Confronting the Opioid Epidemic: The HRSA Response

11/18/2016

Presenters

- **Health Resources Services Administration (HRSA), HIV/AIDS Bureau (HAB)**
  - Amy Griffin, Public Health Analyst, Division of State HIV/AIDS Programs (DSHAP)
  - Glenn Clark, ADAP Advisor, DSHAP
- **HRSA, Office of Planning, Analysis and Evaluation (OPAE)**
  - Karen Wade, Public Health Analyst
- **Midwest AIDS Education and Training Centers (MAETC), Indiana Local Partner**
  - Malinda Boehler, Director
  - Karen Curd, Program Manager

Learning Objectives

- At the end of this session, participants will be able to:
  - Explain the impact of the opioid epidemic and its implications for HIV/AIDS
  - Identify how HRSA and the Ryan White HIV/AIDS Program (RWHAP) community can respond to opioid misuse and outline strategies for community preparedness in high risk communities
  - Describe the Midwest AIDS Education and Training Centers (AETC) response to the HIV Outbreak in Indiana

Agenda

- The Impact of the Opioid Epidemic
- HRSA's Response to the Opioid Epidemic
- The Ryan White HIV/AIDS Program Response
- Strengthening Systems of Care to Support People Living With HIV/AIDS (PLWH) Experiencing Substance Use Disorders
- Responding to an HIV Outbreak, the Experiences of the Mid-Atlantic (Midwest AETC)
- Discussion

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Disclosures

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HIV/AIDS Bureau Vision and Mission

Vision

Optimal HIV/AIDS care and treatment for all.

Mission

Provide leadership and resources to assure access to and retention in high quality, integrated care, and treatment services for vulnerable people living with HIV/AIDS and their families.

HIV/AIDS Bureau Priorities

- **NHAS 2020/PEPFAR 3.0 -** Maximize HRSA HAB expertise and resources to operationalize NHAS 2020 and PEPFAR 3.0
- **Leadership -** Enhance and lead national and international HIV care and treatment through evidence-informed innovations, policy development, health workforce development, and program implementation
- **Partnerships -** Enhance and develop strategic domestic and international partnerships internally and externally
- **Integration -** Integrate HIV prevention, care, and treatment in an evolving healthcare environment
- **Data Utilization -** Use data from program reporting systems, surveillance, modeling, and other programs, as well as results from evaluation and special projects efforts to target, prioritize, and improve policies, programs, and service delivery
- **Operations -** Strengthen HAB administrative and programmatic processes through Bureau-wide knowledge management, innovation, and collaboration

Impact of the Opioid Epidemic

Amy Griffin
Public Health Analyst
HAB/DSHAP

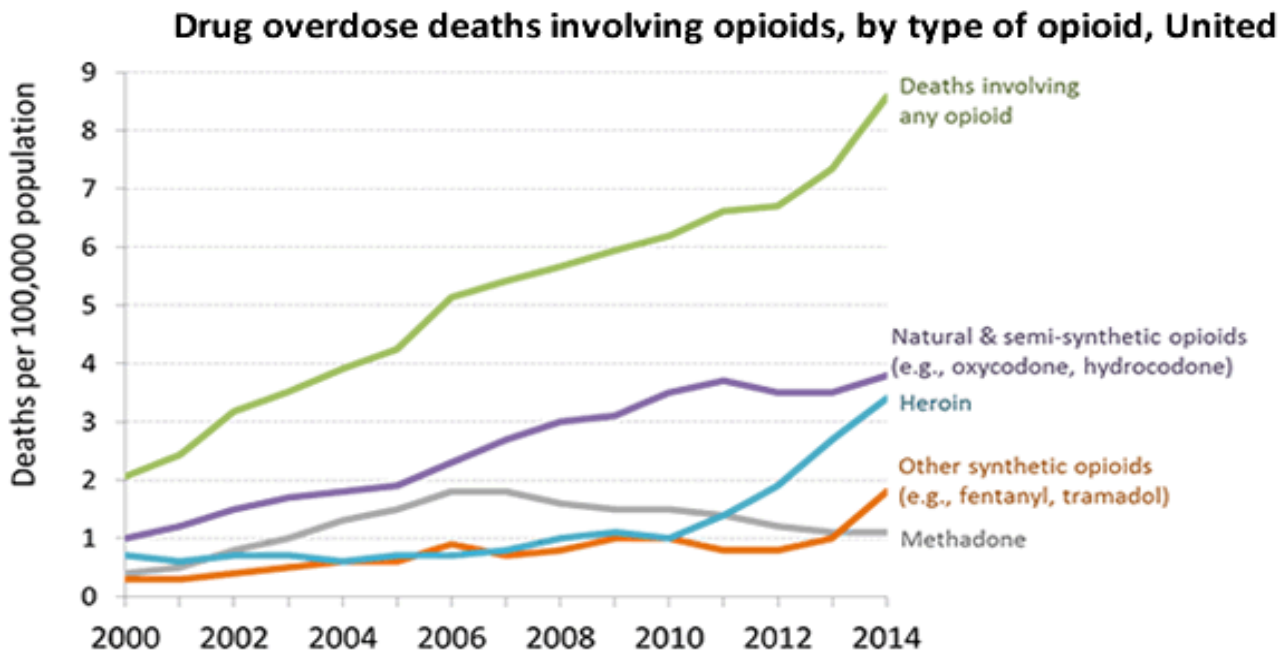
Understanding the Opioid Epidemic

More people died from drug overdoses in 2014 than in any year on record. The majority of drug overdose deaths (more than six out of ten) involve an opioid.[1] And since 1999, the number of overdose deaths involving opioids (including prescription opioid pain relievers and heroin) nearly quadrupled.[2] From 2000 to 2014 nearly half a million people died from drug overdoses. 78 Americans die every day from an opioid overdose.

1. Centers for Disease Control and Prevention. Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014. MMWR 2015; 64;1-5.
2. CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at http://wonder.cdc.gov.
3. Quote was taken from the Centers for Disease Control and prevention, Injury Prevention and Control: Opioid Overdose webpage: http://www.cdc.gov/drugoverdose/epidemic/index.html . Downloaded July 18, 2016

CDC Analysis of Drug Overdoses

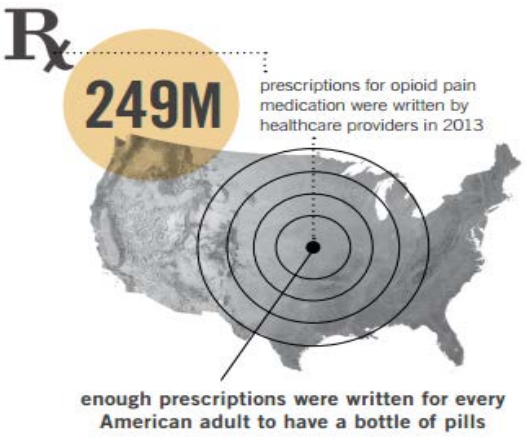
Opioid overdoses driving increase in drug overdoses overall



SOURCE:
Centers for Disease Control and Prevention. Increases in Drug and Opioid Overdose Deaths – United States, 2000 to 2014. MMWR 2015.
www.cdc.gov/drugoverdose

