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Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Clinical Case Management** (Last Review/Approval Date: November 2021)	
HRSA Service Category Title: **RWGA Only**	**Medical Case Management**
Local Service Category Title:	**Clinical Case Management (CCM)**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not applicable.
HRSA Service Category Definition: **RWGA Only**	*Medical Case Management services (including treatment adherence)* are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
Local Service Category Definition:	**Clinical Case Management**: Identifying and screening clients who are accessing HIV-related services from a clinical delivery system that provides Mental Health treatment/counseling and/or Substance Abuse treatment services; assessing each client's medical and psychosocial history and current service needs; developing and regularly updating a clinical service plan based upon the client's needs and choices; implementing the plan in a timely manner; providing information, referrals and assistance with linkage to medical and psychosocial services as needed; monitoring the efficacy and quality of services through periodic reevaluation; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies.

Target Population (age, gender, geographic, race, ethnicity, etc.):	Services will be available to eligible clients with HIV residing in the Houston EMA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling (i.e. professional counseling), substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. *Clinical Case Management* is intended to serve eligible clients, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.
Services to be Provided:	Provision of Clinical Case Management activities performed by the Clinical Case Manager. *Clinical Case Management* is a working agreement between a client and a Clinical Case Manager for a defined period of time based on the client's assessed needs. *Clinical Case Management* services include performing a comprehensive assessment and developing a clinical service plan for each client; monitoring plan to ensure its implementation; and educating client regarding wellness, medication and health care compliance in order to maximize benefit of mental health and/or substance abuse treatment services. The *Clinical Case Manager* serves as an advocate for the client and as a liaison with mental health, substance abuse and medical treatment providers on behalf of the client. The Clinical Case Manager ensures linkage to mental health, substance abuse, primary medical care and other client services as indicated by the clinical service plan. The Clinical Case Manager will perform *Mental Health* and *Substance Abuse/Use Assessments* in accordance with RWGA Quality Management guidelines. Service plan must reflect an ongoing discussion of mental health treatment and/or substance abuse treatment, primary medical care and medication adherence, per

	client need. *Clinical Case Management is* both office and community-based. Clinical Case Managers will interface with the primary medical care delivery system as necessary to ensure services are integrated with, and complimentary to, a client's medical treatment plan.
Service Unit Definition(s): **RWGA Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services.*
Client Eligibility:	Individuals with HIV residing in the Houston EMA.
Agency Requirements:	*Clinical Case Management* services will comply with the HCPHES/RWGA published Clinical Case Management Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system

Clinical Case Management Services must be provided by an agency with a documented history of, and current capacity for, providing mental health counseling services (categories b., c. and d. as listed under *Amount Available* above) or substance abuse treatment services to PLWH/A (category a. under *Amount Available* above) in the Houston EMA. Specifically, an applicant for this service category must clearly demonstrate it has provided mental health treatment services (e.g. professional counseling) or substance abuse treatment services (as applicable to the specific CCM category being applied for) in the previous calendar or grant year to individuals with an HIV diagnosis. Acceptable documentation for such treatment activities includes standardized reporting documentation from the County's *CPCDMS* or Texas Department of State Health Services' *TCT* data systems, Ryan White Services Report (RSR), SAMSHA or TDSHS/SAS program reports or other verifiable published data. Data submitted to meet this requirement is subject to audit by HCPHES/RWGA prior to an award being recommended. **Agency-generated non-verifiable data is not acceptable.** In addition, applicant agency must demonstrate it has the capability to continue providing mental health treatment and/or substance abuse treatment services for the duration of the contract term and any subsequent one-year contract renewals. Acceptable documentation of such continuing capability includes current funding from Ryan White (all Parts), TDSHS HIV-related funding (Ryan White, State Services, State-funded Substance Abuse Services), SAMSHA and other ongoing federal, state and/or public or private foundation HIV-related funding for mental health treatment and/or substance abuse treatment services. Proof of such funding must be documented in the application and is subject to independent verification by HCPHES/RWGA prior to an award being recommended. |

	Loss of funding and corresponding loss of capacity to provide mental health counseling or substance abuse treatment services as applicable may result in the termination of Clinical Case Management Services awarded under this service category. Continuing eligibility for Clinical Case Management Services funding is explicitly contingent on applicant agency maintaining verifiable capacity to provide mental health counseling or substance abuse treatment services as applicable to persons with HIV during the contract term. **Applicant agency must be Medicaid and Medicare Certified**.
Staff Requirements:	Clinical Case Managers must spend at least 42% (867 hours per FTE) of their time providing direct case management services. Direct case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the Centralized Patient Care Data Management System (CPCDMS) according to CPCDMS business rules. *Must comply with applicable HCPHES/RWGA Houston EMA/HSDA Part A/B Ryan White Standards of Care:* Minimum Qualifications: **Clinical Case Managers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. All clinical case managers must have a current and in good standing State of Texas license (LCSW, LPC, LPC-I, LMFT, LMFT-A). Staff providing Clinical Case Management services with LBSW or LMSW licensure must have accompanying LCDC, CI, Substance Abuse Counselor, or Addictions Counselor certification. The Clinical Case Manager may supervise the Service Linkage Worker. CCM targeting Hispanic persons with HIV must demonstrate both written and verbal fluency in Spanish. Supervision: The **Clinical Case Manager** (CCM) must function with the clinical infrastructure of the applicant agency and receive supervision in accordance with the CCM's licensure requirements. At a minimum, the CCM must receive ongoing supervision that meets or exceeds HCPHES/RWGA published Ryan White Part A/B Standards of Care for Clinical Case Management. If applicant agency also has Service Linkage Workers funded under Ryan White Part A the CCM may supervise the Service Linkage Worker(s). Supervision provided by a CCM that is <u>not</u> client specific is considered **indirect time** and is not billable.

Special Requirements: **RWGA Only**	Contractor must employ full-time Clinical Case Managers. Prior approval must be obtained from RWGA to split full-time equivalent (FTE) CCM positions among other contracts or to employ part-time staff. **Contractor must provide to RWGA the names of each Clinical Case Manager and the program supervisor no later than March 30th of each grant year. Contractor must inform RWGA in writing of any changes in personnel assigned to contract within seven (7) business days of change.** Contractor must comply with CPCDMS data system business rules and procedures. Contractor must perform CPCDMS new client registrations and registration updates for clients needing ongoing case management services as well as those clients who may only need to establish system of care eligibility. Contractor must issue bus pass vouchers in accordance with HCPHES/RWGA policies and procedures.

FY 2024 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**	Date: **06/08/2023**

Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**	Date: **06/01/2023**

Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**	Date: **05/2023**

Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/19/2023**

Recommendations:	Financial Eligibility:
1.	
2.	
3.	

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Building a Healthy Community

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FY 2020 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

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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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Highlights from FY 2020 Performance Measures

Measures in this report are based on the *2021-2022 Houston Ryan White Quality Management Plan*, *Appendix B. HIV Performance Measures*. The document can be referenced here: https://publichealth.harriscountytx.gov/Services-Programs/Programs/RyanWhite/Quality

Clinical Case Management
- During FY 2020, from 3/1/2020 through 2/28/2021, 1,046 clients utilized Part A clinical case management. According to CPCDMS, 580 (56%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing clinical case management.
- Among these clients, 46% accessed mental health services at least once during this time period after utilizing clinical case management.
- For clients who have lab data in CPCDMS, 73% were virally suppressed.

Ryan White Part A
HIV Performance Measures
FY 2020 Report

Clinical Case Management
All Providers

For FY 2020 (3/1/2020 to 2/28/2021), 1,046 clients utilized Part A clinical case management.

