Integrating Behavioral Health into Primary HIV Care — Covering the Bases

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Objectives

1. Explain the World Health Organization's Optimal Mix of Services: Pyramid Framework continuum of behavioral health severity and needed support.
2. Describe the benefits of using a multidisciplinary approach to addressing behavioral health in HIV primary care clinics.
3. Describe the six steps recommended for integration of behavioral health into HIV primary care clinics.

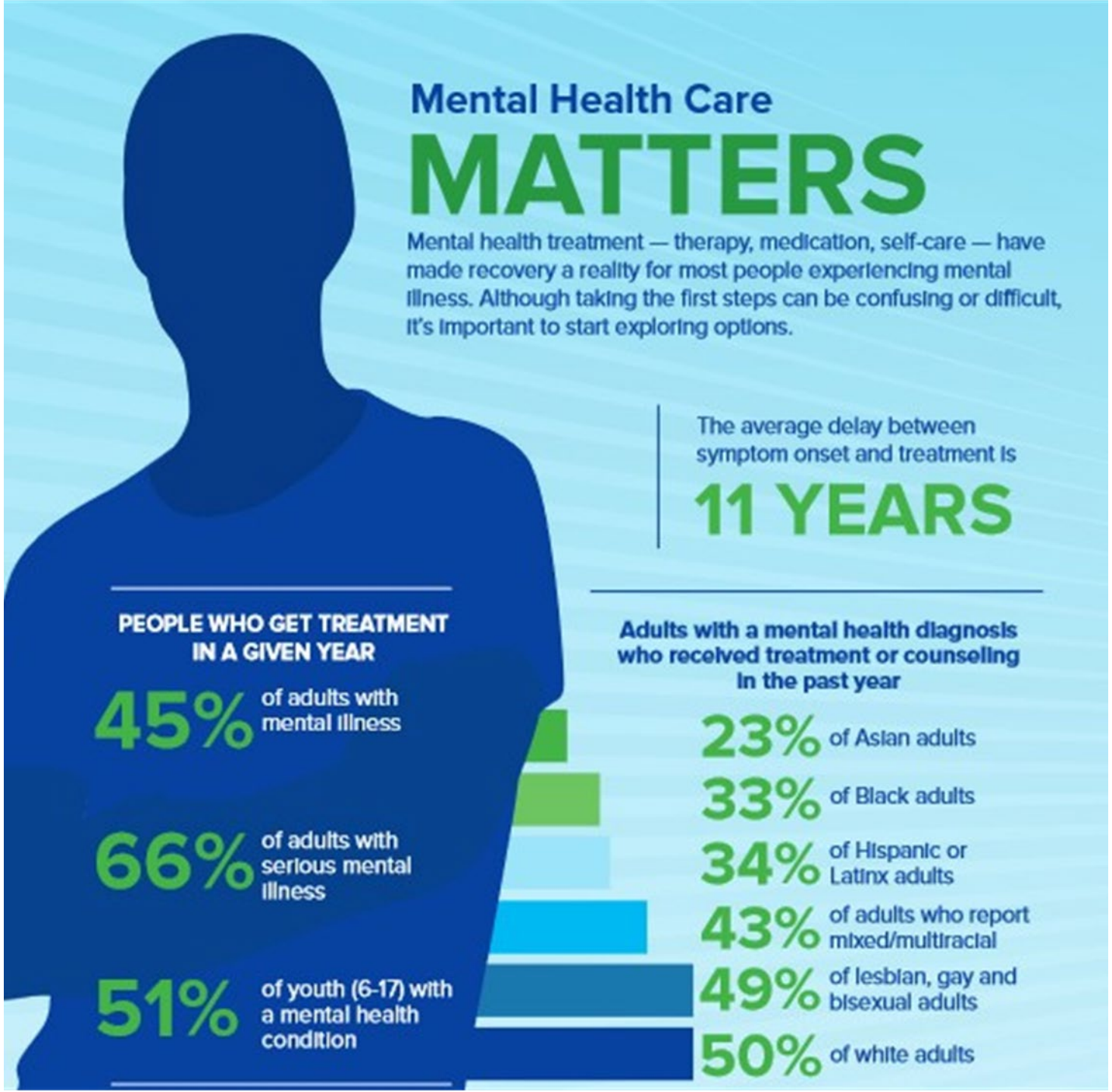
AETC HIV Comorbidity Community of Practice