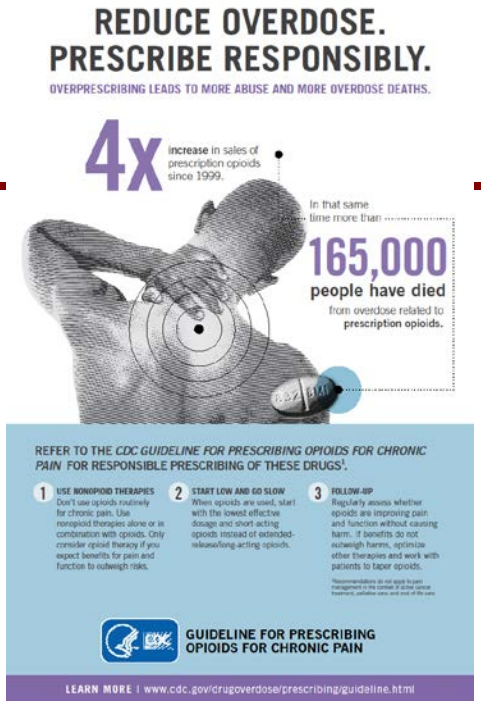
What Is Driving the Epidemic?
Prescription Pain Medication

- **Prescription of Pain Medications**
  - According to US Department of Substance Abuse and Mental Health's (SAMHSA), 2014 National Survey on Drug Use and Health, **43.3 million** people are current nonmedical users of pain medications.
    http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf



  - According to the Centers for Disease Control and Prevention (CDC), there were enough prescriptions for opioid pain medications written by health care providers in 2013 for every American adult to have a bottle.

CDC Treatment Guidelines



- **CDC published in the March 18, 2015**
  Morbidity and Mortality Weekly Report
  guidelines for prescribing Opioids
- **The goal of the guideline is to**
  - Ensure that clinicians and patients consider safer and more effective treatment
  - Improve patient outcomes
  - Reduce the number of persons who develop opioid use disorder, overdose, or experience other adverse events related to these drugs.
- **To read guidelines:**
  http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

What Is Driving the Epidemic?
Heroin

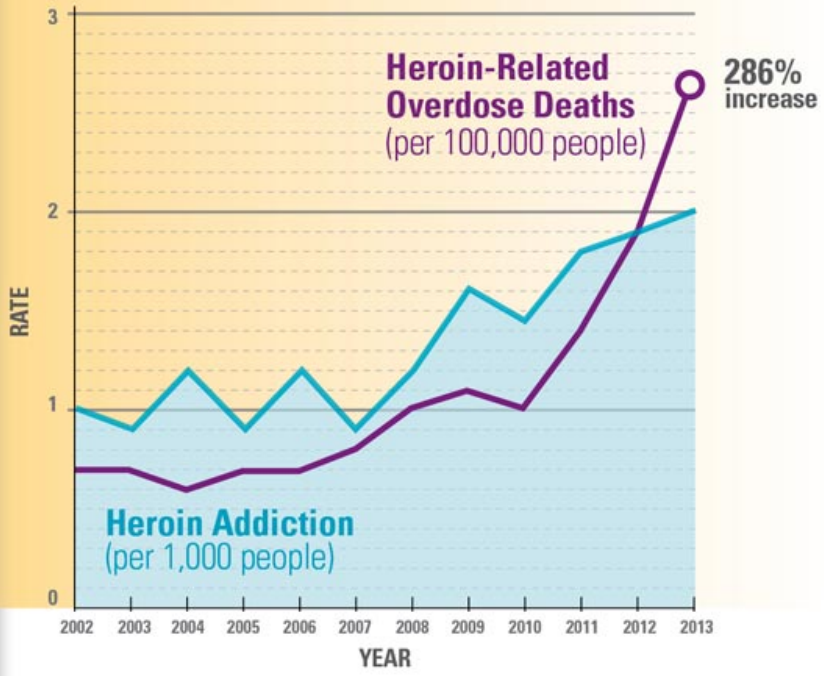
- Nearly all (96 percent) people who reported heroin use also reported using at least one other drug in the past year with more than half (61 percent) using at least three other drugs.
- People who abuse or are dependent on:
  - prescription opioid painkillers are 40 times more likely to abuse or be dependent on heroin.
  - cocaine are 15 times more likely to abuse or be dependent on heroin.
  - marijuana are 3 times more likely to abuse or be dependent on heroin.
  - alcohol are 2 times more likely to abuse or be dependent on heroin.

Data taken from the CDC Press Release entitled, "New research reveals the trends and risk factors behind America's growing heroin epidemic" published July 7, 2015.
http://www.cdc.gov/media/releases/2015/p0707-heroin-epidemic.html

Heroin Use Has INCREASED Among Most Demographic Groups

	2002-2004*	2011-2013*	% CHANGE
SEX			
Male	2.4	3.6	50%
Female	0.8	1.6	100%
AGE, YEARS			
12-17	1.8	1.6	--
18-25	3.5	7.3	109%
26 or older	1.2	1.9	58%
RACE/ETHNICITY			
Non-Hispanic white	1.4	3	114%
Other	2	1.7	--
ANNUAL HOUSEHOLD INCOME			
Less than $20,000	3.4	5.5	62%
$20,000–$49,999	1.3	2.3	77%
$50,000 or more	1	1.6	60%
HEALTH INSURANCE COVERAGE			
None	4.2	6.7	60%
Medicaid	4.3	4.7	--
Private or other	0.8	1.3	63%

Heroin Addiction and Overdose Deaths are Climbing



SOURCES: National Survey on Drug Use and Health (NSDUH), 2002-2013.
National Vital Statistics System, 2002-2013.

- From CDC's *Vital Signs: Today's Heroin Epidemic Infographics.* July 15, 2015. Downloaded July 18, 2016. http://www.cdc.gov/vitalsigns/heroin/infographic.html

What Is Driving the Epidemic?
Fentanyl

- Fentanyl is a synthetic opioid commonly used in surgery. According to the CDC, it is 50 to 100 times more potent than morphine.

- Dealers cut it with Heroin to increase the high but it is more likely to lead to overdose.

- Overdose deaths involving synthetic opioids other than methadone, which includes fentanyl, increased by 80% from 2013 to 2014. Approximately, 5,500 people died from overdoses involving synthetic opioids other than methadone in 2014.

CDC, Injury Prevention & Control: Opioid Overdose. Downloaded from http://www.cdc.gov/drugoverdose/opioids/fentanyl.html on July 21, 2016.