HIV Performance Measures	FY 2019	FY 2020	Change
A minimum of 75% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing clinical case management	732 (56.4%)	580 (55.5%)	**-0.9%**
35% of clinical case management clients will utilize mental health services	413 (31.8%)	485 (46.4%)	**14.6%**
80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	548 (80.2%)	381 (73.3%)	**-6.9%**
Less than 5% of clients will be homeless or unstably housed	142 (10.9%)	98 (9.4%)	**-1.5%**

According to CPCDMS, 13 (1.2%) clients utilized primary care for the first time and 84 (8.0%) clients utilized mental health services for the first time after accessing clinical case management.

Clinical Chart Review Measures	FY 2019
85% of clinical case management clients will have a case management care plan developed and/or updated two or more times in the measurement year	7%
Percentage of clients identified with an active substance abuse condition referred to substance abuse treatment	*100%

*Of the 26 clinical case management clients with active substance use disorder, all 26 (100%) received a referral for further treatment.

Harris County
Public Health
Building a Healthy Community

Ryan White Part A
Quality Management Program- Houston EMA
Case Management Chart Review FY 2020-21
Ryan White Grant Administration

CUMMULATIVE SUMMARY, DE-IDENTIFIED

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Overview

Each year, the Ryan White Grant Administration Quality Management team conducts chart review in order to continuously monitor case management services and understand how each agency implements workflows to meet quality standards for their funded service models. This process is a supplemental complement to the programmatic and fiscal audit of each program, as it helps to provide an overall picture of quality of care and monitor quality performance measures.

A total of 624 medical case management client records were reviewed across seven of the ten Ryan White-Part A funded agencies, including a non-primary care site that provides Clinical Case Management services. The dates of service under review were March 1, 2020- February 28, 2021. The sample selection process and data collection tool are described in subsequent sections.

Case Management is defined by the Ryan White legislation as a, "range of client-centered services that link clients with health care, psychosocial, and other services," including coordination and follow-up of medical treatment and "adherence counseling to ensure readiness for and adherence to HIV complex treatments." Case Managers assist clients in navigating the complex health care system to ensure coordination of care for the unique needs of People Living With HIV. Continuous assessment of need and the development of individualized service plans are key components of case management. Due to their training and skill sets in social services, human development, psychology, social justice, and communication, Case Managers are uniquely positioned to serve clients who face environmental and life issues that can jeopardize their success in HIV treatment, namely, mental health and substance abuse, poverty and access to stable housing and transportation, and poor social support networks.

Ryan White Part-A funds three distinct models of case management: Medical Case Management, Non-Medical Case Management (or Service Linkage Work), and Clinical Case Management, which must be co-located in an agency that offers Mental Health treatment/counseling and/or Substance Abuse treatment. Some agencies are also funded for Outreach Services, which complement Case Management Services and are designed to locate and assist clients who are on the cusp of falling out of care in order to re-engage and retain them back into care.

The Tool

A copy of the Case Management Chart Review tool is available in the Appendix of this report.

The Case Management Chart Review tool is a pen and paper form designed to standardize data collection and analysis across agencies. The purpose of the tool is to capture information and quantify services that can present an overall picture of the quality of case management services provided within the Ryan White Part-A system of care. This way, strengths and areas of improvement can be identified and continuously monitored.

The coversheet of the chart abstraction tool captures basic information about the client, including their demographics, most recent appointments, lab results, and any documented psychological, medical, or social issues or conditions that would be documented in their medical record.

The content of the second sheet focuses on coordination of case management services. There is space for the chart abstractor to record what type of worker assisted the client (Medical Case Manager, Service Linkage Worker, Outreach Worker or Clinical Case Manager) and what types of services were provided. It is expected that any notes about case management closure are recorded, as well as any assessments or service plans or documented reasons for the absence of assessments or service plans.

The Sample

In order to conduct a thorough and comprehensive review, a total of 624 client records were reviewed across seven agencies for the 2020-2021 grant year. This included sixty-one (61) Clinical Case Management charts at a non-primary care site. In this Case Management Chart Review Report, any section that evaluated a primary care related measure excludes the sample of the non-primary care site. Minimum sample size was determined in accordance with *Center for Quality Improvement & Innovation* sample size calculator based on the total eligible population that received case management services at each site.

Agency	A	B	C	D	E	F	G
# of Charts Reviewed	79	85	91	105	105	98	61

TOTAL   624 (563 excluding non-Primary Care site)

For each agency, a randomized sample of clients who received a billable Ryan White- A service under at least one (1) of eleven (11) case management subcategory codes during the March 1, 2020- February 28, 2021 grant year was queried from the Centralized Patient Care Data Management System database. Each sample was determined to be comparable to the racial, ethnic, age, and gender demographics of each site's overall case management patient population.

Cumulative Data Summaries

APPOINTMENTS & ENCOUNTERS

The number of HIV-related primary care appointments and case management encounters in the given year were counted for each client.

HIV-RELATED PRIMARY CARE APPOINTMENTS

For this measure, the number of face-to-face encounters and virtual telehealth visits for an HIV-related primary care appointment with a medical provider was counted. Each encounter was assessed for a minimum of 3 medical appointments. Any Viral Load that accompanied the appointment was also recorded.

HIV MEDICAL # appt	A	B	C	D	E	F	TOTAL	PERCENT
0	1	4	11	31	8	4	59	**10%**
1	5	23	9	40	42	10	129	**23%**
2	18	27	10	26	38	15	134	**24%**
3	55	31	61	8	17	69	241	**43%**
Total	79	85	91	105	105	98	563	

The overall sample trends towards a higher number of primary care appointment in the year, with most of the case management review clients having at least 3 appointments in the year (43%), followed by (24%) of the clients having 2 appointments in the year.

CASE MANAGEMENT ENCOUNTERS

Frequency of case management encounters were also reviewed. The number and types of the encounters (face-to-face vs. phone), as well as who provided the service (Clinical, Medical, or Non-Medical Case Manager) were also recorded.

The distribution of frequency of case management encounters could be described as evenly distributed across encounters.

CASE MGMNT # appointments	A	B	C	D	E	F	G	TOTAL	PERCENT
1	19	23	17	35	19	32	8	153	**25%**
2	21	17	13	12	30	23	6	122	**20%**
3	9	10	12	12	22	24	15	104	**17%**
4	17	19	16	22	10	10	13	107	**18%**
5	13	16	33	24	24	9	19	138	**22%**
Total	79	85	91	105	105	98	61	624	

VIRAL SUPPRESSION

Any results of HIV Viral Load laboratory tests that accompanied HIV-related primary care appointments were recorded as part of the case management chart abstraction. Up to three laboratory tests could be recorded. Lab results with an HIV viral load result of less than 200 copies per milliliter were considered to be virally suppressed.

Upon coding, clients who were suppressed for all of their recorded labs (whether they had one, two, or three tests done within the year), were coded as "Suppressed." Clients who were unsuppressed (>200 copies/mL) for all of their labs were coded as "Unsuppressed." Clients who had more than one laboratory test done and were suppressed for at least one and unsuppressed for at least one were coded as "Mixed Status," and clients who had no laboratory tests done within the entire year were coded as "Unknown."

