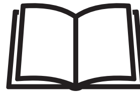
SSC | Strengthening Systems of Care for People with HIV & Opioid Use Disorder

RYAN WHITE HIV/AIDS PROGRAM
SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

JSI NASTAD



STATE STRATEGIES IN ACTION:

USING DATA PARTNERSHIPS TO INTEGRATE HIV AND OPIOID USE DISORDER SERVICES

The Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program Special Projects of National Significance initiative Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) provides coordinated technical assistance across HIV and behavioral health/substance use service providers. The project aims to enhance system-level coordination and networks of care among Ryan White HIV/AIDS Program recipients and other federal, state, and local entities. The purpose of this initiative is to ensure that people with HIV and opioid use disorder (OUD) have access to care, treatment, and recovery services that are client-centered and culturally responsive.

SSC developed this resource in response to the needs of the nine state project partners. For more information and additional resources, visit
https://targethiv.org/spns-ssc

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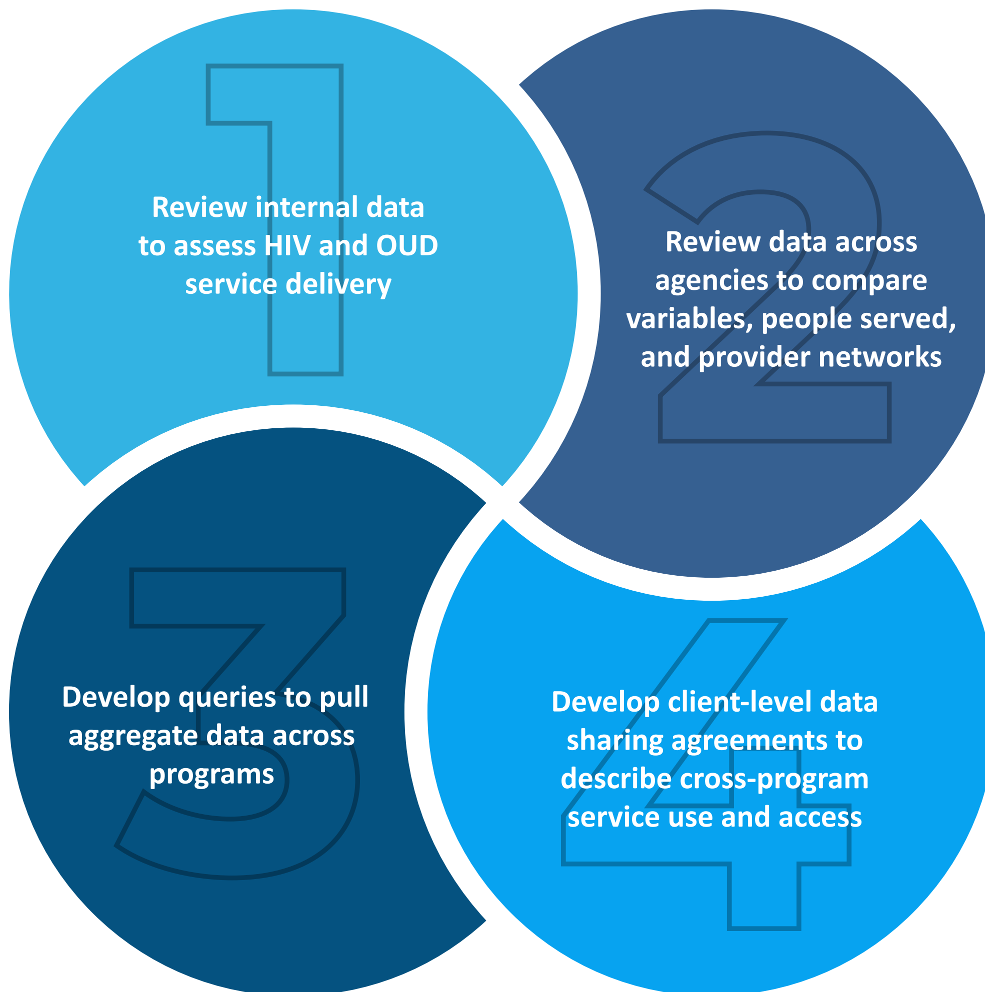
This resource is part of the State Strategies into Action series; a compilation of strategies and lessons about a variety of topics related to strengthening systems of care for people with HIV and opioid use disorder (OUD). Each resource responds to common technical assistance (TA) needs identified across states partnering with JSI Research & Training Institute, Inc. as part of the Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) project.

DEFINING DATA PARTNERSHIPS

Data partnerships help coordinate HIV and opioid use disorder (OUD) services across state programs. For example, reviewing and comparing data on incidence, prevalence, and service availability helps state agencies identify service overlap and gaps. Programs that start by reviewing their own data and that of partner agencies can understand how different programs report HIV and OUD service delivery. Programs can then identify common goals and start to collaborate more. Data partnerships do not have to have formal data sharing agreements or share client-level data. They can vary according to the structure and capacity of the state agencies involved (Figure 1).

Figure 1. HIV, Behavioral Health, and Medicaid Data Partnership Continuum



This document presents ways that state HIV and behavioral health programs can build data partnerships. The examples below are a starting point for more formal and complex data partnerships.

BUILDING PARTNERSHIPS

A successful data partnership starts with meaningful and sustained relationships. New Jersey and Virginia built such partnerships by reviewing client and provider data sources within each system, and meeting regularly to share information about their Ryan White HIV/AIDS Program (RWHAP) and behavioral health programs.

- **Sharing data dictionaries:** In New Jersey, program staff from RWHAP and the Division of Mental Health and Substance Use started with a simple but helpful exercise. They compared the data dictionaries each program used to collect program and client information. A data dictionary has information about each variable in a data set or database. It often defines acceptable values for each data element. The two programs focused on:
    - Client demographics (race, age, ethnicity).
    - Location (ZIP code).
    - Mode of HIV transmission.
    - Insurance status.