Figure 5 Fentanyl reports in NFLIS, by State, January–June 2009

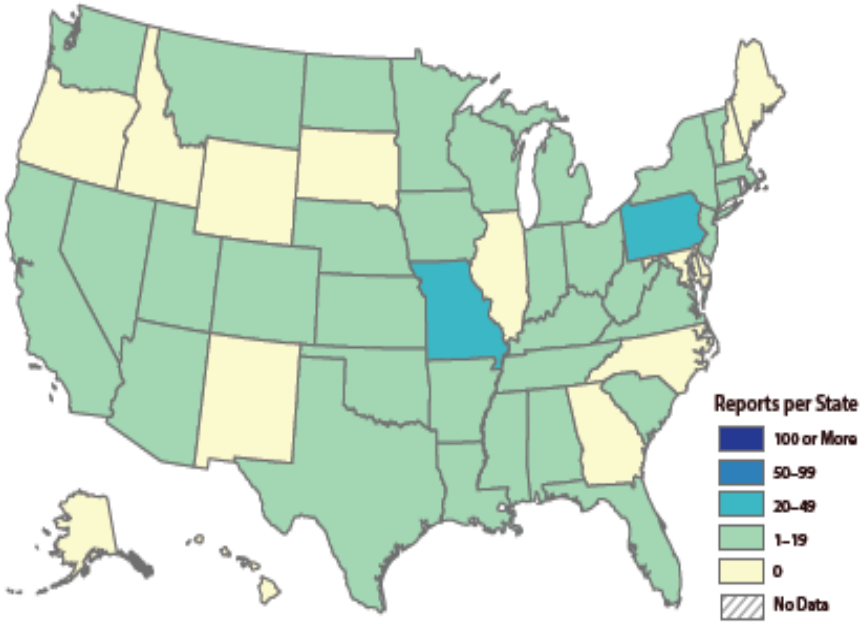
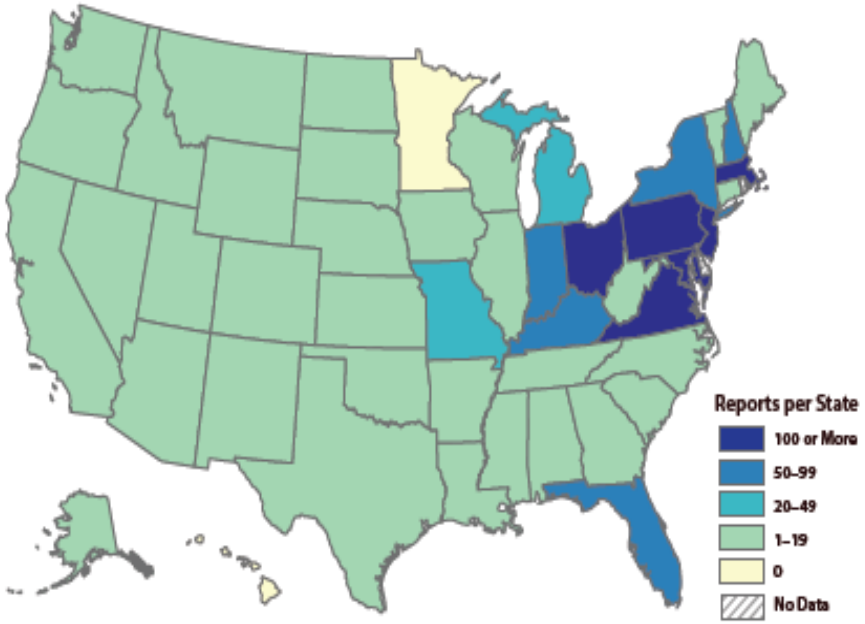


Figure 6 Fentanyl reports in NFLIS, by State, January–June 2014



Fentanyl reports increased by 259% from the second half of 2013 to the first half of 2014.

US Dept of Justice, Drug Enforcement Administration, Office of Diversion Control, National Forensic Laboratory Information System. *Special Report: Opiates and Related Drugs Reported in NFLIS, 2009-2014.* Revised February 2016. Downloaded July 2016 from http://www.deadiversion.usdoj.gov/nflis/spec_rpt_opioids_2014.pdf

HRSA's Response to the Opioid Epidemic

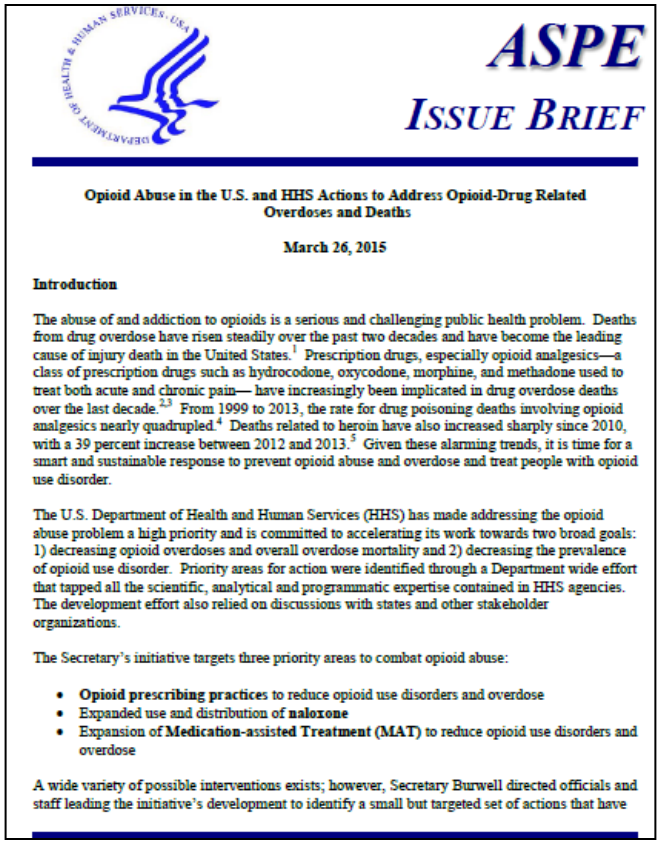
Karen Wade
Public Health Analyst
Office of Planning, Analysis and Evaluation

Historical Data

- Since 2000, the rate of opioid overdoses has tripled
- In 2014, opioids were involved in 28,647 deaths
- Only 2% of US physicians have obtained Drug Enforcement Administration (DEA) Drug Addiction Treatment Act (DATA) waivers to prescribe buprenorphine
  - Only 16% of all psychiatrists have obtained waivers
  - Only 3% of all primary care physicians have obtained waivers
- More than 30 million Americans live in counties without access to buprenorphine treatment
  - 82% of the counties without a physician who could prescribe were in rural areas

HHS Opioid Initiative

- **Launched by Secretary Burwell in March 2015**
- **Three priority areas**
  - Improve opioid prescribing
  - Increase use of naloxone to reverse opioid overdose
  - Expand use of Medication-Assisted Treatment (MAT) for opioid use disorders



ASPE

ISSUE BRIEF

Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths

March 26, 2015

Introduction

The abuse of and addiction to opioids is a serious and challenging public health problem. Deaths from drug overdose have risen steadily over the past two decades and have become the leading cause of injury death in the United States.[1] Prescription drugs, especially opioid analgesics—a class of prescription drugs such as hydrocodone, oxycodone, morphine, and methadone used to treat both acute and chronic pain— have increasingly been implicated in drug overdose deaths over the last decade.[2,3] From 1999 to 2013, the rate for drug poisoning deaths involving opioid analgesics nearly quadrupled.[4] Deaths related to heroin have also increased sharply since 2010, with a 39 percent increase between 2012 and 2013.[5] Given these alarming trends, it is time for a smart and sustainable response to prevent opioid abuse and overdose and treat people with opioid use disorder.

