Local Service Category:	**Care Coordination (Non-Medical Case Management) Targeting Substance Use Disorder**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. Direct medical costs and Substance Abuse Treatment/Counseling cannot be billed under this contract.
DSHS Service Category Definition:	**Care Coordination** is a continuum of services that allow people living with HIV to be served in a holistic method. Services that are a part of the Care Coordination Continuum include case management, (both medical and non-medical, outreach services, referral for health care, and health education/risk reduction. **Non-Medical Case Management (N-MCM)** model is responsive to the immediate needs of a person living with HIV (PLWH) and includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, entitlements, housing, and other needed services. **Non-Medical Case Management Services (N-MCM)** provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. N-MCM services may also include assisting eligible persons living with HIV (PLWH) to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication (e.g., face-to-face, phone contact, and any other forms of communication) as deemed appropriate by the Texas DSHS HIV Care Services Group Ryan White Part B program. Limitation: Non-Medical Case Management services do not involve coordination and follow up of medical treatments.
Local Service Category Definition:	***Non-Medical Case Management:*** The purpose of Non-Medical Case Management targeting Substance Use Disorders (SUD) is to assist PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. N-MCM targeting SUD is intended to serve eligible people living with HIV in the Houston EMA/HSDA who are also facing the challenges of substance use disorder. Non-Medical Case Management is a working agreement between a PLWH and a Non-Medical Case Manager for an indeterminate period, based on PLWH need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis and assists PLWHs who do not require the intensity of Medical Case Management. Non-Medical Case Management is both office-based and field based. N-MCMs are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWH may be identified, including substance use disorder treatment/counseling and/or recovery support personnel. Such incoming referral coordination includes meeting prospective PLWHs at the referring provider location in order to develop rapport with and ensuring sufficient support is available. Non-Medical Case Management also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those PLWHs who have not returned

	for scheduled appointments with the provider nor have provided updated information about their current Primary Medical Care provider (in the situation where PLWH may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Non-Medical Case Management extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services.
Target Population (age, gender, geographic, race, ethnicity, etc.):	**Non-Medical Case Management targeting SUD** is intended to serve eligible people living with HIV in the Houston EMA/HSDA, especially those underserved or unserved population groups who are also facing the challenges of substance use disorder. The target populations should also include individuals who misuse prescription medication or who use illegal substances or recreational drugs and are also: – Transgender, – Men who have sex with men (MSM), – Women or – Incarcerated/recently released from incarceration.
Services to be Provided:	**Goals:** The primary goal for N-MCM targeting SUD is to improve the health status of PLWHs who use substances by promoting linkages between community-based substance use disorder treatment programs, health clinics and other social service providers. N-MCM targeting SUD shall have a planned and coordinated approach to ensure that PLWHs have access to all available health and social services necessary to obtain an optimum level of functioning. N-MCM targeting SUD shall focus on behavior change, risk and harm reduction, retention in HIV care, and lowering risk of HIV transmission. The expectation is that each Non-Medical Case Management Full Time Equivalent (FTE) targeting SUD can serve approximately 80 PLWHs per year. **Purpose:** To promote Human Immunodeficiency Virus (HIV) disease management and recovery from substance use disorder by providing comprehensive Non-Medical Case Management and support for PWLH who are also dealing with substance use disorder and providing support to their families and significant others. **N-MCM targeting SUD** assists PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. **N-MCM targeting SUD** is a working agreement between a person living with HIV and a Non-Medical Case Manager (N-MCM) for an indeterminate period, based on identified need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis. The purpose of **N-MCM targeting SUD** is to assist PLWHs who do not require the intensity of *Clinical or Medical Case Management*. **N-MCM targeting SUD** is community-based (i.e. both office- and field-based). This Non-Medical Case Management targets PLWHs who are also dealing with the challenges of substance use disorder. N-MCMs also provide "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Efforts may include coordination with other case management providers to ensure the specialized needs of PLWHs who are dealing with substance use disorder are thoroughly addressed. For this population, this is not a