  Program staff identified which data elements they were using, if and how HIV and OUD data were collected, and opportunities to match data or conduct data queries within each data set. They also shared reports to understand each other's program and population.

- **Comparing RWHAP and behavioral health provider network data:** Program staff compared data to identify overlap between RWHAP and behavioral health providers in New Jersey. They matched the two data sets but were challenged because data on RWHAP and behavioral health providers are collected in different ways. For example, RWHAP provider data do not include a National Provider Identifier (NPI), a unique 10-digit identifier that the Centers for Medicare and Medicaid Services assigns. However, behavioral health providers in New Jersey are required to report their NPI. The New Jersey RWHAP team added NPIs to their RWHAP provider data set so they would have a common variable to compare to the behavioral health data set. In doing so, they found 12 providers who were listed in both the RWHAP and behavioral health data sets. Program staff conducted focus groups with these providers to learn about HIV and OUD integration, funding barriers and facilitators, and ways to bring people with HIV and OUD to care.

- **Building on historic partnerships:** The New Jersey Division of Mental Health and Substance Use got Substance Abuse and Mental Health Services Administration/Minority AIDS Initiative funds to increase HIV testing and prevention services among behavioral health providers. When the funding ended, data sharing across the HIV surveillance and behavioral health programs continued. This allowed the state to identify providers serving areas with the greatest need and give them HIV testing resources. Though data sharing has continued, a formal agreement is not in place, so RWHAP and behavioral health program staff are working to use past experience as a basis for a new, formal data sharing relationship. The goals of the new arrangement are to: 1) understand people with HIV and OUD, including demographics and location; and 2) track people with OUD's HIV treatment adherence.

- **Assessing RWHAP services report data:** In Virginia, RWHAP staff and the SSC technical assistance team reviewed data collected through the RWHAP Services Report (RSR). The goal was to learn about RWHAP clients' access to and use of OUD services. The RSR is a yearly requirement for the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB). It collects data on RWHAP recipients, providers, and clients.

Figure 2. RSR Data Questions on OUD

1. Within your organization/agency, identify the number of physicians, nurse practitioners, or physician assistants who obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat OUD with medications.
2. How many of the above physicians, nurse practitioners, or physician assistants prescribed MAT (e.g., buprenorphine, vivitrol) for OUD in the reporting period?
3. How many RWHAP clients were treated with MAT during the reporting period?

See RSR Instruction Manual for more information about these questions.

In 2019, HRSA HAB added three questions to the RSR about medication-assisted therapy (MAT) for OUD (Figure 2).

RWHAP staff in Virginia reviewed the most recent RSR data to see how many providers were prescribing MAT. However, they found that there may be gaps in the data: RWHAP providers may only report on clients who are treated with MAT by the RWHAP-funded department or unit within the organization. Clients who get services that are not paid for by RWHAP may not be included in the data, either. Staff thought about asking providers for this information. RWHAP staff also discussed other data sources that may identify MAT service provision and use among RWHAP clients, such as through Medicaid and the behavioral health program. These data inquiries could provide a more complete picture of the OUD services that RWHAP clients use that are not paid for with RWHAP funds.

CONSIDERATIONS FOR STATE ACTION

States can consider the actions below as they build data partnerships across programs:

1. **Internally analyze existing data sets**
Data partnerships across state agencies can start with small steps to see what information data sets provide about HIV and OUD services. States should review data across RWHAP and behavioral health (including provider network data) to document matching variables related to HIV and OUD. This internal analysis will also help to identify gaps in data collected. Two queries that states can consider are shown in Table 1 below.

Table 1. HIV and OUD Data Sources, Variables, and Outcomes

<table>
<tr><th>Source</th><th>Variables</th><th>Matching outcome</th></tr>
<tr><td>Substance Use (SU)/Behavioral Health (BH) Program</td><td>SU/BH program served clients (personally identifiable data set with matching indicators to HIV surveillance)</td><td rowspan="2">How many SU/BH program-served clients live with HIV, what was their mode of HIV transmission, what are their demographics, where do they live, and what is their insurance status?</td></tr>
<tr><td>HIV surveillance data</td><td>Individuals with diagnosed HIV, including demographics and zip code, mode of transmission, and insurance status</td></tr>
<tr><td>SU/BH Program</td><td>SU/BH program-funded providers</td><td rowspan="2">How many SU/BH program-funded providers are also RWHAP-funded providers?</td></tr>
<tr><td>RWHAP Part B</td><td>RWHAP Part B-funded providers</td></tr>
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2. **Compare cross-program provider network data**
Provider network data sets usually describe agency information, including name, location, and services. Yet they are often overlooked as a source of information about HIV and OUD service availability in a state. Provider information is collected across RWHAP, behavioral health, and Medicaid and often stored in provider network lists or directories. While the specific data may vary by program, variables that can be compared across data sets can indicate service overlap across programs.

3. **Identify and build on existing relationships**
There may be HIV and behavioral health program data partnerships related to former grants and initiatives. These past data sharing agreements, even if no longer in effect, are an important starting point for new data sharing relationships to support HIV and OUD coordination. Similarly, there may be ongoing data sharing activities in a state. Several states are assessing data sharing relationships across HIV surveillance and Medicaid programs. There may be opportunities to build HIV and OUD into those efforts.

4. **Use data to make decisions**
The goal of any data partnership across HIV, behavioral health, and/or Medicaid programs should be to guide program decisions and improve service delivery. States can encourage programs to use data through accessible and timely reports or dashboards. Advisory committees and other cross-agency bodies should use these reports and dashboards to inform policy and programmatic decisions.