Responding to the Opioid Epidemic through a Team Approach in HIV Primary Care Settings

National Latinx HIV/Hep C Conference

May 20, 2018
Presenters

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Objectives

• Describe the components of the standardized intervention

• Illustrate implementation lessons learned from implementation of the intervention, with an in depth focus on implementation at Centro Ararat’s Faith Clinic in Juana Diaz, PR

• Identify ways this intervention can be incorporated into your agency/clinic through case studies and small group discussions
Project Background

• Four-year Cooperative Agreement with HRSA’s Special Projects of National Significance (SPNS)
• Funding amount of $3 million/year, with $2.4 million going to implementing sites
• Replicates four previously-implemented SPNS initiatives
Interventions Being Replicated

Transitional Care Coordination
From Jail Intake to Community HIV Primary Care

Peer Linkage and Re-Engagement of HIV-Positive Women of Color

Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care

Enhanced Patient Navigation for HIV-Positive Women of Color
AIDS United
Implementation and Technical Assistance Center (ITAC)

Select & Fund 12 Sites
Provide TA
Coordinate Experts
Boston University

Dissemination and Evaluation Center (DEC)

- Adapt and design 4 intervention models for replication.
- Design and implement multi-site evaluation
- Studying both patient outcomes (including retention in care and viral suppression) and implementation findings (what works in practice and what facilitates/hinders implementation)
- Publish and disseminate final adapted interventions and study findings
HIV Care Continuum: Background and Data Overview
Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016

- Any Opioid
- Other Synthetic Opioids (e.g., fentanyl, tramadol)
- Heroin
- Natural & Semi-Synthetic Opioids (e.g., oxycodone, hydrocodone)
- Methadone

HIV CARE CONTINUUM:

The series of steps a person with HIV takes from initial diagnosis through their successful treatment with HIV medication.
Viral Suppression among RWHAP Clients, by State, 2010 and 2016—United States and 2 Territories

Viral suppression: ≥1 OAHS visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.

* Puerto Rico and the U.S. Virgin Islands.

### Viral Suppression among Clients with HIV Infection Attributed to Injection Drug Use Aged ≥13 Years Served by the Ryan White HIV/AIDS Program, 2016—United States and 3 Territories

<table>
<thead>
<tr>
<th>Subpopulation</th>
<th>Viral Suppression (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDU overall</td>
<td>85.1</td>
</tr>
<tr>
<td>25-29 years</td>
<td>68.6</td>
</tr>
<tr>
<td>30-34 years</td>
<td>72.7</td>
</tr>
<tr>
<td>35-39 years</td>
<td>78.3</td>
</tr>
<tr>
<td>40-44 years</td>
<td>77.9</td>
</tr>
<tr>
<td>No health care coverage</td>
<td>76.3</td>
</tr>
<tr>
<td>Temporary housing</td>
<td>78.9</td>
</tr>
<tr>
<td>Unstable housing</td>
<td>72.5</td>
</tr>
</tbody>
</table>

**Notes:**
- **IDU:** injection drug use.
- Data represent clients who reported injection drug use as their transmission risk category; data do not include non-IDU transmission risk behavior. Data do not include male-to-male sexual contact and injection drug use nor sexual contact and injection drug use among transgender clients.
- **N** represents the total number of clients in the specific subpopulation.
- Viral suppression is defined as ≥1 OAH5 visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.
- Guam, Puerto Rico, and the U.S. Virgin Islands.
Integration of Buprenorphine in HIV Primary Care: Intervention Overview
This intervention is intended for implementation in HIV primary care settings that do not already provide on-site buprenorphine treatment services.

Follows principles of harm reduction, enabling providers to treat addiction along with other chronic medical conditions experienced by their patients.
Overview

• **Target population:** People living with HIV and opiate use disorder.

• **Time frame of the intervention:** No predetermined time frame as the time from induction to stabilization to maintenance will vary for each patient.