	duplication of service but rather a set of agreed upon coordinated activities that clearly delineate the unique and separate roles of N-MCMs and medical case managers who work jointly and collaboratively with the PLWH's knowledge and consent to partialize and prioritize goals in order to effectively achieve those goals. N-MCMs should provide activities that enhance the motivation of PLWHs on N-MCM's caseload to reduce their risks of overdose and how risk-reduction activities may be impacted by substance use and sexual behaviors. N-MCMs shall use motivational interviewing techniques and the Transtheoretical Model of Change, (DiClemente and Prochaska - Stages of Change). N-MCMs should promote and encourage entry into substance use disorder services and make referrals, if appropriate, for PLWHs who are in need of formal substance use disorder treatment or other recovery support services. However, N-MCMs shall ensure that PLWHs are not required to participate in substance use disorder treatment services as a condition for receiving services. For those PLWH in treatment, N-MCMs should address ongoing services and support for discharge, overdose prevention, and aftercare planning during and following substance use disorder treatment and medically-related hospitalizations. N-MCMs should ensure that appropriate harm- and risk-reduction information, methods and tools are used in their work with the PLWH. Information, methods and tools shall be based on the latest scientific research and best practices related to reducing sexual risk and HIV transmission risks. Methods and tools must include, but are not limited to, a variety of effective condoms and other safer sex tools as well as substance abuse risk-reduction tools, information, discussion and referral about Pre- Exposure Prophylactics (PrEP) for PLWH's sexual or drug using partners and overdose prevention. N-MCMs should make information and materials on overdose prevention available to appropriate PLWHs as a part of harm- and risk-reduction. Those PLWHs who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing Non-Medical Case Management services from provider**.**
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct services or coordination of care on behalf of PLWH.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Eligibility for Services:	PLWHs dealing with challenges of substance use/abuse and dependence. Resident of the Houston HSDA.
Agency Requirements **(TRG Only)**:	These services will comply with the TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system as well as DSHS Universal Standards and Non-Medical Case Management Standards of Care. **Non-Medical Case Management targeted SUD** must be planned and delivered in coordination with local HIV treatment/prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

	Subrecipients must document established linkages with agencies that serve PLWH or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV primary care providers.
Staff Requirements:	Minimum Qualifications: **Non-Medical Case Management Workers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing services to PLWH may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Non-Medical Case Management Workers must have a minimum of one (1) year work experience with PLWHA and/or substance use disorders. Supervision: The Non-Medical Case Management Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Universal Standards and non-Medical Case Management Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. Contractor must be licensed in Texas to directly provide substance use treatment/counseling. Non-medical Case Management services can be delivered via telehealth and must follow applicable federal and State of Texas privacy laws.

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
2.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #2**	Date: **04/16/2024**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

SAMHSA ADVISORY
Substance Abuse and Mental Health Services Administration

COMPREHENSIVE CASE MANAGEMENT FOR SUBSTANCE USE DISORDER TREATMENT

The definition of case management varies by setting, but in general terms it is a coordinated, individualized approach that links patients[1] with appropriate services to address their specific needs and help them achieve their stated goals. Case management for patients with substance use disorders (SUDs) has been found to be effective because it helps them stay in treatment and recovery. Also, by concurrently addressing other needs, it allows patients to focus on SUD treatment. The types of settings offering SUD case management include specialty treatment programs, federally qualified health centers, rural health centers, community mental health centers, veterans' health programs, and integrated primary care practices.

This *Advisory* is based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Improvement Protocol (TIP) 27, *Comprehensive Case Management for Substance Abuse Treatment*. It surveys the underlying principles and models of case management, discusses reasons SUD treatment providers might consider implementing or expanding the use of case management, and lists some case management-related resources and tools.