The U.S. Department of Health and Human Services (HHS) has made addressing the opioid abuse problem a high priority and is committed to accelerating its work towards two broad goals: 1) decreasing opioid overdoses and overall overdose mortality and 2) decreasing the prevalence of opioid use disorder. Priority areas for action were identified through a Department wide effort that tapped all the scientific, analytical and programmatic expertise contained in HHS agencies. The development effort also relied on discussions with states and other stakeholder organizations.

The Secretary's initiative targets three priority areas to combat opioid abuse:

- **Opioid prescribing practices** to reduce opioid use disorders and overdose
- Expanded use and distribution of **naloxone**
- Expansion of **Medication-assisted Treatment (MAT)** to reduce opioid use disorders and overdose

A wide variety of possible interventions exists; however, Secretary Burwell directed officials and staff leading the initiative's development to identify a small but targeted set of actions that have

HRSA's Opioid Response

- HRSA supports a range of efforts from all three of the Secretary's priority areas with a specific emphasis on priority area one.
- The agency's efforts targets providers, HRSA staff, and relevant stakeholder groups.
- By focusing on each of these groups, HRSA will be able to increase impact and ensure the needs of the safety-net are met.

HRSA Key Activities

HRSA's primary activities include:

- Distributing educational materials to HRSA-supported providers, staff, grantees, and stakeholders;
- Providing access to training and technical assistance to help health professionals make informed prescribing decisions;
- Stakeholder engagement with an emphasis on health professional schools and professional associations.

Examples of HRSA Efforts

- **Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Intervention (HAB)**
  - Demonstration on integrating Buprenorphine treatment into two HIV primary care sites, scheduled to start in Sept 2016
- **2016 Substance Abuse Service Expansion (BPHC)**
  - In March 2016, BPHC awarded $94 million to approximately 271 health center grantees for the expansion of substance abuse services
- **Substance Abuse Warmline (BPHC)**
  - Peer-to-peer telephone consultation, focusing on substance use evaluation and management for primary care clinicians
- **SAMHSA-HRSA Center for Integrated Health Solutions (OPAE)**
  - Provides training and TA on integrating behavioral health and primary care
- **Secretary's 50 State Convening Focused on Preventing Opioid Overdose (ORO)**
  - Delegates from across the country convene to collaborate, take action on opioid epidemic

Examples of HRSA Efforts

- **HRSA Funded Research**
  - Example: The FORHP funded Maine Rural Health Research Center project "Catastrophic Consequences: The Rise of Opioid Abuse in Rural Communities”
- **The Rural Opioid Overdose Reversal Grant Program (FORHP)**
  - In September 2015, the FORHP awarded $1.8 million to support rural communities in reducing morbidity and mortality related to opioid overdoses
- **Health Care for the Homeless Demonstration Project (HAB)**
  - 5-year initiative that supports innovative practices to increase entry and retention into HIV care, as well as support services for patients who are homeless or unstably housed and those who are living with mentally illness or substance use disorders
- **Behavioral Health Workforce Education and Training Program (BHW)**
  - Supports the training of the behavioral workforce to ensure an adequate supply of professional and paraprofessionals across the country, and in particular, within underserved and rural communities (FY2014)

The Ryan White HIV/AIDS Program (RWHAP) Response

Glenn Clark
ADAP Advisor
HAB/DSHAP

Ryan White HIV/AIDS Programs
Examining Components of a Program

- A robust RWHAP service delivery system for people with substance use disorders should incorporate the following components:
  - Assessment/Diagnostic Services
  - Treatment options
  - Capacity to assess and refer within other service categories such as Medical Case Management
  - Programs to support adherence
- Consult with substance use disorder experts as part of your community planning process

Ryan White HIV/AIDS Program
Substance Abuse Outpatient Care

- Provision of outpatient services for the treatment of drug or alcohol use disorders
- Allowable Service Category for RWHAP Part A, B, C and D
- Includes the following services:
  - Screening
  - Assessment
  - Diagnosis, and/or
  - Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

Ryan White HIV/AIDS Program
Substance Abuse Services (Residential)

- Provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder.
- Allowable Service Category under RWHAP Part A and B
- Includes the following services:
  - Pretreatment/recovery readiness program
  - Harm reduction
  - Behavioral Health Counseling
  - Medication Assisted Therapy
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

Ryan White HIV/AIDS Program
The AIDS Drug Assistance Program (ADAP)

- RWHAP Part B-funded AIDS Drug Assistance Program's (ADAP) exist in every State and Territory. Each State and Territory chooses which FDA-approved medications to include on their formularies

- As of the 2015 NASTAD ADAP Formulary Database, five (5) ADAPs include buprenorphine on their formularies

- ADAPs can also provide health insurance assistance to clients, paying for health insurance premiums, and medication-related deductibles and co-payments. As such, ADAPs can help PLWH get onto and maintain health insurance coverage and the access to care and treatment it provides.

Ryan White HIV/AIDS Program
Service Categories with Ancillary Substance Abuse Components- Core Medical

Outpatient/Ambulatory Health Services (OAHS)

- OAHS includes :
  - Treatment and management of physical and behavioral health conditions; behavioral risk assessment, subsequent counseling, and referral; treatment adherence; and, education and counseling on health and prevention issues.

Medical Case Management (MCM)

- May involve assessment services, linkage to substance use treatment, treatment adherence support, and monitoring of progress
- Focus on improving health outcomes.

Non- Medical Case Management (N-MCM)

- Involves a range of client-centered services including substance use treatment aimed at improving access to services.

Ryan White HIV/AIDS Program
Service Categories with Ancillary Substance Abuse Components- Supportive Services

Housing

- Eligible housing support may include some type of medical or supportive services (such as residential substance use disorder services or mental health services).

Early Intervention Services (EIS)

- For Part A and Part B EIS must include 4 components related to diagnosing people and getting them into care. One component is: *Access and linkage to HIV care and treatment services such as HIV OAHS, Medical Case Management (MCM), and Substance Abuse Care.*
- Part C EIS requires *referral and linkage to care of HIV-infected clients to OAHS, MCM, and substance abuse care and other services as part of a comprehensive are system including a system for tracking and monitoring referrals.*

Ryan White HIV/AIDS Program: Part F
Examining Substance Abuse Treatment Options and Best Practices

- **Special Projects of National Significance (SPNS)** ***Dissemination of Evidence-Informed Interventions to Improve Health Outcomes along the HIV Care Continuum***
  - Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care
  - Current project looking at strategies for implementing a Buprenorphine Treatment protocol in HIV primary care settings.
  - http://www.hab.hrsa.gov/abouthab/special/buprenorphine.html

- **AETC's Integrating Mental Health and Substance Use Care into HIV Primary Care Toolkit:**
  - http://aidsetc.org/toolkit/mental-health

Strengthening Systems of Care to Support PLWH Experiencing Substance Use Disorders