• **Enrollment numbers:** at least 25 participants enrolled in the first 12 months of implementation and at least an additional 25 enrolled in the following six months of implementation.
Core Elements of Buprenorphine Intervention

- Clinic buy-in
- Introduce the intervention to client
- Initiating treatment
- Monitoring treatment
- Integration of treatment into the clinical setting
Intervention Activities

• Relationship building (e.g. checking in with client; providing emotional support)
• Conduct monitoring appointment
• Develop a patient care plan
• Conduct client intake and/or needs assessment
• Follow up with provider to discuss client
• Provide coaching on living skills
• Provide client support during maintenance or stabilization
• Arrange for substance use treatment / services appointment
• Assist with obtaining transportation services
• Urinalysis

Note: Activities conducted by the prescribing providers are captured in the chart abstraction. Only activities conducted by the Clinical Coordinator are recorded through the Encounter Form.
Integration of Buprenorphine in HIV Primary Care: Selected Sites
Bluegrass Care Clinic
The MetroHealth System
Centro Ararat
A brief video
## Enrollment Across Buprenorphine Sites
(as of 4.30.18)

<table>
<thead>
<tr>
<th></th>
<th>[Participant Form pending]</th>
<th>Active</th>
<th>Withdrawn</th>
<th>Moved out of service area</th>
<th>Not Clinically Indicated</th>
<th>Deceased</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Kentucky Research Foundation</td>
<td>0</td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>Centro Ararat</td>
<td>0</td>
<td>17</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>24</td>
</tr>
<tr>
<td>The MetroHealth Foundation</td>
<td>2</td>
<td>23</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>29</td>
</tr>
</tbody>
</table>
Top Reported Client Needs

- Transportation
- Substance use treatment
- Mental health services
- Insurance to cover cost of MAT
- Housing
- Help with applying for SSI or SSDI benefits
Were you surprised by the top needs and most frequently provided intervention activities? Why or Why not?
Centro Ararat’s Experience
Implementing the Buprenorphine for Opioid Use Disorder in HIV Primary Care
Centro Ararat: Mission and Vision

• **CA’s Mission:** To offer cutting edge healthcare services, with the highest quality standards in primary care, while promoting education and prevention in an inclusive environment, with the utmost respect for the liberty and diversity of all humankind.

• **CA’s Vision:** To be the best healthcare services provider in Puerto Rico, supported by avant-garde medical standards, to guarantee maximum client satisfaction and the added value of an integrated, preventive care for all of our patients.

• **CA’s Values:** Excellence, Respect, Solidarity, Equality
## Centro Ararat: Core Medical Service

<table>
<thead>
<tr>
<th>Core Medical Service</th>
<th>Early Intervention Services (EIS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS Pharmaceutical Assistance</td>
<td>Referral for Health Care and Support Services</td>
</tr>
<tr>
<td>Medical Case Management, including Treatment Adherence Services</td>
<td></td>
</tr>
<tr>
<td>Outpatient/Ambulatory Health Services</td>
<td></td>
</tr>
<tr>
<td>Medical Nutrition Therapy</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Outpatient Care</td>
<td></td>
</tr>
<tr>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td>Health Education, Risk Reduction, and High Risk targeted HIV testing</td>
<td></td>
</tr>
</tbody>
</table>
Personas viviendo con VIH/SIDA en Puerto Rico
al 31 de Diciembre de 2017

San Juan
4,472

Aguadilla
600

Arecibo 1,483

Área Metro
2,320

Mayagüez
1,003

Bayamón 3,163

Fajardo 643

Caguas 2,362

Ponce 2,573

Fuente:
HIV/AIDS Surveillance Program
Office of Epidemiology and Research, Puerto Rico Health Department
n= 20,105 HIV/AIDS cases diagnosed as of December 31, 2017

www.centroararat.org
CENTRO ARARAT, INC.
CA Facilities, Programs, & Services

CLINICS

ARARAT CLINIC
Ponce
San Juan
Juana Díaz

PREVENTION DIVISION

ATCH the WAVE
Ponce
San Juan

PHARMACIES

CA PHARMACY
Ponce
San Juan

SUPPORT

Grace PROJECT
Ponce

TRANSLucent Project
San Juan

BELIEVE Project
San Juan

DISSEMINATION OF
EVIDENCE-INFORMED INTERVENTIONS
Patient Distribution
Centro Ararat: Geographic Setting