Key Messages

- Case management is framed around screening to identify a patient's medical, psychosocial, behavioral, and functional needs, and then working directly and/or through community resources to address these needs while the SUD is treated.
- Case management is increasingly used to support treatment engagement and retention while reducing the impact of SUDs on the community.
- The SUD treatment program can select a case management model that matches its treatment approach and best suits its patients and the service setting.
- In any type of case management model employed, all care team members should contribute to and endorse the patient's treatment plan, and effectively communicate with each other as the plan is implemented.

Case Management Overview

The percentage of U.S. SUD treatment programs using case management has risen since 2000, from 66 percent of the 13,418 facilities then in operation to 83 percent of the 15,961 facilities operating in 2019 (SAMHSA, 2020c; SAMHSA, Office of Applied Studies, 2002).

[1]This publication uses only the term "patients" to describe recipients or potential recipients of case management services. In practice, depending on the setting and the context, the terms "clients" or "participants" are also frequently used.

Definitive statements about the overall effectiveness of case management cannot be made, because studies vary in their definitions of the term, methodology, study populations, intervention designs, and outcome measures. However, multiple analyses (Joo & Huber, 2015; Kirk et al., 2013; Penzenstadler et al., 2017; Rapp et al., 2014; Regis et al., 2020) have found positive outcomes for one or more measures, such as treatment adherence, overall functioning, costs, decreases in substance use, reductions in acute care episodes, and increased engagement in nonacute services. A 2019 meta-analysis comparing case management with treatment as usual showed a small yet statistically significant positive effect, which was greater for treatment-related tasks than for personal functioning outcomes such as improved health status and family relations and reductions in substance use and legal involvement (Vanderplasschen et al., 2019).

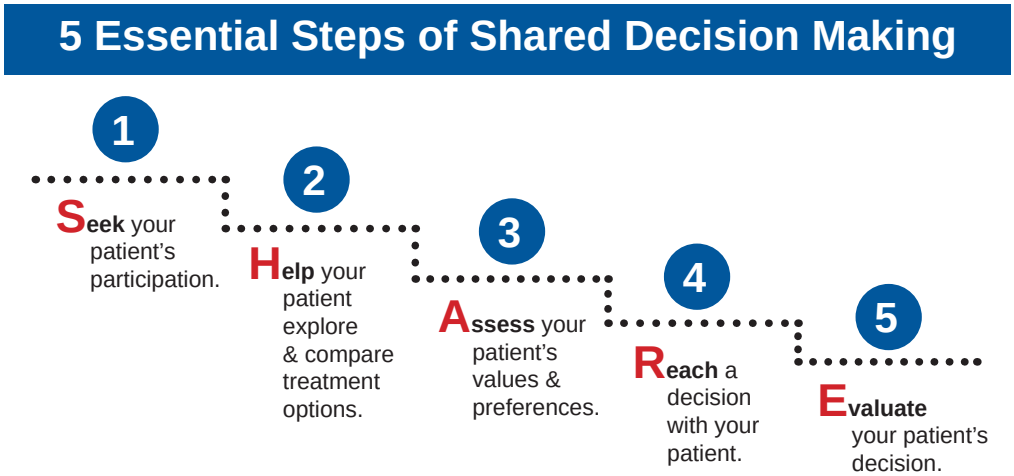
Principles of case management

It offers the patient a single point of contact with the health and social services system. The case manager assumes responsibility for coordinating the care of patients who receive services from multiple agencies. This replaces a haphazard process of referrals with a single, more well structured service.

It is patient centered. Each patient's right to self-determination is emphasized. The case manager is familiar with the patient's experiences and world, and uses this understanding to identify psychosocial stressors and anticipate needs. The case manager works with the patient to set reasonable goals (see box) and helps the patient access the chosen services.

Shared Decision Making

One aspect of patient-centered care is using shared decision making rather than a directive approach with patients. Shared decision making is an emerging best practice that "aims to help people in treatment and recovery have informed, meaningful, and collaborative discussions with providers" (SAMHSA, 2020d) about the behavioral healthcare services they receive. The federal Agency for Healthcare Research and Quality (AHRQ) has developed a five-step process for shared decision making and resources for implementing it.



