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Houston EMA/HSDA Ryan White Part A 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 <i>Financial Eligibility for Houston EMA/HSDA Services</i> .
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

	<p>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.</p>
<p>Staff Requirements:</p>	<p>Must meet all applicable State licensing requirements and Houston EMA/HSDA Part A/B Standards of Care.</p>
<p>Special Requirements: RWGA Only</p>	<p>Not Applicable.</p>

FY 2020 RWPC “How to Best Meet the Need” Decision Process

Step in Process: Council		Date: 06/13/19
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Steering Committee		Date: 06/06/19
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Quality Improvement Committee		Date: 05/14/19
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: HTBMN Workgroup #2		Date: 04/23/19
Recommendations:	Financial Eligibility: 300%	
1.		
2.		
3.		

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FY 2017 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

Highlights from FY 2017 Performance Measures

Measures in this report are based on the 2017 Houston Ryan White Quality Management Plan, Appendix B. HIV Performance Measures.

Substance Abuse Treatment

- During FY 2017, 12 (46%) clients utilized primary medical care after accessing Part A substance abuse treatment services.
- Among clients with viral load tests, 67% were virally suppressed during this time period.

HCPH is the local public health agency for the Harris County, Texas jurisdiction. It provides a wide variety of public health activities and services aimed at improving the health and well-being of the Harris County community.

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Ryan White Part A
HIV Performance Measures
FY 2017 Report

Substance Abuse Treatment
All Providers

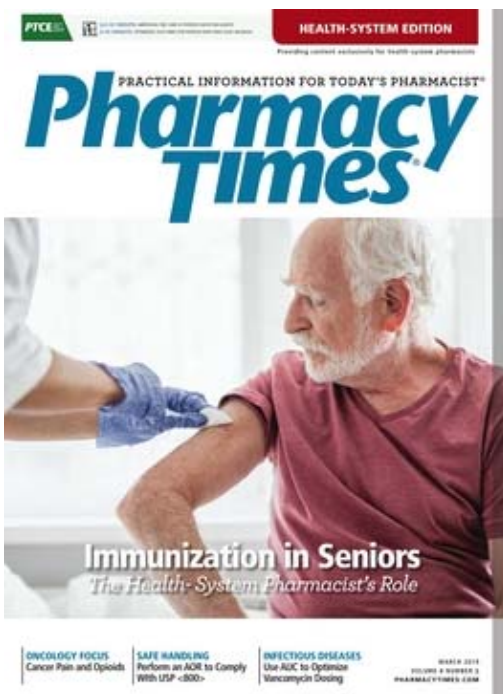
HIV Performance Measures	FY 2016	FY 2017	Change
A minimum of 70% of clients will utilize Parts A/B/C/D primary medical care after accessing Part A-funded substance abuse treatment services*	18 (62.1%)	12 (46.2%)	-15.9%
55% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	17 (73.9%)	14 (66.7%)	-7.2%
Change in the rate of program completion over time	See data below		

***Overall, the number of clients who received primary care in FY 2017 was 15 (62.5%), with 12 receiving the services through Ryan White and 3 receiving the services through other insurance such as Medicare.**

Number of clients completing substance abuse treatment program during FY 2017 (March 2017 to February 2018): **16**

Number of clients engaged in substance abuse treatment program during FY 2017: **24**

Number of clients completing substance abuse treatment during FY 2017 who entered treatment in FY 2016: **4**



Study: Rate of Opioid-Related Deaths Increasing in Patients With HIV

MARCH 15, 2019

Concomitant HIV infection and opioid use is common throughout the United States.¹⁻⁴ Patients with HIV are more likely to have chronic pain, be prescribed opioid therapy, and receive higher doses of opioids.¹ While not every patient who is prescribed opioids becomes addicted, these characteristics increase the likelihood of opioid use disorder (OUD) and the potential for opioid-related death among this patient population.

OUD has a negative impact on HIV care, adherence and outcomes, and is cited as a potential risk for increased transmission.² It also appears that OUD may be a notable risk factor for mortality in HIV patients.