- The Buprenorphine Initiative was implemented at FAITH Clinic in Juana Diaz.
- Juana Diaz is one of 15 municipalities collectively known by the Puerto Rico Health Department as the Ponce Health Region (PHR).
- With the exception of Ponce, the municipalities in the PHR are considered "rural" by USDA programs operating in Puerto Rico.
- Ponce is the second largest city in Puerto Rico. It is an industrial, governmental and commercial center for the region.
- In 2010, The entire region had a combined population of over 565,000.
# Centro Ararat: Clinic Demographics

<table>
<thead>
<tr>
<th>Age</th>
<th>45</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,139 / 66%</td>
</tr>
<tr>
<td>Female</td>
<td>490 / 28%</td>
</tr>
<tr>
<td>Transgender</td>
<td>107 / 6%</td>
</tr>
<tr>
<td>Other: Genderqueer</td>
<td>1/ --</td>
</tr>
</tbody>
</table>

- Total Number of Patients: 1737
- Total Number of Patients with HIV: 798
## Centro Ararat: Clinic Demographics (N=1737)

<table>
<thead>
<tr>
<th>Race</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian</td>
<td>0 / --</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>2 / --</td>
<td></td>
</tr>
<tr>
<td>Black/African American</td>
<td>73 / 4%</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>582 / 34%</td>
<td></td>
</tr>
<tr>
<td>Multiracial</td>
<td>1076 / 62%</td>
<td></td>
</tr>
<tr>
<td>Unknown/Refused</td>
<td>4 / --</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hispanic, Latino/a or Spanish origin</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>9 / --</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1724 / 99%</td>
<td></td>
</tr>
<tr>
<td>Refused</td>
<td>4 / --</td>
<td></td>
</tr>
</tbody>
</table>
CA HIV Population - Gender

- Male: 655 (82%)
- Female: 136 (17%)
- MCF: 7 (1%)

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS
CA HIV Population - Age

- 13-23: 3%
- 24-44: 38%
- 45-64: 50%
- 65+: 9%
CA HIV Cascade

- HIV Patients: 100%
- Retention in Care: 96%
- On ARV: 99%
- Viral Load Supression: 95%
FAITH HIV Cascade

- 100% HIV Patients
- 78% Retention in Care
- 99% On ARV
- 92% Viral Suppression
Buprenorphine Cascade

- HIV Patients: 100%
- Retention in Care: 100%
- On ARV: 89%

IN PROGRESS
### Centro Ararat Buprenorphine Patient Profile (N=25)

<table>
<thead>
<tr>
<th>Age</th>
<th>47 (32-64)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>4 / 16%</td>
</tr>
<tr>
<td>Male</td>
<td>21 / 84%</td>
</tr>
<tr>
<td>Transgender</td>
<td></td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>22 / 88%</td>
</tr>
<tr>
<td>Employed</td>
<td>3 / 12%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Marital Status</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>2 / 8%</td>
</tr>
<tr>
<td>Single</td>
<td>17 / 68%</td>
</tr>
<tr>
<td>Significant Other</td>
<td>6 / 24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Education</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Elementary School</td>
<td>2 / 8%</td>
</tr>
<tr>
<td>Middle School</td>
<td>8 / 32%</td>
</tr>
<tr>
<td>High School</td>
<td>12 / 48%</td>
</tr>
<tr>
<td>Associate D.</td>
<td>1 / 4%</td>
</tr>
<tr>
<td>Post Graduate D.</td>
<td>1 / 4%</td>
</tr>
</tbody>
</table>
## Implementation – Project Structure