Adapted from material in the public domain.

It is community based. The case manager helps the patient access and integrate formalized and informal care services, overcome barriers to services, and transition between services. Case managers vary in how much they are directly involved with community services (e.g., whether they make warm handoffs or accompany patients to meetings).

It is equity driven. Typically, the case manager begins by addressing a patient's urgent and tangible needs, such as stable and safe housing, food, child care, or income. The case manager does this work recognizing that when viewed through a social determinants of health (SDOH) lens (see box), some populations disproportionately lack such life-enhancing resources—and that for some patients, access to one or more of these resources may be a prerequisite for focusing on treatment.

> ***Social Determinants of Health***
>
> SDOH have been defined as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (U.S. Department of Health and Human Services, n.d.), including risk for substance misuse and related health consequences (Office of the Surgeon General, 2016). Case managers can play a central role in assessing SDOH and in assisting to develop a plan that effectively takes them into account (Fink-Samnick, 2018).

It involves advocacy. The case manager promotes the patient's best interests. This can include educating service providers, negotiating for services, and recommending actions (e.g., using sanctions instead of jail time for patients involved with the justice system). Advocacy can also involve speaking out and acting on behalf of a patient who is refused services (e.g., because of discriminatory attitudes toward people with SUDs) or who requires assistance with meeting basic needs.

It is culturally sensitive and nonstigmatizing. The case manager is knowledgeable and nonjudgmental about the patient's culture. This enables the case manager to effectively connect with the patient and service providers in the patient's community. Another key function of the case manager is to model nonstigmatizing language, attitudes, and actions for other service providers (Volkow, 2020).

It is pragmatic. The case manager may also teach skills helpful to recovery (e.g., assertive communication, collaboration with a team of providers, day-to-day skills for living in the community). These pragmatic skills may be taught explicitly, or simply modeled during interactions between the case manager and client.

Care management versus case management

"Care management" refers to services that help a patient manage one or more chronic diseases, such as diabetes or cardiovascular disease. Case management is usually more limited in scope and time commitment (Ahmed, 2016; Centers for Medicare & Medicaid Services, 2019). For example, a case manager may be involved in a patient's care for only one or a few specific needs, such as transportation to treatment or help in applying for Medicaid (Case Management Society of America, 2020; Treiger, 2020). However, a patient with an SUD may need the kind of sustained help that is more like care management. Assistance from a case manager may be offered along the full continuum of care, and for as long as it benefits the patient.

Models of case management

Variations in the case manager's role are illustrated in the "Models of Case Management" table, which compares four case management models across 11 activities. (See TIP 27, Introduction, pp. 9–11, for descriptions of each model.) Whichever model is used, all members of the care team should contribute to and endorse a shared care plan for the patient, and effectively communicate with each other as the plan is implemented (van Dongen et al., 2016). It is important to note that certification programs exist for case managers, but not all case managers are required to be certified by the relevant authorities (e.g., state Medicaid authorities and/or state mental health authorities).