Amy Griffin
Public Health Analyst
HAB/DSHAP

Ryan White HIV/AIDS Program
Developing a Local Response

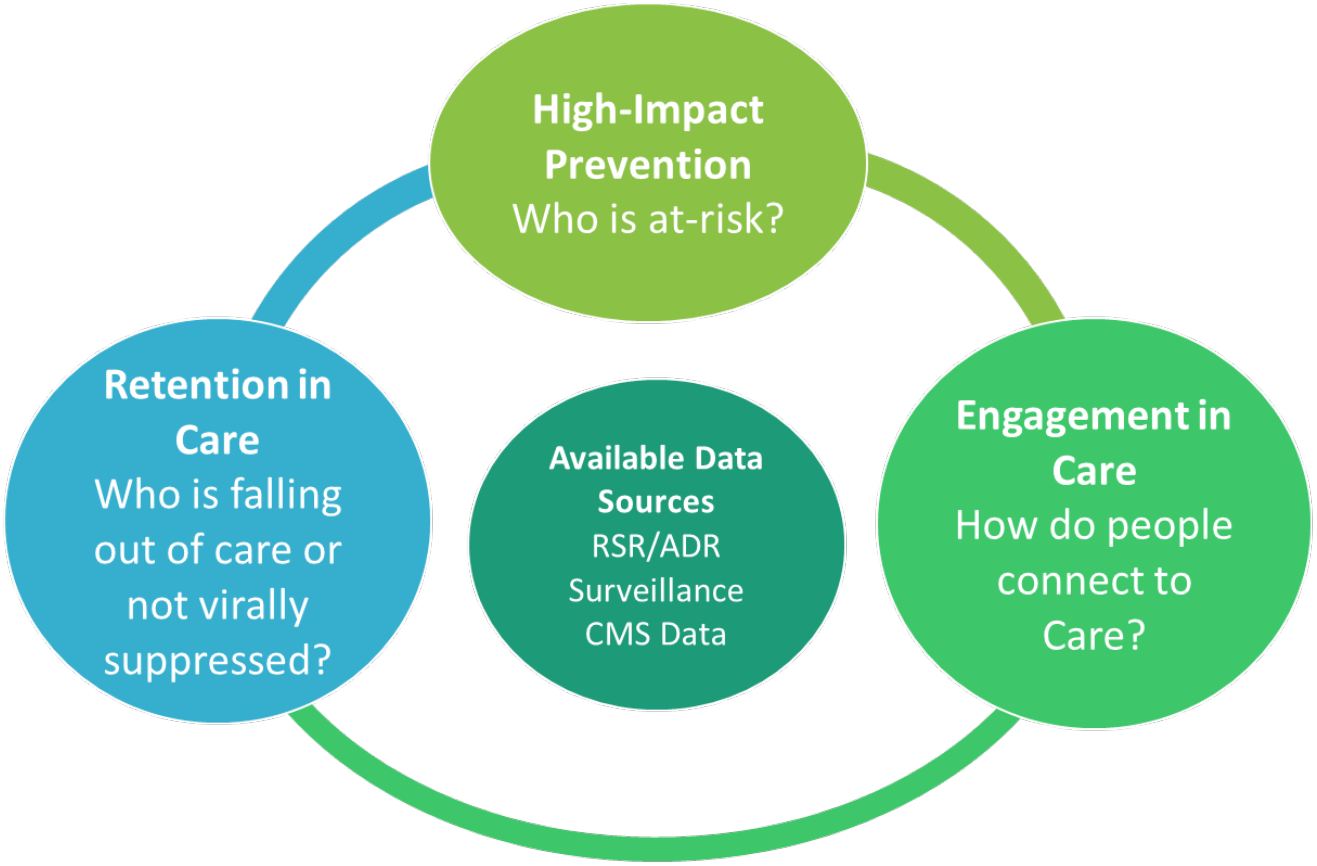
- How well does the program support people with addiction disorders to stay in care and become virally suppressed?
- Are we prepared to handle an HIV outbreak should it ever happen?
  - At this time the well publicized outbreak in Austin, Indiana is unique.
  - However, having a plan in the event of an outbreak can:
    - Expedite a jurisdictional response
    - Strengthen the system of care to provide services to current PLWH population experiencing substance abuse disorders

Research Local Impact
Use Your Data

- Review available data sources for potential opioid use impact
  - State Authority responsible for public health, substance abuse treatment/prevention, and/or injury reporting (overdose deaths)
  - Ryan White HIV/AIDS Program Services Report (RSR) data
  - State level data from Prescription Drug Monitoring Programs (PDMP)
  - Medicare D Opioid Claim Mapping Tool
  - Local Sources such as Emergency Room data

- Additional data resources:
  - **County-level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs, United States,** http://journals.lww.com/jaids/Abstract/publishahead/County_level_Vulnerability_Assessment_for_Rapid.97209.aspx
    - Van Handel, Michelle M MPH; Rose, Charles E PhD; Hallisey, Elaine J MA; Kolling, Jessica L MPH; Zibbell, Jon E PhD; Lewis, Brian BS; Bohm, Michele K MPH; Jones, Christopher M PharmD, MPH; Flanagan, Barry E PhD; Siddiqi, Azfar-E-Alam MD, PhD; Iqbal, Kashif MPH; Dent, Andrew L MA, MBA; Mermin, Jonathan H MD, MPH; McCray, Eugene MD; Ward, John W MD; Brooks, John T MD

Coordinate with HIV Prevention/Surveillance Systems



Strategic Partners
Map Out A Plan

- **Map out a plan for maximizing resources for clients with substance use disorders and to prepare for a potential outbreak.**
  - State Public Health Department
  - State Mental Health and Substance Abuse Authority
  - Medicaid
  - Medical Case Management
  - Department of Corrections
  - Healthcare Providers
  - Disease Intervention Specialists
  - AIDS Education and Training Centers
  - Data Resources
- **Develop relationships and service delivery agreements ahead of time**

Questions

NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Responding to an HIV Outbreak: Experiences of the Midwest AIDS Education and Training Center