SUPPRESSION STATUS	A	B	C	D	E	F	TOTAL	PERCENT
Suppressed for all labs	32	31	43	72	72	33	283	**50%**
Mixed status	0	0	0	3	10	0	13	**2%**
Unknown (no recent labs on file)	44	51	37	21	10	55	218	**39%**
Unsuppressed for all labs	3	3	11	9	13	10	49	**9%**
Total	*79*	*85*	*91*	*105*	*105*	*98*	*563*	

Across all primary care sites, the case management clients reviewed for these samples had a viral load suppression rate of 50%. In contrast, this result is much lower than what is typical for the Ryan White Part A Houston Primary Care Chart review, which has hovered around 85% for the past several years. This difference may be due to several factors, mainly the Covid-19 pandemic and reduction of in-person labs due to telehealth visits. The Primary Care chart review sample is collected from a pool of clients who are considered *in care*, or have at least two medical appointments with a provider with prescribing privileges in the review year. Additionally, "fluctuating viral load" is one of the eligibility criteria for medical case management, so clients who have challenges maintaining a suppressed viral load are more likely to be seen by case management and be included in this sample.

CARE STATUS

The chart abstractor also documented any circumstances in the record for which a client was new, lost, returning to care, or some combination of those care statuses. A client was considered "New to Care," if they were receiving services for the first time at that particular agency (not necessarily new to HIV treatment or the Houston Ryan White system of care). "Lost to Care" was defined as not being seen for an HIV-related primary care appointment within the last six months and not having a future appointment scheduled, even beyond the review year. "Re-engaged in Care" was defined as any client who was previously lost to care, either during or before the review year, and later attended an HIV-related primary care appointment.

CARE STATUS	A	B	C	D	E	F	TOTAL	PERCENT
New to Care	11	5	11	1	2	5	35	6%
Lost to Care	11	2	1	15	11	2	42	7%
Re-engaged in Care	0	0	0	1	0	0	1	1%
Both New and later Lost to Care in the same review year	8	2	20	3	17	15	65	12%
Re-engaged and later lost again	0	0	0	1	1	0	2	<1%
N/A	49	76	59	84	74	76	418	74%
Total	*79*	*85*	*91*	*105*	*105*	*98*	*563*	

Overall, 6% of the sample was considered New to Care, 7% was Lost to Care, and <1%was Re-engaged in Care.

When a client's attendance met one of the above care statuses, their medical record was reviewed to understand if case management or other staff was involved in coordinating their care. Activities that counted as "Coordination of Care" were any actions that welcomed the client into or back into care or attempted to retain them in care, such as: reminder phone calls, follow-up calls, attendance, or introduction at the first appointment, or home visits.

6

COMORBIDITIES
To understand and document common comorbidities within the Houston Ryan White system of care, co-occurring conditions were recorded, including mental health and substance abuse issues, other medical conditions, and social conditions. This inventorying of co-morbidities may prove particularly helpful for selecting future training topics for case management staff.

MENTAL HEALTH & SUBSTANCE USE DISORDER (history or active)

Any diagnosis of a mental health disorder (MH) or substance use disorder issue (SUD) was recorded in the chart review tool, including a history of mental illness or substance use. All Electronic Medical Records include some variation of a "Problem List" template. This list was often a good source of information for MH and SUD diagnoses, but providers sometimes also documented diagnoses or known histories of illness within progress notes without updating the Problem List. Clients sometimes also self-reported that they had been diagnosed with one of the below conditions by a previous medical provider. Any indication of the presence of mental illness or SUD, regardless of where the information was housed within the medical record, was recorded on the chart abstraction tool. Clients could also have or have had more than one of the MH or SUD issues. Any conditions other than alcohol misuse, other SUD, depression, bipolar disorder, anxiety, or schizophrenia were recorded as "Other." The most common types of condition coded as "Other" was Post-Traumatic Stress Disorder.

Diagnosis or Issue	A	B	C	D	E	F	G	TOTAL	PERCENT
Alcohol abuse/dependence	3	2	5	1	13	6	20	50	9%
Other Substance dependence	14	1	5	0	15	7	19	61	10%
Depression	16	11	32	14	42	33	37	185	32%
Bipolar disorder	6	5	7	1	5	10	14	48	8%
Anxiety	9	12	14	51	28	22	32	168	29%
Schizophrenia	1	1	0	14	1	2	7	26	4%
Other	2	0	11	2	12	9	10	46	8%

Overall, 93% of the sample had either an active diagnosis or history of a mental health or substance abuse issue documented somewhere within their medical record. This is inclusive of the Clinical Case Management site, for which diagnosis with or clinical indication of a MH or SUD issue is an eligibility criteria.

MENTAL HEALTH & SUBSTANCE USE DISORDER REFERRALS

For clients with an *active* diagnosis of a mental health or SUD issue, the chart abstractor recorded if they were referred or already engaged in MH/SUD services.

MH referral	A	B	C	D	E	F	TOTAL	PERCENT
N/A	75	82	55	100	97	88	497	**88%**
Yes	3	3	13	5	8	10	42	**7%**
No	1	0	23	0	0	0	24	**4%**
Total	82	85	91	105	105	98	563	

Overall, 88% of the sample would not have been appropriate for a MH or SUD referral based on the information available in their medical record. An additional 7% either did receive a referral or were already engaged in treatment and 4% did not receive a referral.

MEDICAL CONDITIONS

Medical conditions other than HIV were also recorded in an effort to understand what co-occurring conditions may be considered commonly managed alongside HIV within the case management population. Sexually Transmitted Infections and Hypertension were common, at 33% and 25% prevalence within the sample, respectively. The site visit tool does not list obesity as a medical condition however, obesity was the most common co-occurring condition that was coded in the "Other" category.

Medical Condition	A	B	C	D	E	F	TOTAL	PERCENT
Smoking (hx or current)	10	7	12	11	33	10	83	**16%**
Opportunistic Infection	0	0	3	6	0	0	9	**2%**
STIs	38	16	48	3	39	31	175	**33%**
Diabetes	5	11	8	4	20	22	70	**13%**
Cancer	0	3	1	6	0	1	11	**2%**
Hepatitis	7	5	1	7	9	9	38	**7%**
Hypertension	12	37	21	11	22	28	131	**25%**
Other	2	3	5	0	8	1	19	**4%**

SOCIAL CONDITIONS

Any indication within the medical record that a client had experienced homelessness/housing-related issues, pregnancy/pregnancy-related issues, a release from jail or prison, or intimate partner violence at any point within the review year was recorded in the chart abstraction tool. Homelessness and housing issues were the most commonly identified "Social Condition" within the sample.

Social Issue	A	B	C	D	E	F	G	TOTAL	PERCENT
Homelessness or housing-related issues	5	0	3	4	15	1	10	38	6%
Pregnancy or pregnancy-related issues	6	2	0	0	0	0	0	8	1%
Recently released	0	0	1	0	2	0	0	3	<1%
Intimate Partner Violence	3	0	0	0	5	0	10	18	2%

COMPREHENSIVE ASSESSMENTS

A cornerstone of service provision within case management is the opportunity for the client to be formally assessed at touchpoints throughout the year for their needs, treatment goals, and action steps for how they will work with the case manager or care team to achieve their treatment goals. Agencies need to use an approved assessment tool and service plan, which may either be the sample tools available through Ryan White Grant Administration or a pre-approved tool of the agency's choosing.

The Ryan White Part-A Standards for medical case management state that a comprehensive assessment should be completed with the client at intake and that they should be re-assessed at least every six months for as long as they are receiving medical case management services. A more formal, comprehensive assessment should be used at intake and annually, and a brief reassessment tool is sufficient at the 6-month mark. In other words, the ideal standard is that every client who receives case management services for an entire year should have at least two comprehensive assessments on file. A service plan should accompany each comprehensive assessment to outline the detailed plan of how the identified needs will be addressed with the client.