Models of Case Management				
Primary Case Management Activities	**Broker/Generalist**	**Strengths Perspective**	**Assertive Community Treatment**	**Clinical/ Rehabilitation**
Conducts outreach and case finding	Not usually	Depends on agency mission & structure	Depends on agency mission & structure	Depends on agency mission & structure
Provides assessment and ongoing reassessment	Specific to immediate resource acquisition needs	Strengths-based; applicable to any of a patient's life areas	Broad-based; part of a comprehensive (biopsychosocial) assessment	Broad-based; part of a comprehensive (biopsychosocial) assessment
Assists in goal planning	Generally brief; related to acquiring resources, possibly informal	Patient-centered; teaches how to set goals and objectives; goals may include any of a patient's life areas	Comprehensive; goals may include any of a patient's life areas	Comprehensive; goals may include any of a patient's life areas
Makes referrals to needed resources	Initiates contact, or patient may contact on own	Contacts resource or accompanies a patient, or patient may contact on own	Multiple resources, as needed, are integrated into a broad package of case management services	Contacts resource or accompanies a patient, or patient may contact on own
Monitors referrals	Makes follow-up checks	Closely involved in ongoing relationship between patient and resource	Closely involved in ongoing relationship between patient and resource	Closely involved in ongoing relationship between patient and resource
Provides therapeutic services beyond resource acquisition (e.g., therapy, skills teaching)	Provides referral to other sources for these services if requested	Usually limited to answering patient questions about treatment, helping identify strengths and self-help resources	Provides many services within a unified package of treatment/case management services	Provides therapeutic activities central to the model
Helps develop informal support systems	No	Develops informal resources—neighbors, places of worship, family—a key principle of the model	Through implementation of drop-in centers and shelters	Stresses family & mutual-help support via therapeutic activities

continued on next page

***Models of Case Management* (continued)**				
Primary Case Management Activities	**Broker/Generalist**	**Strengths Perspective**	**Assertive Community Treatment**	**Clinical/ Rehabilitation**
Responds to crises	Responds to crises related to resource needs such as housing	Responds to crises related to mental health and resource needs; active in stabilization and then referral	Responds to crises related to mental health and resource needs; active in stabilization and then referral	Responds to crises related to mental health and resource needs; stabilizes situation, provides further therapeutic intervention
Engages in advocacy on behalf of individual patients	Usually only at level of line staff	Assertively advocates for patients' needs with multiple systems, including agencies, families, legal systems, and legislative bodies	Assertively advocates for patients' needs with multiple systems, including agencies, families, legal systems, and legislative bodies	Assertively advocates for patients' needs with multiple systems, including agencies, families, legal systems, and legislative bodies
Engages in advocacy in support of resource development	Not usually	Usually in the context of specific patient needs	Advocates for needed resources or may create resources	Usually in the context of specific patient needs
Provides direct services related to resource acquisition (e.g., drop-in center, employment counseling)	Provides referral to resources that provide direct services	Helps prepare patient to acquire resources (e.g., by role-playing, accompanying patient to interviews)	Provides many direct services within a unified package of treatment/case management	Provides services that are part of a rehabilitation services plan; offers skill teaching
Adapted from TIP 27, Figure 1-2, pp. 7–8.				

Factors Underlying the Increased Use of Case Management for Patients With SUD

Reasons behind the increasing use of case managers in SUD treatment programs include the following:

Many patients with SUDs have co-occurring mental disorders and comorbid conditions that providers recognize need concurrent treatment. For example, in 2019, an estimated 49 percent of adults with an SUD also suffered a co-occurring mental illness, and of these individuals an estimated 38 percent had a serious mental illness (SAMHSA, 2020b). Common comorbid diseases include cardiovascular disease, hepatitis, and HIV/AIDS (National Institute on Drug Abuse, 2020). The services of a case manager become especially important for patients with an SUD who must navigate complex health systems to obtain treatment for all their psychiatric and medical care needs or who must adhere to

a medication regimen that may involve multiple prescriptions from one or more care providers. In such an instance, the case manager must be familiar with the patient's full medication regimen (National Council for Behavioral Health, 2020).

Programs increasingly recognize that helping patients address basic needs, as determined by a comprehensive SDOH assessment, is essential to treatment (American Public Health Association, 2014). For example, based on needs identified in the comprehensive SDOH assessment, case managers may help patients apply for Medicare, obtain transportation vouchers, or receive housing assistance so that they are better positioned to engage in and benefit from treatment. (See Chapter 5 of TIP 27 for strategies on assisting special needs populations.)