Malinda Boehler, MSW, LCSW and Karen Curd, BS

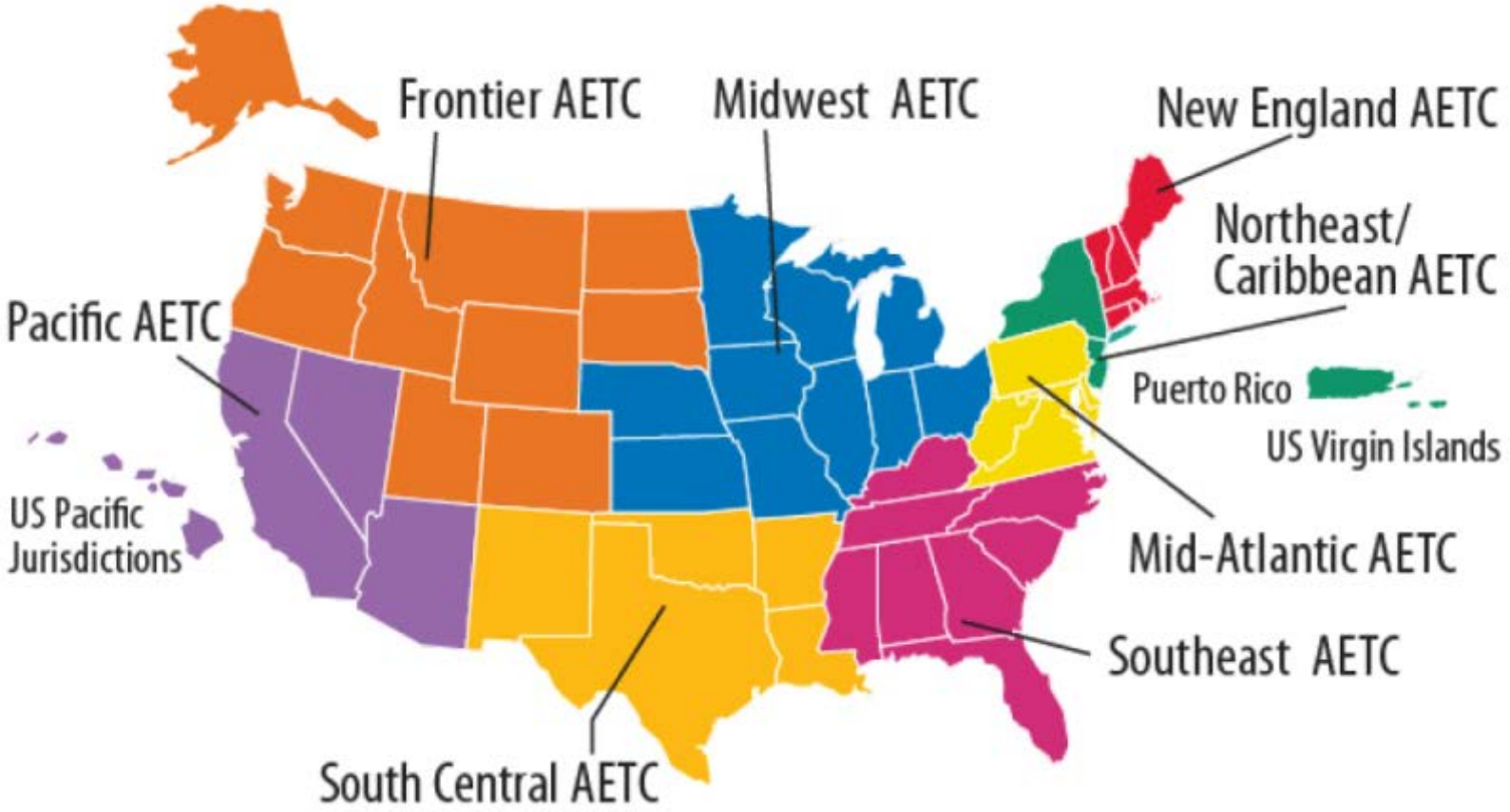
Midwest AIDS Education and Training Center – Indiana

HRSA Ryan White & Global HIV/AIDS Programs

OBJECTIVES

1. Describe the Midwest AETC's response to the HIV Outbreak in Indiana.
2. Discuss how other AETCs can prepare for the next HIV outbreak.
3. Explain how HRSA and HAB can contribute prevention efforts to reduce the risk of another HIV outbreak.

Midwest AETC



MATEC-IN

Eskenazi Health

720 Eskenazi Avenue

Fifth Third Bank Building - Bell Flower Clinic

Indianapolis, IN 46202

Our Staff

Christine Balt, DNP
Clinical Coordinator

Malinda Boehler
Site Director

Karen Curd
Site Manager

Rachel Bates
Visual Media Coordinator

Dr. Diane Janowicz
Medical Director

On Feb. 25, 2015, the Indiana State Department of Health issued a press release announcing there had been 26 confirmed and four preliminary cases of HIV in Southeastern Indiana since mid-December (2014).

Where is Scott County?

State of Indiana:
Pop 6,619,680 [1]

Scott County:
Pop 23,744 [1]

Town of Austin:
Pop 4,295 [2]

Source: 1. U.S. Census Bureau, population estimates, July 1, 2015, (V2015)2. U.S. Census Bureau, 2010 Census.

Why Austin?

Health Indicators

Length of Life: 92nd of 92 Indiana counties

Quality of Life: 89th of 92 Indiana counties

Health Infrastructure:
Only one health care provider – no specialists

Source: http://www.countyhealthrankings.org/app/indiana/2016/rankings/scott/county/factors/overall/snapshot. Accessed 3-31-16

Socio-Economic Challenges

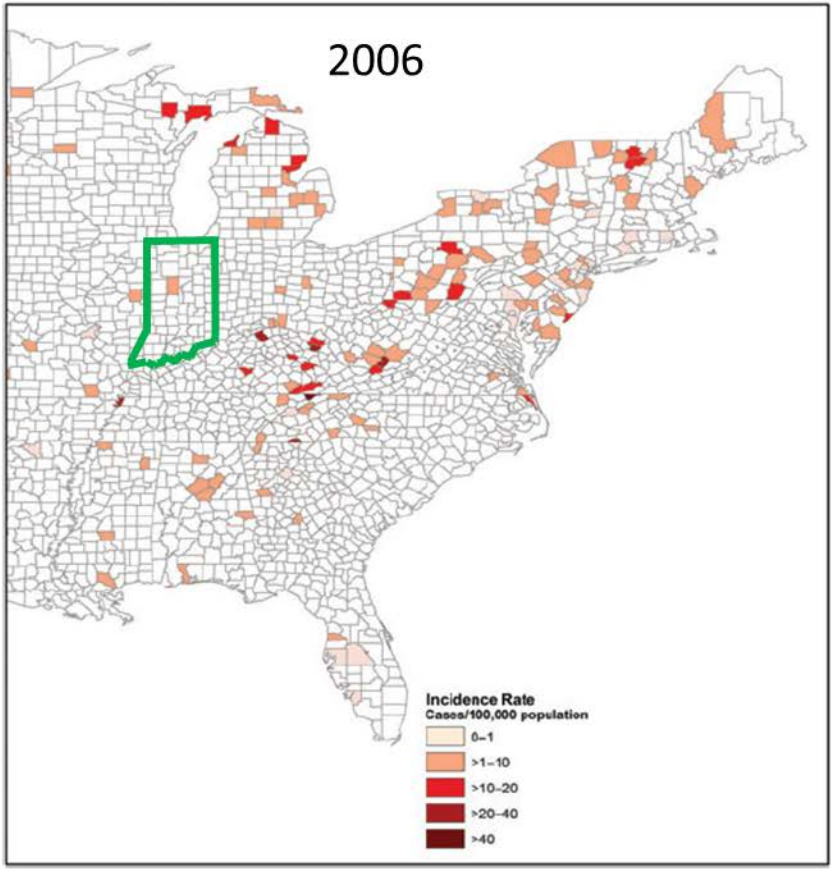
Socio-Economic Factors:
90th of 92 Indiana counties[1]