# of Comp assessments	A	B	C	D	E	F	G	TOTAL	PERCENT
0	62	85	78	100	89	83	0	497	79%
1	17	0	13	3	16	15	15	79	13%
2	0	0	0	2	0	0	9	11	2%
N/A	0	0	0	0	0	0	37	37	6%
Total	79	85	95	105	105	98	61	624	

The client was considered "N/A" for a comprehensive assessment if they did not work with a medical case manager throughout the year. As outlined above, 6% of the sample did not work with a Medical Case Manager within the year. 79% of the sample received zero comprehensive assessments, 13% received one, and 2% received two.

SERVICE PLANS

As mentioned, each comprehensive assessment should be accompanied by a service plan, otherwise known as a care plan, to outline what action(s) will be taken to address the needs identified on the comprehensive assessment. A service plan can be thought of as an informal, working, contract between client and social worker for accountability of needed actions, and in what order, to meet a client's determined treatment goals. As with the comprehensive assessment, each completed service plan was recorded in the chart abstraction tool, along with any documented justification for why a service plan was missing if it should have been completed.

# of service plans	A	B	C	D	E	F	G	TOTAL	PERCENT
0	65	82	91	102	95	98	7	540	**87%**
1	14	3	0	2	10	0	10	39	**6%**
2	0	0	0	1	0	0	7	8	**1%**
N/A	0	0	0	0	0	0	37	37	**6%**
Total	79	85	91	105	105	98	61	624	

It is notable that less service plans are completed than comprehensive assessments, even though the two processes are intended to occur together, one right after the other. RWGA experienced a transition in CM chart review auditors midway through the chart review process. As a result, it is unclear what the criteria for determining a client was "N/A" at agency "G".

BRIEF ASSESSMENTS

Like Medical Case Management, Non-Medical Case Management is guided by a continuous process of ongoing assessment, service provision, and evaluation. Clients should be assessed at intake using a Ryan White Grant Administration approved brief assessment form and should be reassessed at six-month intervals if they are still being serviced by a Non-Medical Case Manager.

# of Brief assessments	A	B	C	D	E	F	TOTAL	PERCENT
0	52	73	55	56	30	80	346	**61%**
1	24	12	34	38	54	18	180	**33%**
2	3	0	2	7	1	0	13	**2%**
N/A	0	0	0	4	20	0	24	**4%**
Total	79	85	91	105	105	98	563	

Completion of brief assessments were recorded. 4% of the sample would not been applicable for a brief assessment, as they did not receive services from a Non-Medical Case Manager. 61% of the sample received zero brief assessments, 33% received one, and 2% received two.

ASSESSED NEEDS

All data from assessment tools was captured in the chart review tool. A total of 624 Comprehensive Assessments and 563 Brief Assessments were reviewed and recorded to quantify the frequency of needs. The count recorded is a raw count of how many times a need was recorded, encompassing both comprehensive and brief assessments and including clients who may have had the same need identified more than once at different points in time.

The most frequently assessed needs were: 1) Medical/Clinical, 2) Dental Care, 3) Vision Care, 4) Medication Adherence Counseling, 5) Mental Health, and (6) Insurance. It should be noted, however, that there are no universal standards or instructions across case management systems on how to use these tools or how these needs are defined. Anecdotally, some case managers reported that they automatically checked "Medical/Clinical" and "Medication Adherence Counseling" as a need, regardless of whether or not the client needed assistance accessing medical care, because it was their understanding that this section *always* needed to be checked in order to justify billing for medical case management services. Therefore, this compilation of comprehensive and brief assessments should not be considered representative of *true need* within the HIV community in Houston, but rather, as representative of issues that case managers are discussing with clients.

Need identified on assessment	A	B	C	D	E	F	G	TOTAL	PERCENT
Medical/Medication	42	12	41	37	24	35	8	199	8%
Vaccinations	10	7	0	44	22	0	6	89	4%
Nutrition/Food Pantry	10	8	16	0	18	1	4	57	3%
Dental	31	11	18	16	29	14	8	127	5%
Vision	19	11	31	12	14	13	5	105	4%
Hearing Care	15	9	26	1	0	12	1	64	3%
Home Health Care	10	3	8	0	1	2	0	24	1%
Basic Necessities/Life Skills	41	9	28	4	5	32	5	124	5%
Mental Health	33	9	45	16	24	44	14	185	7%
Substance Use Disorder	43	12	37	4	5	35	6	142	6%
Abuse	27	11	17	1	12	15	2	85	4%
Housing/Living Situation	41	12	35	9	10	34	8	149	6%
Support Systems	47	12	42	3	3	33	1	141	6%
Child Care	14	6	4	0	0	4	0	28	1%
Insurance	52	11	31	3	9	46	4	156	6%
Transportation	36	12	55	11	6	35	6	161	6%
HIV-Related Legal Assistance	25	8	21	0	1	27	0	82	3%
Cultural/Linguistic	28	1	12	0	0	20	0	61	3%
Self-Efficacy	40	1	12	0	0	40	4	97	4%
HIV Education/Prevention	21	12	40	3	4	36	0	116	5%
Family Planning/ Safer Sex	9	11	7	0	4	2	1	34	2%
Employment	39	7	39	0	4	33	4	126	5%
Education/Vocation	35	10	30	0	0	10	0	85	4%
Financial Assistance	8	10	12	21	15	8	13	87	4%
Medication Adherence Counseling	44	9	43	19	27	43	17	182	7%
Client Strengths	1	0	0	1	0	0	3	5	1%

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Conclusion

The 2020-2021 Case Management chart review highlighted many trends about the case management client population, strengths in case management performance, and areas identified for future attention and improvement. This report also gives consideration to challenges and barriers related to Covid-19 pandemic.

The most common co-occurring conditions were: Sexually Transmitted Infections (33%), Depression (32%), and Hypertension (25%). Diabetes and Obesity were also relatively common and providing overview information on nutrition counseling may be a useful topic in frontline case management trainings. The prevalence of complex co-morbidities emphasizes the unique benefit that case managers contribute to the HIV treatment setting.

There were also areas of high performance displayed in this chart review. Most (43 %) of the clients in the sample had at least three HIV-related primary care appointments within the review year. Case Management staff demonstrated a high level of coordination of care in areas. For example, 90% of the clients who were New, Lost, or Returning to Care (or some combination) received coordination of care activities from case management to retain them in care.

Appendix (Case Management Chart Review Tool)

CASE MANAGEMENT CHART REVIEW TOOL

Chart Review Date _____/_____/_____

Agency: ☐AHF ☐AH ☐Ave360 ☐HHS ☐Legacy ☐SHF

Review Period:
3/1/20__ - 2/28/20__

CLIENT INFORMATION

Pt. ID # _____   Race: _____

Client Case Status: ☐ Open/Active ☐ Closed ☐ Unk.   Gender: _____

Last OAMC Appts:	Virally Suppressed?			← If No, linked to CM?
1.	☐Y	☐N	☐Unk.	
2.	☐Y	☐N	☐Unk.	
3.	☐Y	☐N	☐Unk.	
☐ No appts. during review period				

Last CMngmt. Contact:	Type (F2F/PC/Consult.) + short description)	Signed/Dated/Clear?
1.		
2.		
3.		
4.		
5.		

During the review period, was the client: ☐ New to care   ☐ Lost to care   ☐ Re-engaged in care   ☐NA

If yes…. was there documentation of coordination of care or contact attempts? ☐Y   ☐N   ☐NA

Does the client have an active diagnosis of the following diagnoses? (Check ALL that apply)

☐ Alcohol abuse/dependence

☐ Other substance abuse/dependence: _____

☐ Depression

☐ Bipolar disorders

☐ Anxiety disorders

☐ Schizophrenia

☐ Other: _____

Was the client referred or already
engaged with MH/SA services?
☐N/A   ☐Yes   ☐No

Does the client have any co-morbidity?