- The AIDS Education & Training Center National Coordinating Resource Center (AETC NCRC) has facilitated a community of practice (CoP) of AETC Program healthcare experts on HIV and HIV comorbidities since 2019.
- For the 2020 – 2021 fiscal year, the topic of behavioral health (BH) was selected as the comorbidity of focus
- The CoP members were divided into two subcommittees:
  - Development of a manuscript on the multidisciplinary need and roles of HIV service care providers in providing BH services
  - Development of a tool to be used by HIV care service teams to use for integrating BH care into primary HIV care services

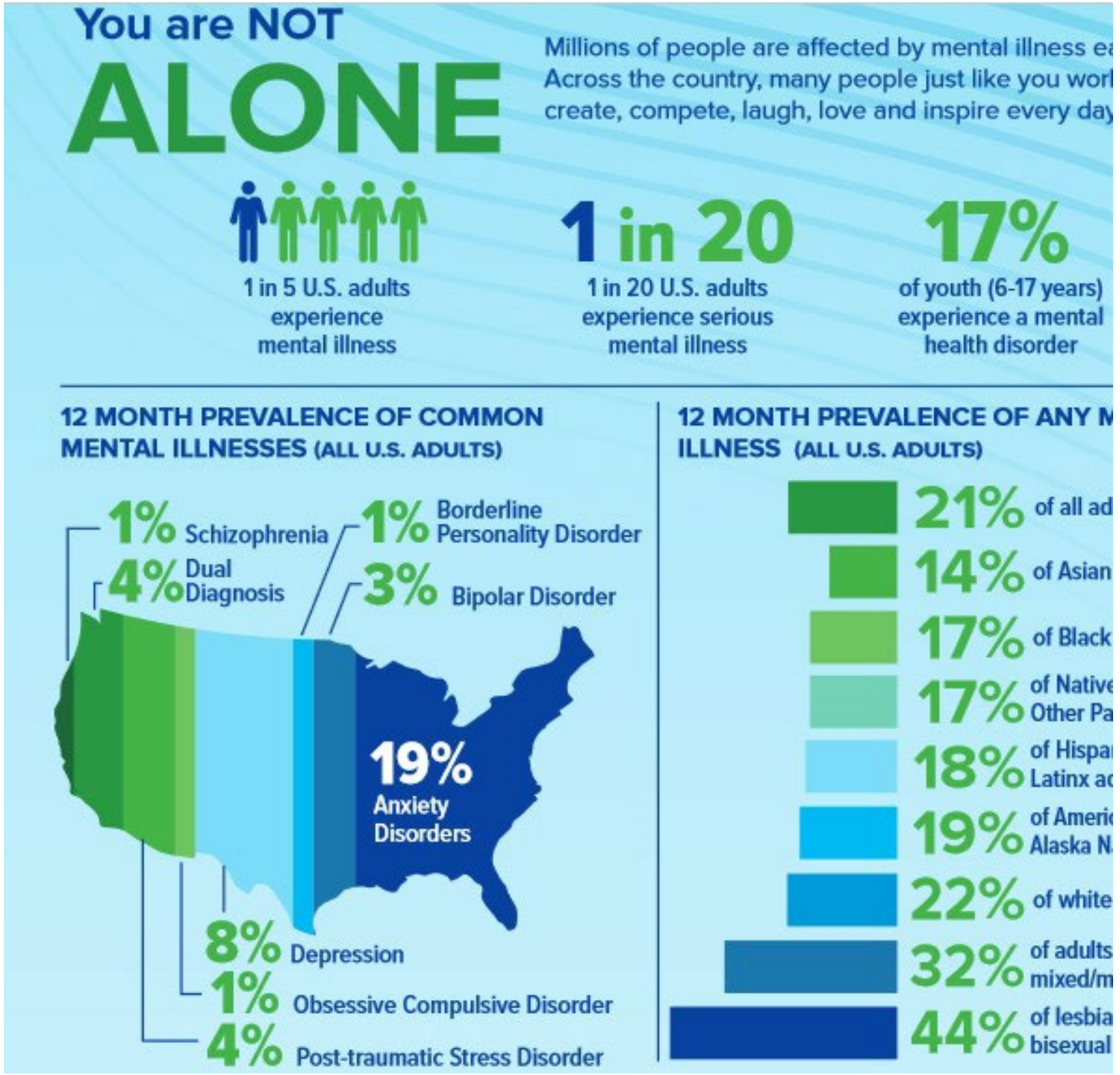
BH Tool Subcommittee Members

- Jennifer Burdge, MEd – Director, Southeast AETC
- Carolyn Chu, MD, MSc – Principal Investigator, National Clinician Consultation Center
- Karen McKinnon, MA – Director, Columbia HIV BH Training Project, Northeast/Caribbean AETC
- John Nelson, PhD, CPNP – Director, AETC NCRC
- Vanessa Carson-Sasso, MSW – Director, New England AETC
- Laurie Sylla, MHSA – Director, Mountain West AETC

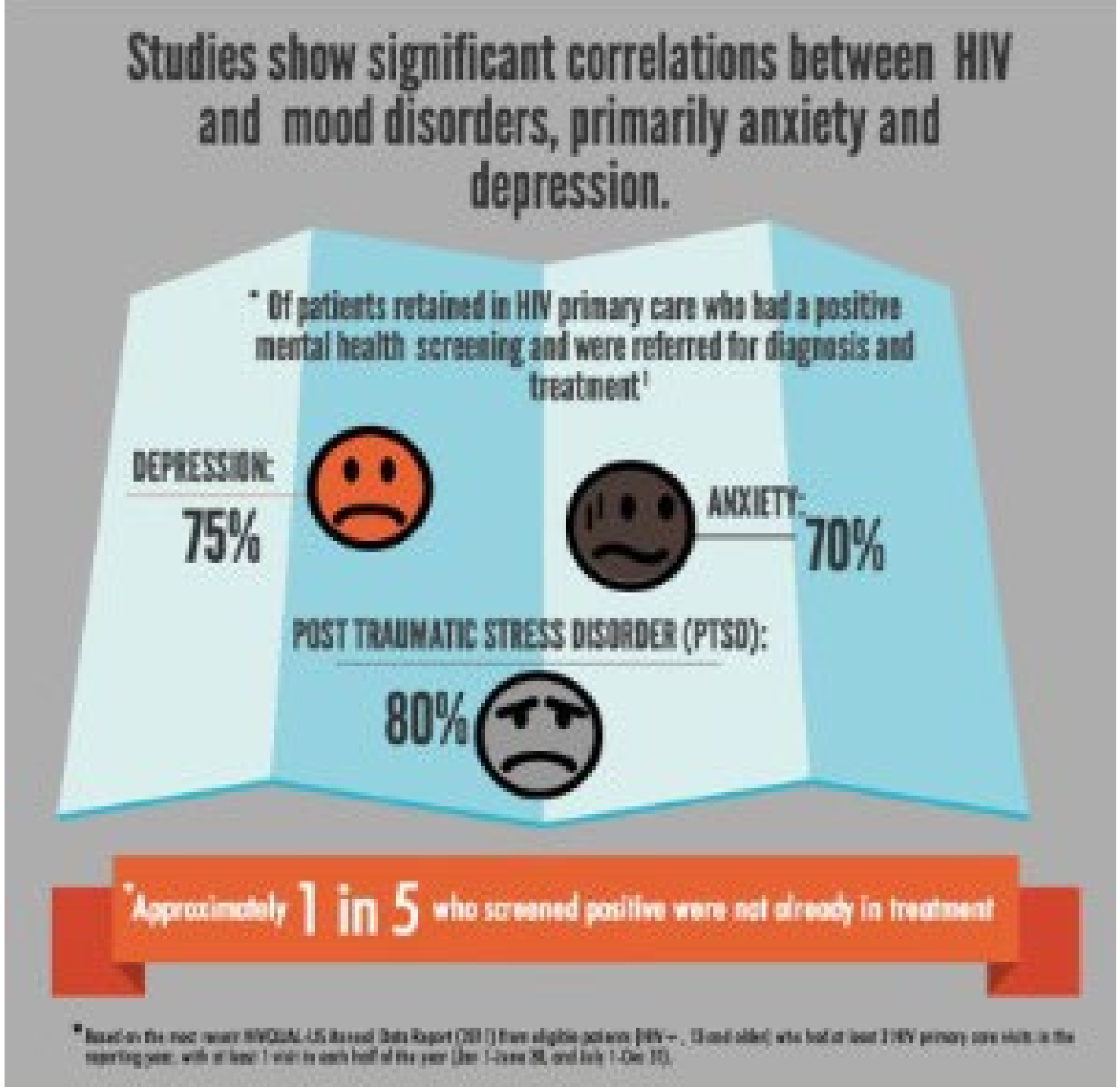
Mental Health Matters, National Alliance of Mental Illness (NAMI) Infographic



