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FY 2017 Houston EMA/HSDA Ryan White Part A/MAI Service Definition

Substance Abuse Services - Outpatient	
(Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	Substance Abuse Services Outpatient
Local Service Category Title:	Substance Abuse Treatment/Counseling
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Minimum group session length is 2 hours
HRSA Service Category Definition: **RWGA Only**	*Substance abuse services outpatient* is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.
Local Service Category Definition:	Treatment and/or counseling HIV-infected individuals with substance abuse disorders delivered in accordance with State licensing guidelines.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected individuals with substance abuse disorders, residing in the Houston Eligible Metropolitan Area (EMA/HSDA).
Services to be Provided:	Services for all eligible HIV/AIDS patients with substance abuse disorders. Services provided must be integrated with HIV-related issues that trigger relapse. All services must be provided in accordance with the Texas Department of Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Service provision must comply with the applicable treatment standards.
Service Unit Definition(s): **RWGA Only**	**Individual Counseling:** One unit of service = one individual counseling session of at least 45 minutes in length with one (1) eligible client. **A single session lasting longer than 45 minutes qualifies as only a single unit** – no fractional units are allowed. Two (2) units are allowed for initial assessment/orientation session. **Group Counseling:** One unit of service = 60 minutes of group treatment for one eligible client. A single session must last a minimum of 2 hours. Support Groups are defined as professionally led groups that are comprised of HIV-positive individuals, family members, or significant others for the purpose of providing Substance Abuse therapy.
Financial Eligibility:	Refer to the RWPC's approved *FY 2017 Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	HIV-infected individuals with substance abuse co-morbidities/disorders.
Agency Requirements:	Agency must be appropriately licensed by the State. All services must be provided in accordance with applicable Texas Department of State

	Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Client must not be eligible for services from other programs or providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. All services must be provided in accordance with the TDSHS/SAS Chemical Dependency Treatment Facility Licensure Standards. Specifically, regarding service provision, services must comply with the most current version of the applicable Rules for Licensed Chemical Dependency Treatment. Services provided must be integrated with HIV-related issues that trigger relapse. Provider must provide a written plan no later than 3/30/17 documenting coordination with local TDSHS/SAS HIV Early Intervention funded programs if such programs are currently funded in the Houston EMA.
Staff Requirements:	Must meet all applicable State licensing requirements and Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2018 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup**		Date: **04/25/17**
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

SUBSTANCE ABUSE SERVICES

Substance abuse services, also referred to as *outpatient alcohol or drug abuse treatment*, provides counseling and/or other treatment modalities to persons living with HIV (PLWH) who have a substance abuse concern in an outpatient setting and in accordance with state licensing guidelines. This includes services for alcohol abuse and/or abuse of legal or illegal drugs.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 24% of participants indicated a need for *substance abuse services* in the past 12 months. 22% reported the service was easy to access, and 2% reported difficulty. 8% stated they did not know the service was available. When analyzed by type of substance concern, 24% of participants cited alcohol, 56% cited drugs, and 26% cited both.

(**Table 1**) When barriers to *substance abuse services* were reported, the most common barrier types were education and awareness (lack of knowledge about location), eligibility (ineligibly), and health-insurance related (being uninsured).

GRAPH 1-Substance Abuse Services, 2016

Legend:
- 24%-Alcohol abuse
- 50%-Drug abuse
- 26%-*Both*

Did not know about service	8%
Did not need service	68%
Needed the service, easy to access	22%
Needed the service, difficult to access	2%

TABLE 1-Top 3 Reported Barrier Types for Substance Abuse Services, 2016		
	No.	%
1. Education and Awareness (EA)	1	33%
2. Eligibility (EL)	1	33%
3. Health Insurance Coverage (I)	1	33%
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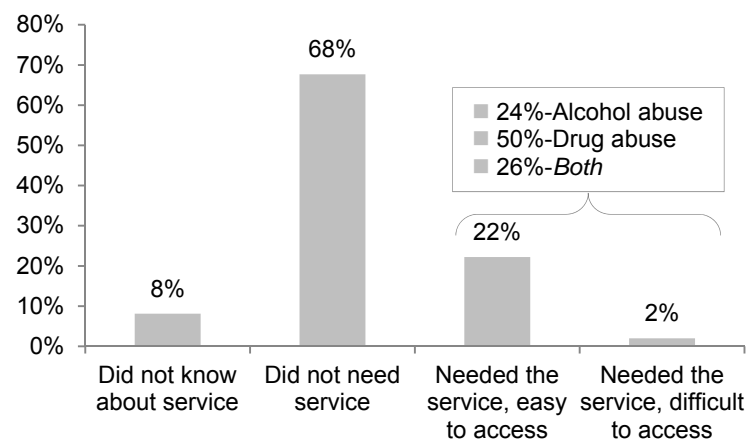
(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *substance abuse services,* this analysis shows the following:

- More females than males found the service accessible.
- More white PLWH found the service accessible than other race/ethnicities.
- More PLWHA age 50+ found the service accessible than other age groups.
- In addition, more recently released, unstably housed, and MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Substance Abuse Services, by Demographic Categories, 2016									
	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	8%	8%	2%	10%	11%	0%	30%	9%	4%
Did not need service	69%	64%	73%	65%	70%	60%	48%	68%	70%
Needed, easy to access	21%	26%	24%	23%	17%	40%	17%	22%	24%
Needed, difficult to access	2%	2%	1%	2%	2%	0%	4%	2%	1%

TABLE 3-Substance Abuse Services, by Selected Special Populations, 2016						
Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	14%	9%	50%	8%	9%	18%
Did not need service	61%	68%	50%	42%	88%	50%
Needed, easy to access	23%	21%	0%	39%	3%	32%
Needed, difficult to access	2%	2%	0%	11%	0%	0%

[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

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FY 2015 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Substance Abuse Treatment

HIV Performance Measures	FY 2015	FY 2016	Change
A minimum of 70% of clients will utilize Parts A/B/C/D primary medical care after accessing Part A-funded substance abuse treatment services*	7 (43.8%)	12 (50.0%)	**6.2%**
55% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	8 (57.1%)	11 (57.9%)	**0.8%**
Change in the rate of program completion over time	See data below		

*Overall, the number of clients who received primary care in FY 2016 was 20 (83.3%), with 12 receiving the services through Ryan White and 8 receiving the services through other insurance such as Medicare.

Number of clients completing substance abuse treatment program from March 2015 to February 2016: **19**

Number of clients engaged in substance abuse treatment program from March 2015 to February 2016: **24**

Number of clients completing substance abuse treatment from March 2015 to February 2016 who entered treatment in FY 2014: **3**

Number of clients who received treatment in FY 2014 who are still in treatment from March 2015 to February 2016: **0**

HIV and Specific Populations

HIV and Drug and Alcohol Users
(Last updated 4/29/2016; last reviewed
4/29/2016)

Key Points

- Drug and alcohol use can increase the risk of getting or transmitting HIV infection. People using drugs or alcohol may have sex without a condom or share needles when injecting drugs. In the United States, HIV is spread mainly by having unprotected sex or sharing needles (or other drug injection equipment) with someone who is infected with HIV.
- Drug and alcohol use can harm the health of a person with HIV. Specifically, drug and alcohol use can weaken the immune system and damage the liver.
- If a person with HIV is using drugs or alcohol, it can be hard to focus on taking HIV medicines every day. Skipping HIV medicines allows HIV to multiply and damage the immune system.
- Taking HIV medicines and recreational drugs such as marijuana, cocaine, or heroin together can be dangerous. Certain HIV medicines can increase the concentration of some drugs to dangerous levels in the body.

What is the connection between HIV and drug and alcohol use?

Drug and alcohol use is related to HIV in the following ways:

- Use of alcohol and recreational drugs such as marijuana (weed, pot), cocaine, or heroin can increase the risk of getting or transmitting HIV infection.
- Drug and alcohol use can harm the health of a person with HIV. Specifically, drug and alcohol use can weaken the immune system and damage the liver.

How does drug and alcohol use increase the risk of HIV infection?

Drugs and alcohol affect the brain, making it hard to think clearly. People using drugs or alcohol may make poor decisions and take risks.

Some risky behaviors can increase the risk of getting or transmitting HIV. For example, a person using drugs or alcohol may have sex without a condom or share needles when injecting drugs.