☐ Opportunistic Infection

☐ Sexually Transmitted Infections (STIs) : _____

☐ Diabetes

☐ Cancer

☐ Hepatitis

☐ Hypertension

☐ Other: _____

Was the client reported to have any of the following conditions?

☐ Homelessness

☐ Pregnancy (or other pregnancy-related conditions)

☐ Recently released

☐ IPV

INSURANCE, BENEFITS, AND INCOME INFORMATION

Health Insurance: ☐ Uninsured ☐ Medicaid _____ ☐ Medicare _____ ☐ Commercial _____
☐ VA ☐ Other? _____

Spouse/partner:	Children:	Other Dependents:	TOTAL HOUSEHOLD SIZE 1 2 3 4 5 6 7 8 9 10 Unk
Client Income $:	Spouse Income $:	Other Income $:	TOTAL HOUSEHOLD INCOME $:

Did the client lose insurance or coverage during the review period? ☐ Y N ☐ Unk. ☐
If so, were they provided with information/education or assistance? ☐ Y N ☐ NA ☐

CASE MANAGEMENT SERVICES

What types of services were provided by a **Medical Case Manager (MCM?)**	What types of services were provided by a **Service Linkage Worker (SLW?)**	Was the client referred for Clinical Case Management services in the review period?
☐ NA (Client not assisted by MCM) ☐ Comprehensive assessment ☐ Service Plan ☐ Medication adherence counseling ☐ Coordination of medical care ☐ Transportation ☐ ADAP/medication assistance ☐ Eligibility ☐ Community resource/benefits brokerage ☐ Other _____ Did client meet criteria for MCM? Y ☐　　N ☐　　Unk. ☐	☐ NA (Client not assisted by SLW) ☐ Brief assessment ☐ SLW referred client to OAMC ☐ OAMC visit scheduled by SLW ☐ SLW accompanied client to OAMC ☐ SLW called client to remind about OAMC visit ☐ Client did not keep OAMC appt. and SLW contacted them ☐ ADAP/medication assistance ☐ Transportation voucher ☐ Eligibility Were any of the above services provided by an Outreach Worker? Y ☐　　N ☐　　Unk. ☐	☐ No- not applicable ☐ No- applicable, but no referral documented ☐ Yes- and there is evidence of coordination of services ☐ Yes- and there is <u>no</u> evidence of coordination of services ☐ Yes- but client refused services or is already engaged in treatment

Was the case discharged/closed for CM during the review period? Y ☐　N ☐　NA ☐　Unk. ☐
If yes……. Client met agency criteria for closure? Y ☐　N ☐　NA ☐　Unk. ☐
Client completed treatment program (CCM) Y ☐　N ☐　NA ☐　Unk. ☐
Date and reason noted? Y ☐　N ☐　NA ☐　Unk. ☐
Summary of services received? Y ☐　N ☐　NA ☐　Unk. ☐
Referrals noted? Y ☐　N ☐　NA ☐　Unk. ☐
Instructions given to client at discharge? Y ☐　N ☐　NA ☐　Unk. ☐

ASSESSMENTS & SERVICE PLANS

		If no assessment or plan:		
Brief Assess. Date 1:	Brief Assess. Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete
Comp. Assess. Date 1:	Comp. Assess. Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete
Service Plan Date 1:	Service Plan Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete

COMPLETED ASSESSMENTS

Domain	MOST RECENT ASSESSMENT TYPE (circle one)	Comprehensive			Brief	NEXT MOST RECENT ASSESSMENT TYPE (circle one)	Comprehensive			Brief
	Assessed?	Need Identified?	Accounted for in Service Plan?	Accounted for in progress notes?	Follow-up (referral, action, etc.)	Assessed?	Need Identified?	Accounted for in Service Plan?	Accounted for in progress notes?	Follow-up (referral, action, etc.)
Medical/Clinical										
Vaccination										
Nutrition/Food Pantry										
Dental Care										
Vision Care										
Hearing Care										
Home Care Needs										
Basic Necessities/Life Skills										
Mental Health										
Substance/Alcohol Use										
Abuse History										
Housing/Living Situation										
Support System										
Child Care/Guardianship										
Insurance Benefits										
Transportation										
HIV-Related Legal										
Cultural/Linguistic										
Self-Efficacy										
HIV Education/Prevention										
Family Planning/Safer Sex										
Employment/Income										
General Education/Vocation										
Financial Assistance										
Medication Adherence										
Client Strengths										
Other										

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THE CASE FOR BEHAVIORAL HEALTH SCREENING IN HIV CARE SETTINGS

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Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

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EFFECTIVE MEDICAL AND BEHAVIORAL HEALTH INTERVENTIONS HAVE TRANSFORMED HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) FROM A DEATH SENTENCE INTO A CHRONIC AND TREATABLE DISEASE. AS INDIVIDUALS LIVING WITH HIV LEAD LONGER LIVES AND ENJOY A GREATER SENSE OF WELL-BEING THAN EVER BEFORE, CLINICS THAT PROVIDE HIV TREATMENT SERVICES MUST BE RESPONSIVE TO THE VARIETY OF HEALTH NEEDS OF THIS POPULATION.

SUBSTANCE USE AND HIV/AIDS
The goal of HIV care is to achieve and maintain viral suppression – a very low level of HIV in the body. Yet, the health of a person living with HIV cannot be defined solely by their viral load levels. Adhering to the antiretroviral treatment (ART) that suppresses HIV and maintaining a healthy life-style are critical to controlling the disease and can be complicated by behavioral health conditions (mental illness and substance use disorders). People living with HIV have much higher rates of be-havioral health disorders than the general population.

Consider these facts about the connections between HIV/AIDS, mental illness, substance use and trauma.
- People living with HIV have high rates of past or current history of alcohol or substance use disorders (SUDs).[i,ii,iii]
- 66 percent have used illicit drugs and 16.5 percent have a history of intravenous drug use.[ii]
- 24 percent report receiving treatment for SUDs.[iii]

MENTAL ILLNESS AND HIV/AIDS
People living with HIV experience mental illness at significantly higher rates than the general popu-lation. A 2008 study stated that the rate of co-occurring mental illnesses in people with HIV was so high that "having a single mental health diagnosis was the exception rather than the rule."[iv] Specifi-cally, people living with HIV have:
- Two to five times higher rates of depression.[v,vi]
- Up to four times higher rates of depression among women with HIV than women who do not have HIV.[vii]
- Higher rates of anxiety.[viii,ix,x,xi]

TRAUMA AND HIV/AIDS
People living with HIV are more likely to have a history of trauma.
- A person who has experienced trauma and has a serious mental illness has an increased likeli-hood of having an HIV infection.[vi]
- The prevalence of traumatic experiences among those with HIV can be as high as 42 percent for women[xii] and up to 70 percent for all people living with HIV – which means that people with HIV are as much as twenty times more likely to have experienced trauma than the general popula-tion.[xiii,xiv]

HOW LIKELY IS IT THAT PEOPLE WITH HIV/AIDS HAVE MULTIPLE CO-OCCURRING MENTAL ILLNESSES AND SUBSTANCE USE DISORDERS?
An estimated 10-28 percent of people with HIV have co-occurring SUDs and mental illnesses.[xv] Many people living with HIV and with depression had several other mental health disorders, includ-ing 78 percent with anxiety disorders and 61 percent with SUDs.[xvi]

IMPACT OF BEHAVIORAL HEALTH CONDITIONS ON HIV CARE

The prevalence of mental illness among people living with HIV poses a threat to the health of the individual and has a profound effect on physical wellness. For example, people with depression and HIV are more likely to have higher viral loads, more symptoms of anxiety and are more likely to have a substance use problem.[xvii] People with HIV and a co-occurring behavioral health condition may increase risky behaviors, such as unprotected sex or sharing needles, or diminish self-care, such as taking medication as prescribed and getting adequate food and rest. Other interrelated social determinants of health, including poverty, low educational attainment and housing insecurity can also complicate HIV treatment and maintenance of a healthy lifestyle. Addressing behavioral health concerns can play a critical role in the public health approach to reducing transmission of HIV. These reasons are why it is important for HIV clinics to conduct behavioral health screenings.