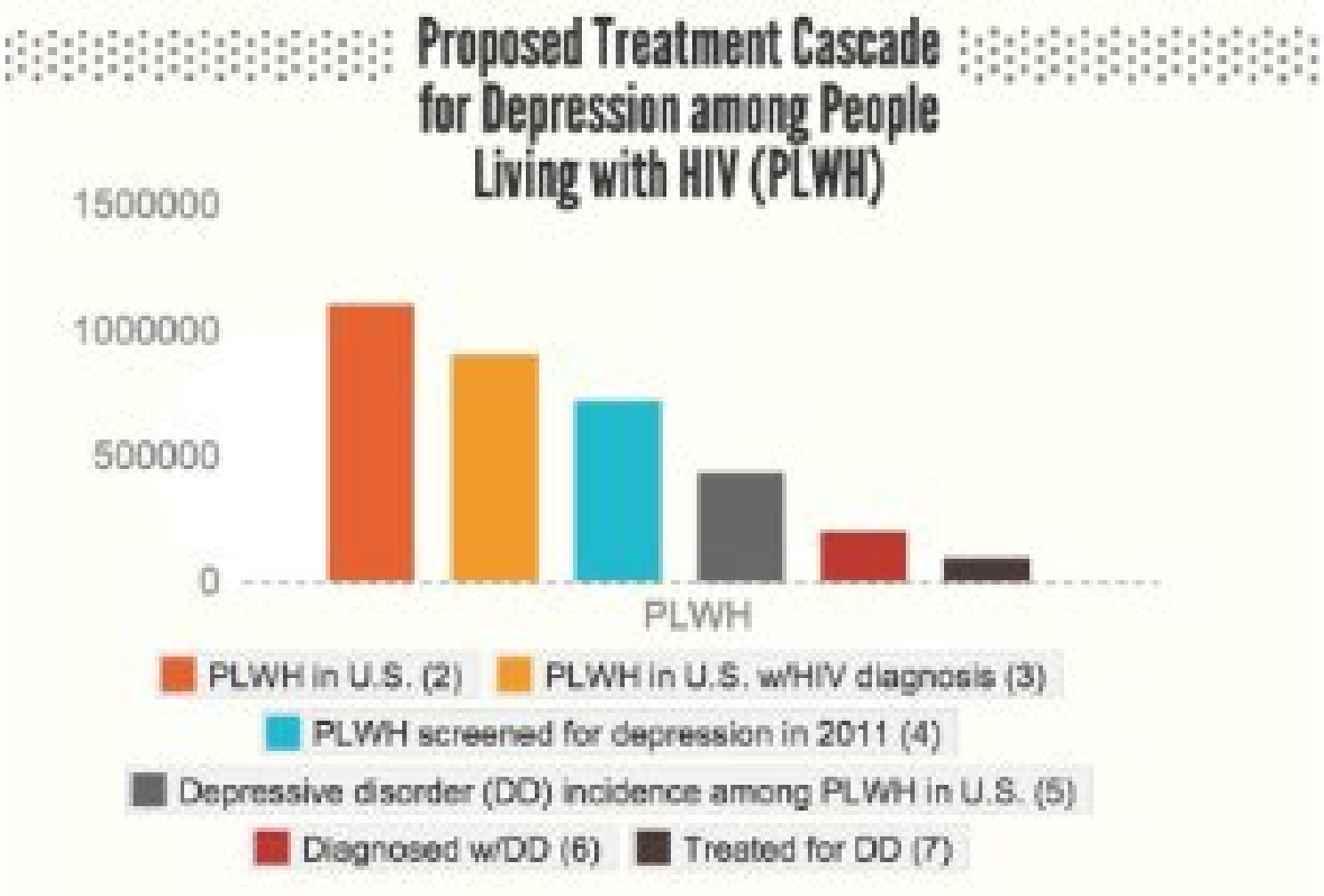
You are Not Alone: National Alliance of Mental Illness (NAMI)