<table>
<thead>
<tr>
<th>Staff Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician*</td>
<td>With buprenorphine Prescribing Privileges. Responsible for all aspects of patient treatment</td>
</tr>
<tr>
<td>Clinical Coordinator*</td>
<td>Nurse- Support patient through treatment process. Provide appropriate follow up to patient and physician referrals</td>
</tr>
<tr>
<td>Data Manager *</td>
<td>Consent patient into the study. Responsible for all aspects of data collection and data cleaning</td>
</tr>
<tr>
<td>Addiction Counselor</td>
<td>Provide individual and group therapy. Supports clinical coordinator</td>
</tr>
<tr>
<td>Outreach Team</td>
<td>Identify potential patients, and provide follow up to active patients</td>
</tr>
</tbody>
</table>

* Staffing requirement per intervention
Activity: Mapping the workflow
1. Identification of potential clients
   1. Screening
      Medical Evaluation
      Induction
      Stabilization
      Maintenance
<table>
<thead>
<tr>
<th>Challenges</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| Low compliance with follow up appointment     | - Appointment reminder calls  
- Use of appointment cards  
- Provide transportation services |
| Low enrollment                                 | - Increasing participation in activities of impact in high-risk communities by performing rapid HIV testing in Community Health Fairs and Community Alliances.  
- Establishing agreements with non-profit agencies that serve the people living with HIV  
- Establishing agreements with non-profit agencies that serve the population with Substance Use Disorders.  
- Creation of an outreach team |
| Pre-candidates not meeting eligibility criteria | - Implementing counseling services for all participants in opioids therapy to confirm or discard opioid use disorder |
| Reduction / loss of funds of non-profit organizations | - Identification of other organizations/agencies as source of referrals. Develop memorandums of agreements with these agencies |
| Lengthy progress note documentation            | Create templates for the electronic record that captures all activities in the distinct stages of the treatment. It helped minimize the time in the documentation process. |
| Need for methadone reduction process           | Established direct referral line with the agency and guided the candidates about the reduction process. |
Other Successful Strategies

- **Hiring of an experienced addiction counselor:**
  - Previous experience with buprenorphine clinics
  - Speedy link to mental health care
  - Relapse prevention
  - Follow-up with other providers
  - Rapid access to higher level of treatment
  - Broad knowledge of MAT protocols and state laws
  - Pre-established relationships with other agencies

- **Integration of outreach team:**
  - Streamlined the process of recruiting new participants
  - Established new partnerships with other non-profit agencies
  - Patient follow-up improving adherence to both HIV and MAT treatment
Unexpected Challenge: Hurricane Maria

- **Hurricane Maria** - On September 20\textsuperscript{th} 2017, Hurricane Maria made landfall as a category 4 hurricane
  - Power outage
  - Lack of water
  - No communication

- **Emergency Action Plan**
  - Pre-Impact Phase
  - Post-impact Phase
  - Results
Overall Outcomes

• Identification and link to care of patients that had been out of care for several years.
• Identification of treatment Naïve HIV patients
• New agency partnerships
• Identification of non OUD patients that were linked to care
• Increase awareness of OUD within the organization
• Increased number of physicians within the organization that are buprenorphine certified
Lessons Learned

• Expectations about treatment is different for each individual.
• Assessment of patient's treatment expectation is crucial prior to initializing treatment.
• Integration of OUD treatment in HIV primary care enabled us as providers to improve overall treatment adherence.
Case Study & Discussion
Client Case Study A

- 56 year old male, HIV positive since 2000.
- The patient is an active Speedball (heroin & cocaine IV) user.
  - At 21 years of age, patient started using Tussionex (codeine) and later experimented with heroin.
  - After 2 years of abstinence, patient began using 3 “bags” of heroin and 1 of cocaine, he felt disappointment and frustration about his relapse.
- History of residential treatment.
- Homeless for several years and is currently in a permanent residential program.
- Adherent to his ART Tx, no mental health history reported.
- Patient was induced and stabilized at suboxone 8/2mg Film bid.
- After being stable for a month, the patient relapsed and had a positive urine screen to heroin and cocaine. Sexual contact (relation, encounter) was identified as a trigger for his relapse.
Discussion of Case Study A