THE PROBLEM: SCREENING IS INCONSISTENT

Despite these compelling data, studies indicate there is insufficient screening for substance use in HIV care clinics.

- 35 percent of patients in 10 HIV care centers reported talking with their primary care provider about their alcohol use.
- 52 percent of those with more serious alcohol and other drug use reported discussing it with their primary care provider.[xviii]
- Fewer than 50 percent of primary care providers in hospital-based HIV care programs conducted recommended screening and brief interventions for reducing alcohol use.[xix]

WHAT SCREENING FORMS ARE AVAILABLE?

Numerous tools are available for screening both general and specific behavioral health issues, including:

- **General Wellness** — Healthy Living Questionnaire or Patient Stress Questionnaire
- **Trauma** — Life Event Checklist
- **Depression** — PHQ-9
- **Generalized Anxiety Disorder** — GAD-7
- **Substance Use Prescreen** — National Institute on Alcohol Abuse and Alcoholism's (NIAAA) 3 Question Screen or National Institute on Drug Abuse's (NIDA) quick screen
- **Substance Use In-Depth** — AUDIT or ASSIST

Visit the Center for Integrated Health Solutions (CIHS) website to learn more about these and other screening tools.

Note: *These tools are examples and do not include all screening forms available. This does not constitute particular recommendations or endorsements for use.*

SCREENING FOR BEHAVIORAL HEALTH: CRITICAL BUT UNDERUSED

A truly effective model for supporting individual and population health integrates behavioral health services (including screening, assessment and treatment) with primary HIV care. Integrating depression screening helps identify those who can benefit from combined psychotherapy and pharmacotherapy interventions.[xx] The Screening, Brief Intervention and Referral to Treatment (SBIRT) model identifies risky substance use, provides brief interventions for those with lower level substance use before it becomes a problem and offers referral for those who need more intensive, specialty care. Early detection through screening can result in earlier intervention and substance abuse treatment, including medication-assisted treatment, which can make a substantial difference in the health of the individual and reduce transmission of HIV by increasing medication compliance[xxi]

Integrated primary HIV and behavioral health care improves physical health outcomes and leads to increased savings in health care costs through reduced emergency room use, increased efficiency, reimbursable use of staff time and other means of cost-savings.[xxii]

Many Federal grant-funded programs require routine or universal screening for a range of health conditions. The Ryan White HIV/AIDS Treatment Extension Act of 2009 requires funded organizations to follow the HHS Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, which includes screening for clinical depression and substance use and, if they are identified, developing a follow-up plan to address these issues. This emphasis on screening for behavioral health conditions helps Ryan White-funded organizations ensure that it is a routine part of coordinated care.

REPORT FROM THE FIELD

ABOUT THIS REPORT
The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) conducted interviews with direct care HIV provider organizations across the United States and an interview with a public health program supporting the statewide implementation of SBIRT for HIV provider organizations. Several of these programs are health centers that include primary HIV medical care, although one program primarily focuses on behavioral health treatment that includes primary care for people living with HIV.

The provider organizations interviewed were at varying levels of integration, ranging from partial co-location of some behavioral health staff and services to fully integrated. Even the most integrated programs referred patients externally for residential treatment, some referred for detox and/or medication-assisted treatment for addiction and others referred for treatment of serious mental illness.

WHAT IS SBIRT?

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce and prevent problematic substance use, abuse and dependence on alcohol and illicit drugs. The SBIRT model responds to a recommendation by the Institute of Medicine for community-based screening of health risk behaviors, including substance use.

The Three Steps of SBIRT:

1 **Screening —** A health care professional assesses a person for risky substance use behaviors through standardized screening tools.

2 **Brief Intervention —** A short nonjudgmental conversation between a health care professional and patient exhibiting risky substance use behaviors, including feedback and advice.

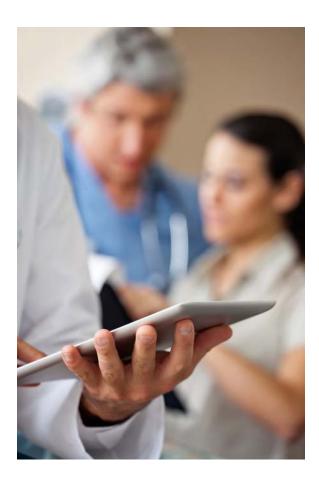**3** **Referral to Treatment —** For patients whose screening results indicate the need for specialty services, a health care professional provides a referral for additional treatment.

Learn more about SBIRT at www.integration.samhsa.gov/ clinical-practice/SBIRT and at www.samhsa.gov/SBIRT.

For more information on SBIRT in HIV care settings, see http://aidsetc.org/sites/default/files/resources_files/sbirt.pdf

WHO SCREENS, WHEN AND WITH WHAT TOOLS?

Almost all of the programs interviewed reported screening between 80 to nearly 100 percent of their patients with HIV for mental health problems, but were less likely to offer universal screening for substance use.

The most commonly used screening instrument was the Patient Health Questionnaire (PHQ-2 and PHQ-9), which screens for depression. Programs who did regularly screen for substance use (or for co-occurring substance use and mental illness) used the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) or other tools. Typically, individuals respond to screening questions and self-report answers using a pen and paper or a tablet computer. Some programs ask patients to fill out a written screening from in the waiting room, while others have medical assistants/technologists, case managers, patient or peer navigators or health educators conduct the screening in the exam room.

Written responses are included in a patient's medical chart. Screenings administered on tablets or other technologies allow responses to go directly to the electronic health record (EHR).

TIPS FOR IMPLEMENTING SCREENING FOR BEHAVIORAL HEALTH

Based on the key informant interviews, the following recommendations are offered as ways HIV clinics can establish consistent behavioral health screening.

ORGANIZATIONAL CULTURE

EXPECT AND SHARE POSITIVE PATIENT OUTCOMES.

"We're committed to it. We saw what a difference it made in the lives of our patients." – Senior Program Manager

- Several participants reported that their organizations believed strongly that screening and treatment for SUDs and mental illnesses improves adherence to ART and better health outcomes.

- Programs ensure that staff are well aware of the link between behavioral health and good health outcomes for people living with HIV and use this knowledge as motivation for conducting the screening and referral to treatment.

- Many of the integrated facilities reported that since they began universal screening, viral suppression of those with behavioral health disorders was reduced to be the same as those

TECHNOLOGY-BASED SCREENING

Electronic Patient Recorded Outcomes (ePRO) is a web-based system that allows patients to complete screenings on a tablet at the beginning of their visit. The ePRO system screens for depression, tobacco, intimate partner violence, learning needs, drug and alcohol use, anxiety, sexual risk behavior, medication adherence, health-related quality of life and physical activity and includes a symptom index.

The software can determine which surveys are appropriate for each visit based on set criteria and determines what issues are most important for each visit based on the results of a brief five-minute screening. Screening results flow directly into the EHR so that they are immediately available to the team of providers. This streamlines documentation workflow, supports data-driven evaluation of individual and group outcomes and monitors for quality assurance.