A study presented at the 2019 Conference on Retroviruses and Opportunistic Infections (CROI) revealed data that, while the overall number of deaths in patients with HIV in the United States is declining, the number of number of opioid overdose deaths in HIV patients is on the rise.³ Using data from the National HIV Surveillance System, the retrospective study showed a 12.7% decline [1630.6 vs. 1,868.8 per 100,000] in overall deaths in HIV patients from 2011 to 2015. In that same period, the amount of opioid-related deaths in patients with HIV rose by 47% [33.1 vs. 23.2 per 100,000].

The highest rate of deaths occurred in injection drug users [137.4/100,000], Caucasians [49.1/100,000], patients aged 50-59 years [41.9/100,000] and women [35.2/100,000]. However, the increase of opioid deaths was consistent across all ages, genders, ethnicities, and transmission categories. Several

demographics saw increases in opioid-related deaths in excess of 50%. These include injectable drug users (80%), heterosexual transmission (74%), and African Americans (74%). Though patients in the fifth decade had the highest consistent overall rates of opioid deaths, the sharpest increases in mortality were seen in patients over the age of 60 years (202%), those 20-29 years (113%), and those 40-49 years (51%).

The West US Census region was the only geographic location in the US where an increase in opioid-related deaths was not seen (2% decline). In contrast, large increases were seen in the South (65%), the Northeast (59%), the Midwest (32%). The authors concluded that prevention efforts could specifically focus or target those groups with the highest overall rates or greatest increases in opioid-related deaths.

While this study suggests where prevention efforts can be focused, by whom prevention should be provided remains unclear. It is not uncommon for HIV patients to be prescribed opioids by the same clinician treating their HIV.^{2,4-5} Several recent studies have highlighted the integration of HIV and OUD care.^{2,4-5} While integration does increase antiviral receipt and patient satisfaction, it has not yet shown to improve HIV outcomes.⁵ Furthermore, the recommended and necessary vigilance for opioid prescribing may not always occur in this setting.

In a study published in *AIDS and Behavior*, HIV physicians acknowledged feeling undertrained in chronic pain management and opioid prescribing.² They also expressed hesitation for creating situations that might hamper the provider-patient relationship essential to optimal HIV-related outcomes or introducing the stress that opioid deprescribing could cause the patient. Subsequently, the task of monitoring patients on opioids often falls to other health care providers. Still, the recognition and treatment of OUD is vital for any patient population; HIV patients in particular may experience benefits beyond sobriety.

The treatment of OUD has been shown to reduce HIV transmission, increase antiviral adherence, improve viral suppression, and decrease mortality.⁶ One meta-analysis revealed that providing medications for OUD reduced HIV transmissions by 54%.⁶

Selecting an agent can be cumbersome. Of the available options, buprenorphine appears to be the best suited for HIV patients in terms of minimal pertinent drug-interactions and easier administration burden. In addition to traditional oral routes, it come as a monthly injection or 6-month implant which can be administered in the clinic.⁶ Methadone metabolism is highly dependent on cytochrome P450 (CYP) enzymes which are known to be induced by several antivirals. Subsequently, HIV patients may require higher methadone doses for effective treatment.⁶ Logistic and dosing barriers can be proactively addressed if appropriately identified. Inclusion of and input from a pharmacist could positively affect these treatment decisions.

The opioid epidemic has raged in almost every demographic and segment of society in the US. This new data indicating that opioid overdoses in HIV patients are threatening to circumvent the enormous strides in HIV treatment and mortality over several decades must be addressed.

Identification and treatment of HIV patients with OUD can help mitigate the rising mortality rates while subsequently improving overall HIV care and outcomes. However, successful treatment for many HIV patients will require a collaborative, interprofessional approach.