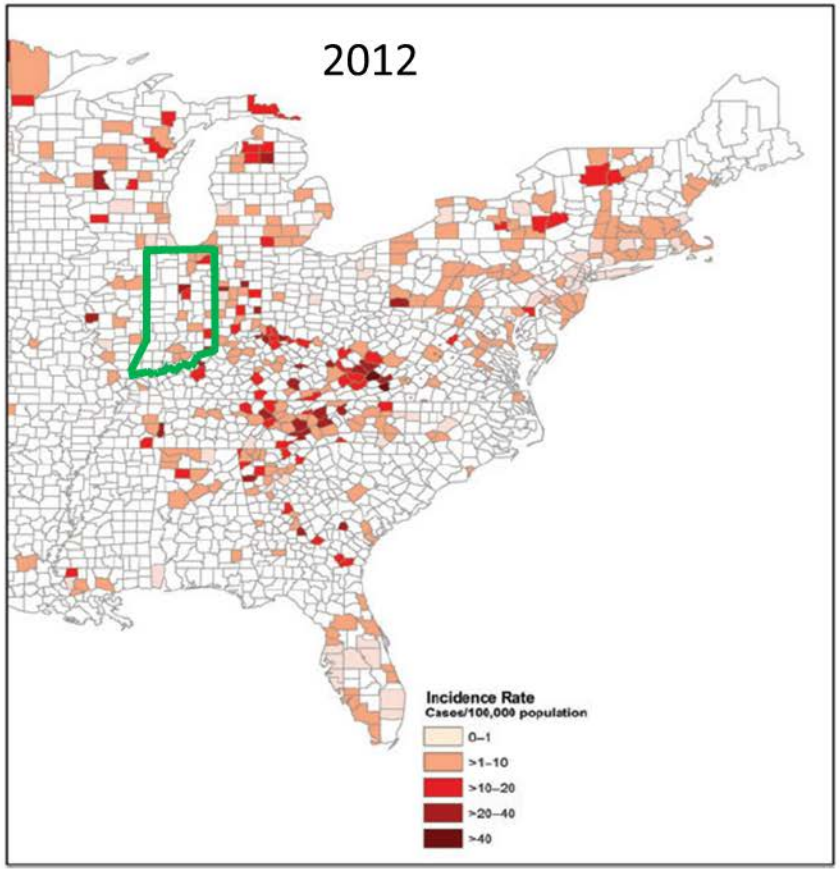
Education: 24% do not graduate from high school[1]

Poverty: 15% live in poverty[2]

Source: 1. http://www.countyhealthrankings.org/app/indiana/2016/rankings/scott/county/factors/overall/snapshot
2. http://www.census.gov/quickfacts/table/EDU635214/00. Accessed 3-31-16

Hepatitis C Among People who Inject Drugs

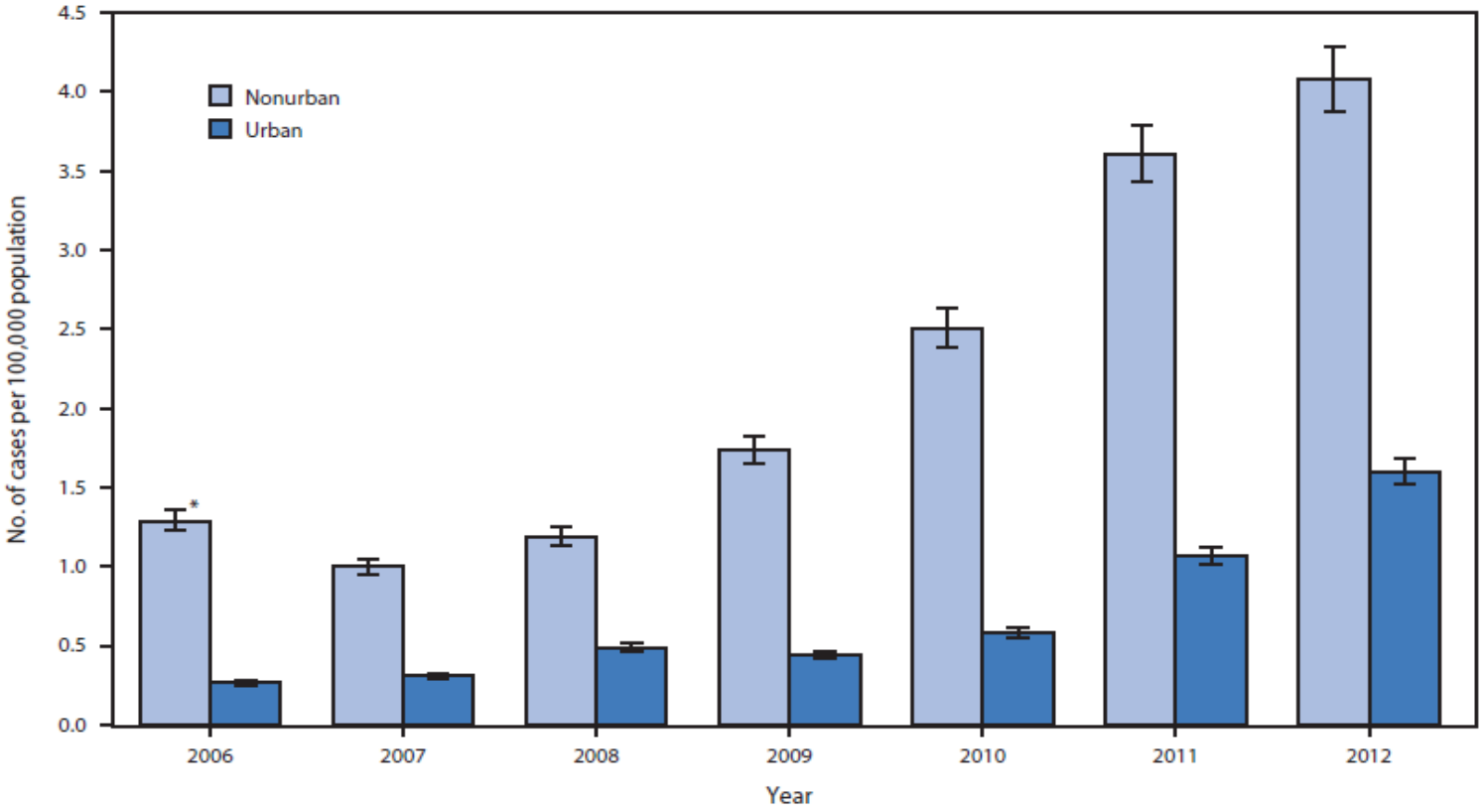




Source: Clin Infect Dis. (2014) 59 (10): 1411-1419. doi: 10.1093/cid/ciu637

Hepatitis C in Rural Areas

FIGURE 1. Incidence of acute hepatitis C among persons aged ≤30 years, by urbanicity and year — Kentucky, Tennessee, Virginia, and West Virginia, 2006–2012



Source: MMWR Morb Mortal Wkly Rep 2015, 64(17): 444-448, "Increases in Hepatitis C Virus Infection Related to Injection Drug Use Among Persons Aged ≤30 Years — Kentucky, Tennessee, Virginia, and West Virginia, 2006–2012"

Hepatitis C in Indiana

Between 1/01/14 – 12/31/14 Indiana identified 5,289 cases of Hepatitis C.