A busy federally qualified health center (FQHC) on the east coast uses the ePRO system to screen all patients. The clinic has about 40 iPads available for use – one per provider. Program evaluations indicate the technology is well received by both patients and staff. While the technology is intuitive and user-friendly, staff are trained to give a brief tutorial on using the iPad for patients who need assistance. ePRO has both English and Spanish language options; however, if a patient speaks another language or cannot use the technology, a staff member can conduct the screening verbally.

The program received a National Institutes of Health grant to study the system's effectiveness and a local health insurance company foundation supported additional iPads. Costs include web-hosting services, storage lockers to charge the iPad and programming to load information directly into the EHR.

without behavioral health disorders. These positive outcomes were shared with staff to reinforce the importance of screening and treatment for mental illnesses and addictions.

FOSTER COLLABORATION BETWEEN PRIMARY AND BEHAVIORAL HEALTH PROFESSIONALS.

"I'm there. I'm in their view. It makes it more likely that they are going to refer to me when they actually see me." — Behavioral Health Clinician

- Programs that reported high rates of screening and referrals to treatment provided opportunities for primary and behavioral health care professionals to communicate and collaborate.

- In programs that were highly integrated, multidisciplinary communication takes place during in-person case conferences from once a week to two times per month. Some programs conduct daily morning "huddles."

- Several program managers noted that face-to-face contact is critical to building effective working relationships that support collaborative and coordinated care

- One behavioral health program emphasized recruiting for onsite primary care providers who understood that communication with the behavioral health clinicians was critical to the team.

- Another program affiliated with a teaching hospital found annual training was necessary to reinforce a culture of communication to interns and residents.

- Several programs noted that both in-person communication and communication through secure EHRs were necessary to distribute critical information to the entire multidisciplinary care team.

HELP PRIMARY CARE PROVIDERS SEE THE VALUE IN SCREENING.

After implementing SBIRT statewide, the value of screening was demonstrated to primary care providers by the number of lower-level substance use issues that were effectively addressed through brief interventions by health educators before they reached the level of SUD. Examples from similar organizations like, "Using SBIRT, a busy HIV clinic like yours identified 15 percent more patients with risky substance use," can be effective tools to demonstrate the value of screening and brief interventions to primary care providers.

- A state health program that implemented SBIRT in all of its contracted HIV clinics observed that some primary care providers incorrectly believe that they already identify individuals with risky substance use or mental health problems without screening.

- A few programs questioned the value of screening, because they believed an effective medical provider should be able to identify behavioral health problems based on their clinical judgment and knowledge of a particular patient. However, research shows that primary care providers recognize depression only 50 to 70 percent of the time.[xx]

- A large HIV clinic using electronic screening methods captured reports of mental health or substance use problems that were previously missed or undocumented by primary care providers for a significant number of patients.[xxiii] Nurses in that clinic are trained to treat the results of screening as "another vital sign," like blood pressure or heart rate.

INFRASTRUCTURE AND IMPLEMENTATION

SCREEN ALL PATIENTS, NOT JUST THOSE WITH HIV.

Programs reporting high rates of screening conduct behavioral health screening on all of their patients, regardless of HIV status. This sets an institutional expectation for screening which helps staff become more comfortable with the process and allows screening to become part of workflow and quality assurance processes. Universal screening reduces the possibility of biases that might influence a decision to skip screening. For example, some programs reported that middle- and upper-income individuals were not always screened. Anything staff can do to "normalize" behavioral health screening demonstrates to patients that it is a routine part of health care.

- In a state that conducts SBIRT throughout its HIV clinics, providers learned to shift their thinking from identifying disorders and referring to treatment only those that they perceive as "high risk" to identifying risk factors and intervening among all patients.

- One program reported that patients sometimes leave a number of questions blank at the end of the PHQ-9 because of fear of hospitalization if there are too many "yes" responses. In those situations, staff recommends a follow-up conversation with the primary care provider or a warm hand-off to a behavioral health professional.
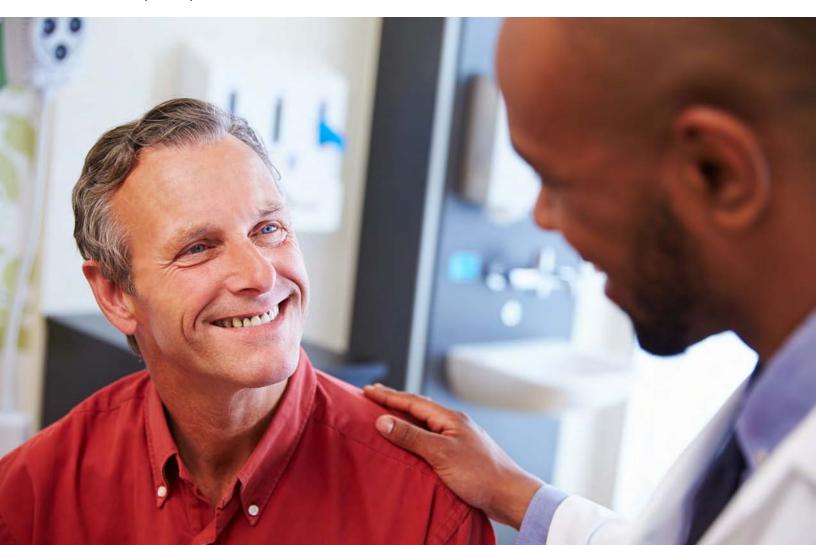
PLAN THE ROLLOUT OF SCREENING CAREFULLY.

Planning for change in a busy primary HIV care program requires an understanding of how the change will affect the larger clinic environment. The planning process should include:

- Carefully selecting validated screening tools and a workflow analysis.

- Implementing screening instruments based on clinic workflow and adjusting as necessary.

- Training all employees in the screening process, including how to conduct screening and respond to results.

- Defining project success to all employees by transparently communicating outcomes.

A "Plan-Do-Study-Act" cycle of analysis may be effective when implementing change. A program that struggled to implement screening said primary care providers were concerned about the time it takes. The clinic — which now boasts a 97 percent screening rate — studied the workflow process and reduced the time for medical assistants to enter results into the chart to four minutes. The program is trying to reduce that time even further.

TRAIN STAFF TO CODE THE SCREENING AND/OR BRIEF INTERVENTIONS FOR BILLING.

The fact that SBIRT was billable under Medicaid was one factor in achieving buy-in for the statewide implementation program. Teaching staff to code for screening and brief interventions ensured the clinic recouped some of the related expenses. Programs should review their states' Medicaid system to determine if brief interventions by paraprofessionals such as health educators or peer specialists are reimbursable.

CONNECTING PATIENTS TO COMPLEX SYSTEMS OF CARE

A west coast behavioral health program that integrated primary care into its services for patients who have HIV or AIDS created a navigation program to connect patients to care, including screenings, assistance navigating the health care system and links to behavioral and mental health service. The goals are to improve patient experiences by delivering care when it is most needed, provide access to additional behavioral health supports and improve behavioral health follow-up.

Patient navigators enhance co-located services by completing patient intake procedures, connecting their assigned patients to the correct services and "tracking" them using the EHR and other internal management information systems. For example, the program uses the PHQ-2 to identify potential depression. If patients are flagged for follow-up based on the screening, they receive medical care and are then connected to the behavioral health specialist on call. The patient navigator consults with other service providers and provides input on treatment for up to three months to ensure the patient follows through on referrals. Quality assurance is measured by assessing the number of patients assisted by the patient navigator and the percentage of patients who follow through with service appointments.

GET BUY-IN FROM KEY STAKEHOLDERS.

- A large urban clinic that uses technology-based screening (see box, page 8) began its rollout slowly, starting with a "champion" on one floor. This early adopter communicated success to others, which paved the way for implementation to the rest of that floor. Program managers studied problems with clinic flow, refined the process and rolled it out on another floor, then another.