• Identify client's needs
• Explain how you would address those as part of the treatment plan
Interventions and Outcomes

• **Intervention:**
  – Increase frequency of visits to assist to better monitor patient and buprenorphine adherence
  – Referred to counseling to address sexual issues that precipitated the use of heroin and affected his recovery

• **Outcomes:**
  – Patient developed strategies to deal with identified trigger
  – Patient stopped heroin use. No relapsed observed during the last 6 months
Client Case Study B

- 44 year male referred to clinic for buprenorphine.
- Unemployed and single. Patient lives with his mother and has no children.
- Started using cocaine and heroin at 24 years old while incarcerated. Prior to starting buprenorphine, the patient was actively using heroin, cocaine, alcohol and nicotine.
- Patient had successful past experience with buprenorphine: in 2014 started buprenorphine treatment in USA and was abstinent from opiates for 2 years.
- Hx of HCV and HIV. Patient was recently lost to HIV medical care: November 2016 until May 2017. No other medical conditions presented or Mental Health history.
- The participant was on parole, and was referred to buprenorphine treatment due to opioid positive urine drug screen.
- Patient began buprenorphine treatment in May 2017. He was induced and was stabilized on suboxone 8/2mg Film bid.
- He continued using heroin despite buprenorphine use. He identified that issues with his mother as a precipitated his continued use of heroin. Patient depended on his mother for transportation and had easy access to heroin through a family member.
Discussion of Case study B

- Identify client's needs
- Explain how you would address those as part of the treatment plan
Interventions

- Outreach team found client and encouraged his return to care.
- Case manager: Referrals to HIV care, oral health, optometry, nutritionist, and addiction counseling. Provided transportation services and food assistance.
- Addiction counselor performed initial assessment, individual and group interventions. Referred to buprenorphine program and later on referred to higher level of treatment. Referred to psychologist for mental health evaluation.
- Clinical Coordinator: referred for medical evaluation, performed UTS, performed home visits.
- Physician performed initial medical evaluation, Labs orders, re-initiated ART, conducted buprenorphine induction.
- Psychologist performed mental health evaluation, individual intervention. Admitted patient to psychology services in site.
- Nutritionist: performed nutritional evaluation and provided nutritional supplements for weight gain.
Outcomes

• Participant was referred to higher level of treatment at partner agency due to multiple positive urine drug screens. Participant was stable at one month, until he abandoned treatment.

• Staff visited participant to schedule a medical visit. Participant visited clinic the next day and was provided with ART and Suboxone treatment for 2 weeks, for re-evaluation.

• The participant was active in heroin use despite Buprenorphine use. The intervention team recommended a new change to higher level of treatment. The participant did not accept the recommendation for two days, but was eventually re-admitted to higher level of treatment at the same partner agency. He abandoned treatment after two weeks.

• After leaving treatment, the patient did return to care and refilled ARV prescription.

• The outreach team contacted his mother who informed the patient had moved out of Puerto Rico. The case manager tried unsuccessfully to communicate with the participant on several occasions. Eventually, the mother called to inform the team that the patient had OD-ed in Pennsylvania.
What would you do?

• What would your clinic need to do to pick this intervention up?
  – Do you think there would be buy-in for this type of intervention in your clinic?
• What substance use treatment services are already available in your community? What are the wrap-around/social support/behavioral health services available for people living with HIV & substance use disorder in your community?
• Do the services available meet the need in your community (are services available, accessible, and responsive to people’s lived experiences)?
• Would this intervention work in your clinic/organization? Why or why not?
Resources & Next Steps
LOOKING AHEAD: CARE & TREATMENT INTERVENTIONS

- Continue monitoring implementation at sites and multi-site outcomes evaluation.
- Analyze and summarize interim findings
- Update adapted interventions
- Release final interventions as CATIs
Resources Currently Available

• The intervention manuals are available for download on the TARGET Center site
  – https://nextlevel.careacttarget.org/

• Training Manuals Coming Soon
  – Anticipated release, Fall of 2018
  – Will also be posted on TARGET Center site
Questions?