References

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CATIE News

Overdoses and smoking are taking the lives of people with HIV who have been cured of hepatitis C

- Researchers studied survival of Canadians co-infected with HIV and hepatitis C
- Cirrhosis-related deaths began to decline in 2013 with new hepatitis C treatments
- Overdose has now overtaken cirrhosis as the leading cause of death for this group

Hepatitis C virus (HCV) infects the liver and can cause chronic infection and inflammation in this vital organ. Over time, this inflammation causes the liver to replace healthy cells with useless scar tissue in a process called fibrosis. If chronic HCV infection is left untreated, scarring gradually spreads across the liver until most or all of this organ is scarred—a condition called cirrhosis. People with cirrhosis are at heightened risk for a range of complications, including severe fatigue, internal bleeding, recurring and serious abdominal infections and problems thinking clearly, as well as liver failure, liver cancer and death.

Over the past five years, highly potent and well-tolerated oral HCV treatments have become available in Canada and other high-income countries. In clinical trials, these drugs—called direct-acting antivirals (DAAs)—have resulted in cure rates of 95% and higher.

Researchers across Canada have been collaborating in a prospective observational study called the Canadian Co-Infection Cohort (code named CTN222). In this study, researchers have been monitoring the health of people co-infected with HIV and HCV.

In the latest analysis from this study, researchers examined trends in health and survival between two periods: 2003 to 2012 and 2013 to 2017. The study reported results from 1,634 people.

The researchers found that in the earlier period of the study, death from cirrhosis-related complications was common. However, in the latter part of the study, when DAAs became available, death from cirrhosis-related complications had declined. From 2013 to 2017, drug overdose was the leading cause of death in people aged 20 to 49. Among people aged 50 to 80, death from complications due to smoking was predominant.

The researchers outlined ways to improve the survival of people who have HCV or who have been cured of HCV.

Study details

Researchers analysed data from 1,634 co-infected people. As people who entered the study in the second period (2013 to 2017) are more reflective of co-infected people today, the average profile of these people upon entering the study was as follows:

- 72% men, 28% women
- Indigenous people – 24% (details on the ethno-racial composition of the rest of participants was not released in this report, but it is likely that a majority would be white)
- 80% had a history of injecting street drugs and about one-third currently injected street drugs
- 90% of participants had a history of smoking and 72% were current smokers
- CD4+ count – 450 cells/mm³
- HIV viral load – 90% had a viral load less than 50 copies/mL
- length of time infected with HCV – 20 years

Results

Over both periods studied (2003 to 2017), 273 people died (17%). Prior to their deaths, about 20% of people who died had disengaged from medical care.

People who died generally had the following factors in common vs. people who survived:

- were between the ages of 43 to 53 years
- had HCV infection for longer
- had a significant degree of fibrosis and/or a history of symptoms of cirrhosis
- had lower CD4+ cell counts (around 330 cells/mm³)
- were not likely to have a suppressed HIV viral load
- were engaged in injecting street drugs
- were smokers

Causes of death

Common causes of death in decreasing order were as follows:

- drug overdose
- complications arising from cirrhosis (also called end-stage liver disease, ESLD)
- smoking-related complications such as heart attack/stroke, pneumonia, cancers of the lungs and throat

- serious infections
- suicide/trauma/accidents

Deaths from AIDS-related complications were rare; only about 2% of such deaths occurred.

Note that despite a thorough review of records, researchers were unable to determine the cause of death in 20% of participants.

Trends

Upon comparing the two study periods—2003 to 2012 and 2013 to 2017—researchers found the following trends:

- Death rates remained stable among people aged 20 to 49 but decreased among people aged 50 to 80.
- Overall, death due to complications of cirrhosis decreased, particularly in people aged 50 to 80 years, and was no longer the leading cause of death.
- Although death from smoking-related complications generally decreased, smoking-related causes accounted for the most deaths in people aged 50 to 80.
- Among people aged 20 to 49, death due to overdose decreased somewhat. However, it still remained the leading cause of death in this age group.

Focus on cirrhosis

The researchers stated that the decrease in deaths from complications arising from cirrhosis is probably due to the following factors:

- the expansion of HCV treatment after 2013 (when DAAs started to become available)
- the more recent availability of highly potent DAAs
- the prioritization by doctors and nurses of treatment for people with a significant degree of liver fibrosis

The researchers stated that people with cirrhosis who have been cured of HCV will need continued monitoring, as their risk for liver cancer remains elevated.