The rate of acute health crises related to drug use continues to increase. Since 1999, U.S. deaths from opioid, other drug, and polysubstance use have trended upward (Centers for Disease Control and Prevention [CDC], 2019), increasing by 10 percent from March 2019 to March 2020 (Ahmad et al., 2020). The numbers of nonfatal overdoses, hospitalizations, and emergency department visits have also increased considerably (AHRQ, 2019, 2020; Vivolo-Kantor et al., 2020; Weiss et al., 2017). For people who enter the health system through emergency services for an SUD-related crisis, case managers can help access follow-up services and care (Sortedahl et al., 2018). For example, a hospital case manager can help coordinate a drug transition plan for a patient with pain seen in the emergency department for prescription opioid overdose. Often, peer recovery support specialists are embedded in these medical settings to help assist with the initial case management needs of patients with an SUD. These specialists have lived experience with recovery and are trained to help patients with SUDs engage in treatment and enter long-term recovery.

Multiple developments in healthcare and behavioral health services are expanding the use of case management (Ahmed, 2016). These include:

- More emphasis on medical and behavioral health integration, which creates a need for coordination of services—a need that case managers can fulfill.
- Greater use of screening, brief intervention, and referral to treatment (SBIRT) tools in care settings, which can involve case managers in implementation, follow-up, and coordination of care.
- Growing adoption of reimbursement for chronic care management and value-based care by Medicare and other insurers; case managers may be involved in monitoring, measuring, and evaluating outcomes achieved by the care team (Tahan et al., 2020).
- The development of health information technology solutions that facilitate care coordination and patient-centered care.
- Increased use of peer recovery support specialists, who can cost effectively extend the services of case managers by guiding people in SUD treatment on their journey through recovery-oriented systems of care (prevention, intervention, treatment, posttreatment).
- Recent changes to the federal regulations governing the confidentiality of SUD patient records that make it easier to use information in such records for case management and care coordination activities (SAMHSA, 2020a).
- The movement of health systems toward a population-based approach to behavioral health care and a systems-wide focus on health equity, cultural competence, and cultural responsiveness. Case managers may participate in community health assessments (CDC, n.d.), and they may also help educate the treatment team about how addressing SDOH can contribute to greater health equity and therefore better health.

Case management services can benefit the individual who needs short-term help in connecting to SUD treatment, or some specific ancillary service that facilitates access to treatment (e.g., transportation, child care). However, case management is especially helpful for people with complex or chronic health and social services needs. Ideally, case management supports the philosophy of "no wrong door." This means that however people enter the healthcare and social services system (whether through the emergency department, a law enforcement encounter, hospitalization, a prevention program, an initial visit to a treatment program, a primary care visit, a shelter stay, or some other entry point), a case manager links them with the range of services they want or need.

Resources

- **Substance Abuse and Mental Health Services Administration (SAMHSA)**
  - Addiction Technology Transfer Center (ATTC) Network Anti-Stigma Toolkit: Guide to Reducing Addiction-Related Stigma
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT) Tools
  - Technical Assistance Publication (TAP) 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*
  - TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (see also the Editor's Note on TIP 27)
  - TIP 59, *Improving Cultural Competence*
- **American Case Management Association (ACMA)**
- **Case Management Society of America (CMSA)**
- **Integrated Communities Care Management Toolkit**
- **National Association of Community Health Centers**
  - Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- **National Institute on Drug Abuse (NIDA)**
  - Words Matter: Terms to Use and Avoid When Talking About Addiction
- **Pair of ACEs Tree**
- **SIREN (Social Interventions Research & Evaluation Network) Resources**
- **2·1·1 Social Services Database**
- **Think Cultural Health**

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SAMHSA ADVISORY

Acknowledgments: This *Advisory* was written and produced under contract number 283-17-4901 by the Knowledge Application Program (KAP) for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Dr. Robert Baillieu served as Product Champion, and Suzanne Wise served as the Contracting Officer's Representative (COR).