- The statewide SBIRT program also used champions within a primary care provider system to support implementation.

FACILITATE COMMUNICATION BETWEEN PRIMARY AND BEHAVIORAL HEALTH CARE PROVIDERS.

Integrated EHRs allow providers to share notes, referrals and medications, which enhances their ability to provide informed care. A 2011 policy paper by the HIV Medicine Association and the Ryan White Medical Providers Coalition states, "EHRs are a key component of effective integrated care and medical home models."[xxiv] The Institute of Medicine (IOM) notes that both in-person and electronic communication facilitates care coordination among providers and are key steps in redesigning effective health systems, creating patient-centered medical homes and ensuring better outcomes.[xxv]

- A program that allows onsite access to EHRs to only one full-time mental health clinician and not to contracted off-site behavioral health clinicians, reported significantly less communication between primary care and behavioral health providers.

PROVIDE SUPPORTS THAT MAKE REFERRAL TO TREATMENT STICK.

Successful programs with increased referrals and high levels of retention with behavioral health interventions are highly integrated, with numerous clinicians who are available to receive a "warm hand-off" from either a primary care provider or a non-medical staff member. Support resources may include

a health educator, case manager or peer/patient navigator focusing on accessing the behavioral health program, filling out paperwork and securing other support services, such as transportation.

DEVELOP EFFECTIVE LINKS TO SUBSTANCE USE DISORDER AND MENTAL HEALTH TREATMENT PROGRAMS.

Even the most integrated primary HIV care programs do not have the full continuum of behavioral health care available onsite such as detox, medication assisted treatment for addiction, intensive outpatient treatment for addiction or mental health or residential treatment. Formal partnerships that outline in a memorandum of understanding, clear roles, responsibilities and communication expectations with shared EHRs and co-location of some services in the primary care site can facilitate referrals.

PEOPLE AND PLACES

CONSIDER USING NON-CLINICAL STAFF FOR SCREENING AND BRIEF INTERVENTIONS.
Most programs use staff without advanced medical training — medical assistants, health educators, peer/patient navigators or community health workers — to conduct the brief screening such as the PHQ-2 and AUDIT-C and used behavioral health providers for longer assessments like the PHQ-9 and AUDIT.

- The state that implemented SBIRT used highly trained health educators to conduct screening and brief interventions for substance use to provide effective and nonjudgmental support and reduced cost.

CHOOSE APPROPRIATE BEHAVIORAL HEALTH CLINICIANS FOR WARM HAND-OFFS AND REFERRALS.
Behavioral health clinicians in an integrated and/or co-located program must be particularly flexible and understand the model for providing services in a primary care setting. This means being available for a warm hand-off for immediate assessment and accepting the responsibility of providing mostly short-term interventions (four to six visits). Referrals are reserved for longer-term therapy.

Not all behavioral health clinicians feel comfortable with this model. Many are used to, or prefer the predictable pace of a 50-minute session that provides the opportunity to develop longer-term relationships with clients. During the interview process, job previews – like having a prospective employee spend time in the clinic shadowing a similar behavioral health clinician or showing videos of the clinic experiences – may be helpful in creating realistic expectations.

HIRE ENOUGH BEHAVIORAL HEALTH PROVIDERS.

Having enough behavioral health staff available increases the probability that further assessment, case consultation and warm hand-offs to behavioral health services will take place. One of the biggest challenges organizations face is too few internal and external behavioral health providers for referrals or case consultation, particularly with psychiatrists or psychiatric nurse practitioners for psychopharmacology.

- A program that reported having enough behavioral health clinicians to be flexible and easily available worried about retaining these positions when the state grant funding that supports their salaries runs out. The growing workforce of peer providers is emerging as an important resource for programs.[xxvi,xxvii]

- Unrealistic workload expectations may affect employee retention and continuity of care. One program reported that its social worker who had a caseload of 190 HIV-positive patients also conducted all the annual assessments, leaving little time for short- or longer-term interventions. The clinic reported high turnover among social workers and struggles with fully integrating behavioral health.

TRAIN, TRAIN, TRAIN.

Retraining capabilities should be built into all training programs.

- One program recognized that the need for increased training to reduce the number of refusals for addiction screening, particularly from the transgender population. The number of refusals dropped among all populations after they offered additional training to screening staff, primary care providers and others.

CONSIDER PHYSICAL LOCATION.

"Space is the final frontier." – Program Manager who successfully argued for an exam room for mental health clinicians

Physical location can influence the outcomes of both screening and subsequent assessment/referral.

- A program that uses tablets for screening conducted a study on differences in refusal rates. The refusal rates were lower when patients were screened in exam rooms compared to screenings in waiting rooms. This suggests that willingness to participate in screening depends on perceived privacy.

Physical location also influences post-screening brief interventions or treatment referral. Availability of onsite assessment and treatment referral facilitates a warm hand-off from the primary care provider to the behavioral health clinician.

- A program reported a 50 percent rate of follow-through when its behavioral health services were 1.5 miles away. Follow-through on referrals increased when services were co-located.

- Co-location itself does not guarantee a warm hand-off. A clinic with a contracted behavioral health clinician was co-located on a floor with primary HIV care; however, the behavioral health clinician — who must bill his/her time — is often behind closed doors, making it difficult to connect patients to him/her.

- Three highly integrated programs report that appropriate scheduling allows their behavioral health clinicians to be available 50 percent of the time for warm hand-offs, detailed assessments, brief interventions, crisis stabilization and other related activities.

- For many programs, grants and other fundraising enables clinicians to be scheduled for non-billable time.

STATEWIDE IMPLEMENTATION OF SBIRT

The efficacy of the SBIRT model in identifying risk of SUDs led a western state to implement it for all Ryan White programs, including clinics and AIDS service organizations. The state's public health program ensured adoption across all programs by requiring use of SBIRT in its contract.

While some SBIRT programs pose one or two questions about substance use, this state asks four key questions. Two questions focus on alcohol — the number of drinks per week and the last time four to five drinks were consumed in one day — one asked about the use of an illegal drug or a prescription drug for nonmedical reasons in the past year and one focused on tobacco use. If the results indicate a possible substance use problem, health educators use additional screens or longer assessment instruments to explore the scope of the issue.

Staff at many primary care programs were skeptical about the effectiveness of screening and worried about its effect on various clinic flow issues. Questions arose about the time it would require, who would perform the screening and brief intervention, where would it take place and finding appropriate places for referral. As training rolled out across the state and similar clinics reported success, primary care providers started to embrace SBIRT. Approximately 85 percent of patients at publicly funded clinics who are HIV-positive are screened with SBIRT at least once a year and 50 to 60 percent are screened annually for mental health concerns.

Focus groups revealed that patients appreciated the opportunity to talk with medical providers about substance use when asked in a respectful way and providers felt it gave them a more complete picture of patients' health. The SBIRT program helped normalize discussions about substance use in medical settings by demonstrating to primary care providers that those who screen positive for some risky behaviors are not necessarily addicted to alcohol or other drugs, but are part of a wider continuum of people who may need intervention.

Lessons learned about supporting SBIRT implementation included the importance of finding champions within each program and using them to develop staff support, define clear protocols that match clinic flow and improve referral systems to ensure that those who need more than a brief intervention receive additional treatment.

CONCLUSION

Behavioral health screening is an important step for health care provider organizations to increase access to quality behavioral health care. By following the steps and examples outlined, organizations can build effective behavioral health screening that supports a system of integrated care. These recommendations and lessons learned, when implemented, can result in a truly effective and more comprehensive model to meet the multiple needs of individuals living with HIV.

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