In the United States, HIV is spread mainly by having unprotected sex or sharing drug injection equipment with someone who is infected with HIV. (Unprotected sex is sex without using a condom.)

How can drug and alcohol use affect a person with HIV?

Drug and alcohol use can harm the health of a person with HIV in several ways.

Drugs and alcohol can weaken the immune system.
HIV damages the immune system, and further damage from drugs or alcohol can make it easier for HIV infection to advance to AIDS.

Drugs and alcohol can damage the liver and cause liver disease.
One of the main functions of the liver is to remove harmful substances (toxins) from the blood. Toxins are produced when the liver breaks down the chemicals we put in our body, including recreational drugs or alcohol.

Drug and alcohol use can damage the liver, making it work harder to remove toxins from the body. The buildup of toxins can weaken the body and lead to liver disease.

Some recreational drugs can interact with HIV medicines.
Taking HIV medicines and recreational drugs together can be dangerous. Certain HIV medicines can block the breakdown of some recreational drugs. In these cases, the recreational drug can increase to a dangerous level in the body.

Drug and alcohol use can make medication adherence harder.
Medication adherence means sticking firmly to an HIV regimen—taking HIV medicines every day and exactly as prescribed. If a person is using drugs or alcohol, it can be hard to focus and stick to an HIV regimen. Skipping HIV medicines allows HIV to multiply and damage the immune system.

If you do use drugs or drink alcohol, take the following steps to protect your health.

If you use drugs or alcohol:

- Don't have sex if you're high.
- If you do have sex, use a condom the right way every time. Read this fact sheet from the Centers for Disease Control and Prevention (CDC) on how to use condoms correctly.

If you drink alcohol:

- Drink in moderation. Moderate drinking is up to 1 drink per day for women and up to 2 drinks per day for men. One drink is a bottle of beer, a glass of wine, or a shot of liquor.
- Visit Rethinking Drinking, a website from the National Institute on Alcohol Abuse and

Alcoholism (NIAAA). This website can help you evaluate your drinking habits and consider how alcohol may be affecting your health.

If you inject drugs:

- Use only sterile needles and drug preparation equipment ("works").
- Never share needles and works.
- Visit CDC's webpage on HIV prevention for more information on how injection drug users can reduce the risk of getting or transmitting HIV.

Learn more about HIV and drug and alcohol use. This fact sheet is based on information from the following sources:

From CDC

- HIV and Injection Drug Use in the United States
- HIV and Substance Use in the United States
- HIV Basics: Prevention

From the Department of Veterans Affairs

- Drugs, Alcohol, and HIV

From the National Institute on Drug Abuse (NIDA)

- How Does Drug Abuse Affect the HIV Epidemic?

Smoking more harmful than HIV for people taking effective treatment, US study suggests

Keith Alcorn
Published: 08 November 2016

Smoking has the potential to shorten the life of a person taking HIV treatment by an average of six years, and is far more harmful to the life expectancy of people living with HIV than well-managed HIV infection itself, a US study reports this month in the *Journal of Infectious Diseases*.

The study found that stopping smoking improved life expectancy, with the greatest gain in life expectancy seen when smoking was stopped by the age of 40.

Dr Rochelle Walensky of the Massachusetts General Hospital Division of Infectious Diseases, senior author of the study, said, "It is time to recognise that smoking is now the primary killer of people with HIV who are receiving treatment."

Smoking reduces life expectancy through cardiovascular disease (stroke and heart attack), cancers and chronic obstructive pulmonary disease (emphysema). In the United States general population the prevalence of smoking has declined from 42% in 1965 to 17% in 2014, but a 2015 study estimated that 40% of people living with HIV in the United States still smoke.

To investigate the impact of smoking on life expectancy among people living with HIV and on treatment in the United States, researchers at Massachusetts General Hospital developed a model of the impact of smoking and smoking cessation in this population.

The study used data from the North American AIDS Cohort Collaboration (NA-ACCORD) to create a model of the population living with HIV in the United States and receiving care. The researchers then modelled the impact of persistent smoking, stopping smoking or never smoking on the life expectancy of people living with HIV, assuming that everyone started treatment with a highly effective antiretroviral regimen on entry to care at the age of 40. The age of 40 was chosen because NACCORD found that the median age at entry to HIV care in its participating cohorts was 43 years.