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Recommended Citation: Substance Abuse and Mental Health Services Administration. (2021). Comprehensive Case Management for Substance Use Disorder Treatment. *Advisory.*

Publication No. PEP20-02-02-013
Published 2021

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Best practice guide

Telehealth for behavioral health care

Tele-treatment for substance use disorders

Substance use disorders impact a significant number of individuals, families, and communities.

When used in combination with other treatment methods, telebehavioral health interventions can be part of an integrated approach to treating substance use disorders. These interventions can include screening and diagnosis, online counseling, consults for prescriptions, and individual and group talk therapy. Treating substance use disorders via telehealth requires expertise and training in addiction care.

Benefits of substance use disorder tele-treatment

- **Shorter wait times.** This means faster access to care and prescriptions.
- **Increased privacy.** Patients can get care from their home without going to a public place like a clinic.
- **Reduced stigma.** Patients have access to providers who understand substance use disorder and are not judgmental.
- **Continuity of care.** Patients can continue treatment with their regular therapist or provider while receiving at home or in-person treatment.
- **Home environment.** Providers get more insight into the patient's condition by observing the patient's home or where they live.
- **Digital tools.** Apps and text messaging can supplement treatment plans by providing immediate support to cope with low-grade cravings.

Considerations for telehealth substance use treatment

- **Use SBIRT.** SBIRT stands for "screening, brief intervention, and referral to treatment," and is a common way to assess a patient's needs to determine and, if necessary, refer the patient for treatment for a substance use disorder.
- **Familiarize yourself with medication-assisted treatment (MAT) and medication for opioid use disorder (MOUD) models.** Medication-assisted treatment is an evidence-based approach that combines behavioral counseling or talk therapy with the use of prescription drugs to curb opioid or alcohol cravings. Medication for opioid use disorder is a treatment approach that focuses on the use of prescription medications without behavioral health therapy to treat patients with an opioid use disorder.
- **Aim for integrated care.** Coordinating primary care with behavioral health increases access and improves care coordination. Integrated care often combines in-person treatment with telehealth.
- **Recognize individuality.** Tailor and integrate your treatment approach to meet the needs and preferences of your patient.
- **Reduce Stigma.** Discrimination and judgment are major barriers to patients seeking treatment. Remember that substance use disorder is a health condition and the words you use and how you communicate with your patient will impact the effectiveness of treatment.
- **Be conscious of language and educational barriers to accessing care.** Offer materials accessible in different formats and multiple languages. Use both images and words in your materials to address different patient literacy levels.
- **Prioritize patient monitoring.** As with any vulnerable patient in your practice, conduct a suicide screen at every contact for those at elevated risk. There are a number of suicide prevention methods that can be used if a patient is at risk of suicide.
- **Review rules and regulations for prescribing controlled substances via telehealth.** Make sure you follow the correct steps and comply with the appropriate laws to prescribe suboxone or other drugs, which are commonly used to treat opioid dependence. Identify vendors and local sites for patient drug testing as needed.
- **Hire support staff.** Some patients with substance use disorder may not have access to a phone or a personal computer. Support staff such as case managers can provide more hands-on help such as calling in prescriptions and connecting patients to treatment centers and social services.
- **Focus on long-term, continued treatment.** Get permission to continue follow-up contact with your patients. Schedule the next session before ending each telehealth appointment, if possible.

More information on telehealth for substance use disorders

- Coalition Webinar - Telehealth and Substance Abuse (video) — from the National Consortium of Telehealth Resource Centers
- Telehealth Models — from the Rural Health Information Hub
- Barriers & Challenges to FQHC Use of Telehealth for Substance Use Disorder (PDF) — from the National Policy Center - Center for Connected Health Policy
- How to Prescribe Controlled Substance to Patient During the COVID-19 Public Health Emergency (PDF) — from the Drug Enforcement Administration
- Medication Assisted Treatment (MAT) and TeleMAT Standards — from the Mid-Atlantic Telehealth Resource Center

Spotlight

University of Maryland, Baltimore Mobile-Care-Unit

The University of Maryland, Baltimore's Department of Psychiatry developed an RV mobile-care-unit. It provides mental health and substance abuse services to underserved and remote communities in and around eastern Maryland. The unit serves 15 to 30 patients a day and focuses on medication-assisted-treatment delivered in person and via telemedicine. To reduce barriers to care, the unit accepts walk-in patients and travels to different locations each week to reach patients who may not have access to reliable transportation. Read more on the University of Maryland, Baltimore's Mobile-Care-Unit.