In the study, nearly all deaths related to complications of cirrhosis occurred in people who were unable to be cured by DAAs.

Reducing death from overdose

Although an epidemic of deaths from opioids has been underway in North America, death from drug overdose among people aged 20 to 49 in the study decreased. According to the researchers, this decrease suggests “that improved linkage and access to harm reduction services may be occurring concurrently with HIV and HCV treatment.”

In another study, the same researchers found that once people are cured of HCV, about 10% of them who were previously injecting street drugs seem to stop injecting. The researchers stated that this reduction implies that “there may be indirect benefits associated with treatment centred around accessing harm reduction programs. However, such programs must be sustained after treatment to reduce re-infection and the harms of injecting street drugs.”

Smoking

The proportion of people in the present study who smoked was extremely high. The researchers found an overall reduction in smoking-related deaths during the course of the study. They propose that a partial explanation for this is the “prolonged engagement in care, with associated health promotion and availability of smoking cessation services.”

Larger issues

The researchers stated that in addition to the need for “universal access to HCV treatment,” there are additional issues that funders need to address, including the following:

- access to harm reduction services
- regulated opioid distribution programs
- drug treatment centres
- easy access to naloxone
- supportive housing programs

The researchers also stated that “providing HCV treatment alone while neglecting to concurrently address the social determinants of health will do little to improve the health outcomes of the majority of individuals with chronic HCV as [a previous study by the same team] has shown.”

—Sean R. Hosein

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https://www.ajmc.com/newsroom/lung-disease-from-smoking-marijuana-more-likely-in-men-with-hiv

Lung Disease From Smoking Marijuana More Likely in Men With HIV

Jaime Rosenberg

While combination antiretroviral therapy has significantly decreased the likelihood of lung disease morbidity and mortality among people living with HIV, it remains a common comorbidity in the patient population, which has higher rates of incidence than uninfected individuals. Higher prevalence of tobacco smoking has previously been indicated as a likely cause behind the increased risk, and now new research is suggesting that marijuana also plays a role.

According to the study, men living with HIV are more likely to develop lung disease from long-term marijuana smoking compared with men without infection, which suggests that healthcare providers [can have a critical role](#) in reducing the risk of certain lung diseases in the patient population by educating them on the risks of marijuana smoking.

“Smoked cannabis is a potential risk factor for lung disease, as it contains many of the same toxic constituents present in tobacco smoke,” explained the researchers. “In the US, the proportion of HIV+ individuals who frequently smoke marijuana is higher than in the general population and has increased in recent years.”

Drawing on data from the Multicenter AIDS Cohort Study, the researchers identified 1352 men living with HIV and 1352 HIV-negative men from biannual study visits between 1996 and 2014. Approximately one-fourth (27%) of men with HIV and 18% of uninfected men reported daily or weekly smoking for at least a year, with a median of 4 years.

The researchers observed that among the men living with HIV, those who reported smoking were more likely to report one or more infectious or noninfectious pulmonary diagnosis compared with nonsmokers (41% vs 30% and 24.8% vs 19%, respectively). The increased risk remained independently of tobacco smoking or other risk factors, and the risk increased even further if they smoked both marijuana and tobacco.

Meanwhile, there was no link between marijuana smoking and infectious or noninfectious pulmonary diagnosis among the uninfected men (24.2% and 20.9% and 14.8% vs 17.7%, respectively).

There are several potential reasons behind this increased risk, the researchers explained, including lung immune cell depletion and dysfunction, persistent immune cell activation, systemic inflammation, respiratory microbiome alterations, and oxidative stress associated with HIV, or a combination of these effects with modifiable risk factors like marijuana.

“Previous studies linked marijuana smoke with alveolar macrophage dysfunction in both humans and mouse models, and a potential additive risk of marijuana smoking and HIV disease may explain the increased prevalence of infectious pulmonary diagnoses in our adjusted analyses,” they added.

Reference

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