The model assumed that people would enter care with a mean CD4 cell count of 360 cells/mm^3 and then compared the effect of entering care at the age of 40 or at 50, so as to model the interaction between later HIV infection and smoking.

Estimates of the impact of smoking on life expectancy were derived from US general population mortality figures, and also assumed that the risk of death would begin to diminish for those who gave up smoking depending on the age at which they stopped. So, for people who gave up at the age of 35, the risk of death had fallen to the same level as the risk of death for those who never smoked by the age of 40, but for those who didn't give up until the age of 55, the risk of death remained 70% higher than for never-smokers. This adjustment reflects the accumulated damage caused by smoking.

The study also adjusted for sex – the risk of death was persistently lower for women who smoked, at all ages – and for higher mortality in HIV exposure categories other than men who have sex with men.

The model produced from these inputs showed that male smokers who entered care at the age of 40, and who kept smoking, had an estimated life expectancy of 65.2 years. Former smokers who quit at the age of 40 would live to the age of 70.9 years and those who never smoked to the age of 71.9 years. Women who entered care at the age of 40, and who kept smoking had an estimated life expectancy of 69.9 years. Women who had stopped smoking would live to 72.7 years and those who never smoked would live to 74.4 years.

This compares with the World Health Organization's estimate of an overall life expectancy for the general population in the United States of 79.3 years (76.9 for men and 81.6 for women). Life expectancy is two to three years higher in Western Europe, Japan and Australasia.

The model finds that the loss of life expectancy due to smoking for people living with HIV is probably greater than the loss of life expectancy due to HIV infection. Indeed, one study in the United Kingdom has found that people with HIV who have a good response to treatment may have life expectancy that matches the general population.

The model found that stopping smoking at 40 resulted in a gain in life expectancy of 5.7 years for men and 4.6 years for women.

Entering care at 50 years – indicating later infection with HIV – was associated with longer life expectancy among smokers but also a less pronounced difference in life expectancy between smokers and former smokers. Male smokers who entered HIV care could expect to live to 69.9 years, those who quit to 73.4 years and those who never smoked to 76.5 years. Women who continued to smoke after entering care at the age of 50 could expect to live to 72.4 years, those who quit to 75.7 years and those who never smoked to 78.8 years.

The study also found that stopping smoking at the age of 40 was associated with greater gains in life expectancy for both men and women than starting antiretroviral treatment at a CD4 count above 500 compared to late initiation.

Based on previous cohort studies, the researchers estimated that 40% of people living with HIV in the United States are current smokers and 20% ex-smokers. They calculated that if 10 to 25% of current smokers with HIV aged 30-64 were to stop smoking, between 106,000 and 265,000 extra years of life would be gained.

The study authors point out that a much lower proportion of people living with HIV quit smoking compared to the rest of the population, and that "smoking cessation should be a major priority in HIV carer programs."

An accompanying editorial commentary by Keri Althoff of Bloomberg School of Public Health, Johns Hopkins University, Baltimore, discusses some of the challenges of improving smoking cessation rates in HIV care, and potential solutions.

A combination of pharmacological treatment and counselling to assess readiness to quit has proved successful, but cessation rates are still "disheartening", she writes. Integrating smoking cessation into a co-morbidities prevention package of care requires a degree of sensitivity: patients may be overwhelmed by interventions to address mental health issues, weight and smoking on entry to care, and interventions need to be carefully staged.

Retention in care could be adversely affected if patients face too many demands at once. "Implementing the intervention among patients who have achieved stability during ART may be preferable, as patients will have demonstrated success with an intervention and may be more ready to tackle another health issue," she suggests.

Recording of tobacco use in the electronic medical record should ideally prompt automatic linkage to local resources for smoking cessation outside the HIV clinic, reducing barriers to accessing these services.

References

Reddy KP et al. *Impact of cigarette smoking and smoking cessation on life expectancy among people with HIV: A US-based modelling study.* J Infect Dis, advance online publication, 3 November 2016.

Althoff KN. *The shifting paradigm of care for adults living with HIV: smoking cessation for longer life.* J Infect Dis, advance online publication, 3 November 2016.