Last updated: December 7, 2022

THE CASE FOR BEHAVIORAL HEALTH SCREENING IN HIV CARE SETTINGS

SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Substance Abuse and Mental Health Services Administration
SAMHSA

HRSA
Health Resources & Services Administration

integration.samhsa.gov

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

ACKNOWLEGEMENTS

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA) by the National Council for Behavioral Health under contract number HHSS283201200031I, with SAMHSA, U.S. Department of Health and Human Services (HHS). Tenly Pau Biggs served as the Government Project Officer.

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RECOMMENDED CITATION

Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration, *The Case for Behavioral Health Screening in HIV Care Settings*. HHS Publication No. SMA-16-4999. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.

ORIGINATING OFFICE

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857. HHS Publication No. SMA-16-4999. 2016.

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 lifestyle 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 behavioral 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 population. 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] Specifically, 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 likelihood 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 population.[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, including 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:

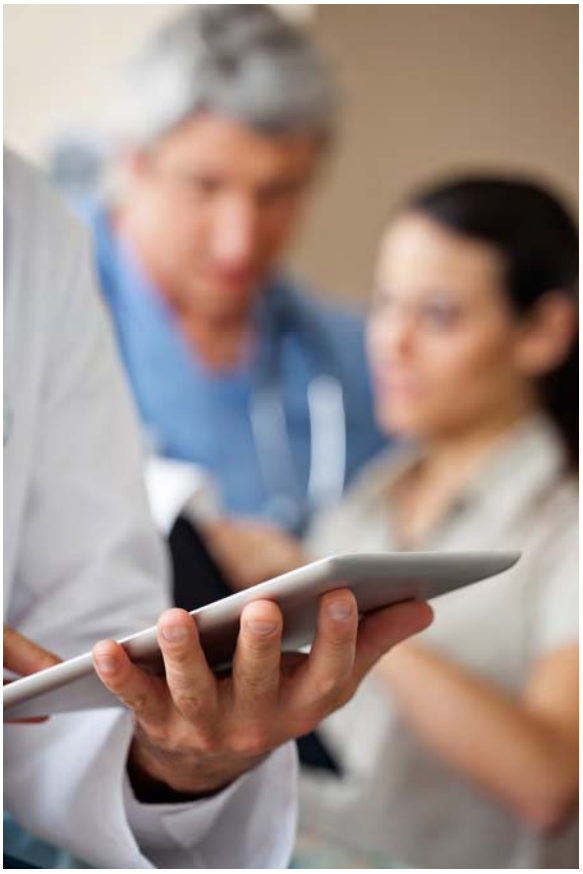
1. **Screening —** A health care professional assesses a person for risky substance use behaviors through standardized screening tools.

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 handoff" 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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SPECIAL THANKS

SAMHSA and HRSA would like to thank the following people for their assistance in the preparation of this document:

- Advocates for Human Potential, Inc., Fran Basche
- AIDS Arms, Inc., Dallas, TX
- Baystate Health, Brightwood Health Center, Springfield, MA
- Fenway Health, Boston, MA
- Health Care Center for the Homeless, Orlando, FL
- Integrated STI/HIV/Viral Hepatitis Care and Prevention Program, Colorado Department of Public Health and Environment, Denver, CO
- Montefiore Medical Group, Bronx, NY
- Tarzana Treatment Centers, Inc. Los Angeles, CA

HHS Publication No. SMA 16-4999