purchase of sterile syringe equipment
 - Another change to state law decriminalizes carrying a new or used syringe, even if it has drug residue in it. However, users must first tell responders or law enforcement that they have it.



Colorado has not identified a substantial number of persons who inject drugs within our population living with HIV

- Department has long supported needle exchange programs - first program was in Boulder county - took 10 years to be expanded elsewhere
- HIV CBO's first to embrace expansion and now operate statewide, & CO supported without being able to supply everything but syringes until new legislation
- Harm Reduction organization partners with health department to expand needle exchange operations to several county health departments - mostly in metro Denver, but expanding
- provide a crucial entry point into medical care, detox and rehabilitation, and mental health treatment.



Screening, Brief Intervention and Referral to Treatment (SBIRT)

- Evidence-based approach to identifying patients who use alcohol and other drugs at risky levels with the goal of reducing and preventing related health consequences, disease, accidents and injuries
- CDPHE funded at 100% with training and implementation at nearly all funded clinics and CBOs. Became part of standard operations
- Now largely billed to third party payers
- Referred patients can be seen within the CBO or clinic, or referred out to traditional intensive outpatient or inpatient treatment
- With increased insurance access, ADAP supported patients costs can be paid by program
- Difficulty is finding a treatment slot - particularly when patient is ready to access services



Critical Events Program

4/1/15 - present, 10 cases access inpatient treatment. 9 meth use and 1 crack cocaine

In 2016:

Currently have 10 clients who have substance use issues (2 are looking for treatment options), and 1 that is engaging in outpatient treatment.

8 clients closed early from the program so far with substance use being a predominant issue.

2015:

19 cases that completed the program reported some form of substance use (often mild use or use in recent past)

20 cases were closed early in 2015 as a direct result of substance use.

Out of 175 total people served, 61 reported some form of substance issue

MOTIVATION for treatment is the problem - **VERY** intensive CM necessary to hand-hold through whole process - "ghosting"



Colorado ADAP process to add SA drugs to formulary

- Upon recommendation of NASTAD, the entire slate of SA medications was submitted to the Medical Advisory Committee - unanimous consent to add - agreed to by ADAP Advisory committee
- Officially added in April 2015
- Utilization has been negligible - but ADAP members were not notified as WA state has
- Workgroup will be convened to expand knowledge and ease process to get Naloxone into appropriate hands - often friends and family members rather than the patient



Colorado ADAP SA drugs added to formulary

- Campral - often preferred for co-infected
- Buprenorphine (Subutex), Naloxone, Suboxone
- Disulfiram (Antabuse)
- Evizio - PA
- Narcan
- Naltrexone injection - Vivitrol
- Naltrexone - oral (Revia, Depade)
- Also Lithium and Trazodone



Other issues with ADAP utilization:

- To prescribe Suboxone, naltrexone, etc. providers have to take a class and are limited to writing a certain number of scripts. PAs can prescribe now (recent). Largest provider received grant to integrate opiate treatment into primary care - will do so at 4 community health centers
- Medicaid is the payer source for most of these patients - many providers don't accept Medicaid.
- Methadone and Suboxone sometimes prescribed through the same clinic. Clinics not set up to bill ADAP currently
- Most patients are injecting methamphetamine, not heroin - Suboxone and Vivitrol been known to work with meth, but unusual to prescribe. Who can administer them?





Todd Grove
todd.grove@state.co.us
(303) 692-2783

www.stdhivco.org



Drug User Health & ADAP: Washington State

Chad Upshaw, HIV Client Services EIP Supervisor
Tim Candela, Drug User Health Consultant

Office of Infectious Disease
Washington State Department of Health
December 13th, 2016



What about Washington?

- Washington did complete a Determination of Need and was found *at-risk for increases in viral hepatitis and HIV due to injection drug use.*
- Next steps and what federal funds???
 - CDC
 - SAMHSA
 - HRSA

What is Early Intervention Services?

- They can be used to support SSPs-no needles, people!!
- They are Ryan White Part B \$\$\$
- They are for People at High Risk of HIV
- People Who Inject Drugs are People at High Risk for HIV
- 30 years later, SSPs are the single most effective strategy at reducing HIV amongst People Who Use Drugs

EIS & SSPs-makes sense?

- To access EIS funds, programs must adhere to the 4 components of EIS
 - Testing
 - Referrals
 - Linkage to Care
 - Health Education/Risk Reduction Counseling
- Sounds like everything SSPs do!

Next Steps in Washington State

- Looking into accessing EIS funds to support SSPs
- Important notes:
 - Communication-with everyone

WA ADAP process to add Naloxone to formulary

- Confirmed that pharmacies can choose, with guidelines, to give Naloxone at the pharmacy counter with a standing order.
- Called six pharmacies across WA State to confirm they were doing this.
- Discussed with WA ADAP Special Emphasis Work Group (ADAP SEW) which includes six HIV physician experts and received their support.
- Cross referenced pharmacies choosing to provide Naloxone without a prescription with pharmacies contracted with our Pharmacy Benefits Manager (PBM).
- Contacted our PBM and added to the formulary
- Mailed all WA ADAP clients a letter announcing the addition, including two brochures on Opioid Overdose and how to use Naloxone.

We also have MAT on ADAP

- MAT on the formulary:
 - Suboxone (Buprenorphine)
 - Antabuse (Disulfiram)
 - Campral (Acamprosate)
 - Catapres (Clonidine)
 - Vivitrol (Naltrexone)

MAT by Number of Clients Served

- 2014
 - Suboxone: 2
 - Naltrexone: 3
- 2015
 - Antabuse: 2
 - Suboxone: 1
 - Campral: 1
 - Naltrexone: 7
- 2016
 - Antabuse: 2
 - Suboxone: 3
 - Campral: 3
 - Naltrexone: 6
 - Naloxone: 1 (our very first one since adding to formulary - a harm reduction success!)

Questions?

Contact Information

Chad Upshaw

360-236-3479

Email: Charles.Upshaw@doh.wa.gov

Tim Candela

Phone: 360-236-3456

Email: Tim.Candela@doh.wa.gov



DISCUSSION

- For states that have added one or more substance use treatment medication to the ADAP formulary, what considerations were taken in this decision? What justifications were identified?
 - Is your ADAP able to report utilization rates for substance use treatment medications? If so, how would you describe utilization rates?
- For ADAPs that have not added one or more substance use treatment medication to your formulary, what challenges or barriers have you had in doing so (e.g., stigma, cost)?

DISCUSSION

- What activities has your Ryan White Part B program used to funded or supported re: access to substance use treatment or the needs of people who use drugs more broadly?
 - How have you funded these efforts?
 - What key partners have you identified?
 - What barriers or challenges have you experienced?
- Has your jurisdiction considered using HRSA funds to support SSP? If so, what SSP activities are being supported?