- 5,169 Chronic Infections
- 120 Acute Infections

57 were in Scott County (1%)

Source: http://www.in.gov/isdh/files/Hepatitis_C(7).pdf Accessed April 7, 2016

DRUG ARRESTS

County	Coverage Indicator (%)	Drug-Related Arrest Rate per 1,000 Persons	Year of Data	Source
Scott	**82.25**	**485**	**2012**	**FBI UCR, 2014**

Source: http://www.drugs.indiana.edu/main/GIS_table.php?page_group=21&tablenum=Intro2.2. Accessed April 7, 2016

Drug Use/Abuse Data

- Drug Overdose Rates[1]
  - 10 fold increase in opioid related overdose deaths from 1999-2014
  - 600% increase in overall drug related deaths

- Opioid Prescribing Rates[2]
  - Indiana prescribers were 9th highest opioid prescribers in the nation, prescribing 109 painkiller prescriptions for every 100 people in the state in 2012

Source: 1. Indiana State Department of Health, Division of Trauma and Injury Prevention Report, Epidemiology Resource Center, Data Analysis Team. 2. Palouzzi et al. Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines — United States, 2012. MMWR July 4, 2014

First Indication of Outbreak: December 2014

3 new HIV diagnoses in Scott County

MATEC-IN Response:

- Acknowledged this is an extremely high rate
- Researched demographics of Scott County
- Raised concerns about resources available for HIV care

Source: http://www.in.gov/isdh/26649.htm. Accessed March 31, 2016

February 2015

26 confirmed cases/ 4 preliminary positives

MATEC-IN Response:

- Collaborated with DIS who deployed to Scott County from Bell Flower STD Clinic in Indianapolis
- Created knowledge base of HIV care resources and services

Source: http://www.in.gov/isdh/26649.htm. Accessed March 31, 2016

INDIANA HIV CARE COORDINATION REGIONS As of January 2016

Agencies by Region

1. Aliveness Project of Northwest Indiana
2. AIDS Ministries/AIDS Assist
3. Positive Resource Connection
4. Aspire – West
5. Meridian Health Services Corporation
6. Aspire – Central
7. Concord Center

   Damien Center

   Eskenazi Health

   LifeCare – IU Health

   Step-Up, Inc.
8. Positive Link-IU Health Bloomington
9. Aspire – Southeast
10. Positive Link – IU Health Bloomington
11. Clark County Health Department
12. AIDS Resource Group of Evansville

Source: http://www.in.gov/isdh/files/CC_Regional_Map_Jan2016.pdf. Accessed March 31, 2016

March 2015

74 confirmed cases/ 7 preliminary positives

Declaration of public health emergency

Establishment of Incident Command Center by Indiana State Department of Health

Public Health Awareness Campaign

MATEC-IN Response:

- MATEC-IN Director attends first Town Hall - March 12th
  - Connected with two local doctors
  - Began fulfilling training requests from local organizations
- First HIV clinic in Austin – March 31st
- Participated in meetings with ISDH and CDC

Source: http://www.in.gov/isdh/26649.htm. Accessed March 31, 2016

April 2015

136 confirmed cases/ 6 preliminary positives

General Assembly passed syringe exchange bill (SEA 461)

One Stop Shop - open and operational

MATEC-IN Response:

- Conducted HIV Screening Trainings – healthcare providers, jail staff, and faith-based organizations
- Provided HIV 101 Trainings – Department of Child Services and Law Enforcement
- Partnered with Indiana Primary Health Care Association (IPHCA) for HIV testing training
- Coordinated offers for assistance from partners

Source: http://www.in.gov/isdh/26649.htm. Accessed March 31, 2016

May 2015

159 confirmed cases/ 3 preliminary positives

Indiana Governor Michael Pence signs SEA 461

MATEC-IN Response:

- Recruited Dr. William Cooke for MATEC's Clinician Scholars Program
- Began developing harm reduction training materials
- Continued trainings for neighboring at-risk communities – Testing, HIV 101, Hepatitis C 101
- Began educating HIV community at large about outbreak (ANAC, IPHCA, local ID providers, statewide HIV/STD Update conference)

- Source: http://www.in.gov/isdh/26649.htm. Accessed March 31, 2016

June 2015

169 confirmed cases/ 1 preliminary positive

End of emergency response and transition to the community for continuation of response

MATEC-IN Response:

- Continued Trainings – HIV Testing, HIV 101, Hepatitis C 101

Source: http://www.in.gov/isdh/26649.htm. Accessed March 31, 2016

July 2015 – Present Day

200 confirmed cases

Continued testing blitz events

One Stop Shop – new permanent location co-located with SEP

MATEC-IN Response:

- Continued Trainings – HIV Testing, HIV 101, Hepatitis C 101
- Training for counties approved for Syringe Exchange
- Partnered with Indiana Primary Health Care Association for Harm Reduction training

Source: http://www.in.gov/isdh/26649.htm. Accessed July 20, 2016.

MATEC Self-Assessment

STRENGTHS

- Well respected
- Committed and talented staff
- Strong relationships
- High level of support
- Geographically accessible

WEAKNESSES

- Few staff to fulfill high demand for services
- Need to promote MATEC in areas with low HIV incidence/prevalence
- Limited experience managing news media
- Maneuvering politics of Public Health Emergency

MATEC Impact – At a Glance

- Level 1 and Level 2 Trainings
  - 22 programs (8 in April 2015)
  - 50 hours of training
  - 719 people trained

- Technical Assistance
  - 9 programs reported
  - 47 hours
  - 129 people supported

Capacity Building

- Scott County Jail now offers HIV screening to all inmates
- Law enforcement personnel better prepared to work with community
- Medical providers are more aware of resources for HIV care and prevention, including PrEP
- Department of Child Services better prepared to assist families dealing with new HIV infection
- Volunteer groups able to provide ongoing HIV screening as part of community outreach

Advice to Other AETCs

- Build and/or maintain strong relationships with your State and County Health Departments
- Research and partner with other training resources in your state (federally funded and otherwise)
  - Who provides training?
  - Who do they train?
- Be prepared to work outside your comfort zone and your normal work hours
- Collaborate early with other AETCs for shared resources
- Increase your profile and efforts in rural communities with same conditions (red flags) as Scott County

Advice (2)

- Build training materials and begin offering training on MAT, Syringe Exchange, and PrEP before the outbreak
- Proactively identify needs and offer scheduled trainings
- Train on Pain Management in HIV – pain control vs. addiction, alternatives for opioids
- Familiarize yourself with media policies of your university or organization
- Be prepared for an overall increase in training requests

Thoughts Moving Forward

- Break down silos between HIV, STD and Viral Hepatitis Programs
  - Care and Prevention
- Continue support for AETC's BASE/Core training efforts or fund rural initiatives
  - Current funding challenges us to reach rural areas adequately
  - Achieving balance between new AETC projects while supporting local training needs
- Expand access to testing and prevention services
  - Routine HIV/HEP C screening in jails and drug treatment facilities
  - Access to Hep C Treatment and PrEP

Thoughts (2)

- Introduce campaigns to increase the number of providers willing to treat HIV and HIV/Hepatitis C co-infected patients
- Intensive HIV training and support for rural providers
- Incentivizing providers to care for people with HIV infection with increased reimbursement
- Foster relationships between urban HIV/Hepatitis C experts and rural communities

Thoughts (3)

- Work with State and Local Recipients to cover:
  - HIV and Hep C treatment in county jails
  - Hep C treatment for HIV co-infected
  - Inpatient detox and rehab
  - PrEP for high-risk negatives
- Advocate for universal Hepatitis C treatment for all co-infected patients

Discussion