AETC Program Infographic, 2014



AETC Program Mental Health Care Continuum for PWH, 2014



Services Needed

World Health Organization, 2007. The optimal mix of services. Mental health policy, planning, and service development information sheet.

Purpose

- Mental health and substance use disorders are highly prevalent among people with and at risk for HIV.
- This tool was designed to assist HIV primary care teams in a range of clinical settings to plan and carry out enhanced integration of mental health and substance use services, referred to as behavioral health (BH). Just as there is a well-known HIV care continuum, there is a BH continuum which consists of screening and diagnosis, referral and linkage, and treatment. This tool will guide you to createworkflowsandotherprocessesinwhichresponsibilityforthekeycontinuumstepsisdelineated.
- Resourcesforhowto implement these steps are provided in the last section of the tool and include considerations for both BH specialty services for people with BH disorders as well as community-based and informal services that support people with sub-threshold BH disorder signs and symptoms.

Overall Operating Considerations - 1

- The client presents to the primary HIV care clinic team for either routine HIV care (initial or follow-up) or for an acute care issue. This may be an in-person or telehealth visit.
- For non-acute care visits, a screening process is in place to routinize BH (mental health and substance use) questions and to destigmatize conversations about BH. Although a similar stance is important for laboratory or immunization-only visits, BH screening is not typically feasible during these appointments.
- For clients who "screen positive" or whose scores fall within a range of concern, a process is in place to get clients to the "next step" of a behavioral health evaluation.
- For acute-care and non-acute care visits with identifiable BH concerns (e.g., changes in mood or thought content that significantly affect day-to-day functioning, self-harming behaviors or urges, suicidal ideation, substance use, etc.), a process is in place to get clients to the "next step" of a BH evaluation.

Overall Operating Considerations - 2

- For each step, designated clinical care team members serve as facilitators to make sure the next step is taken.
- Are your HIV and/or primary care clinic space(s) and processes (in-person and virtual) "welcoming" to clients with a range of cultural meanings about BH and BH literacy[1]? (i.e., accessibility of posters, pamphlets, videos/TV and how successfully they communicate BH concepts with all clients)
- Closed-loop communication, transparency, and oversight between each "step". A designated, skilled person (often an RN, LPN, MA, case manager, patient navigator) is helpful to support smooth transitions from one step to the next.
- Once a BH evaluation is completed and a plan developed in collaboration with the client and put into place, coordinated communications continue in a systematic way to prevent the client from falling out of recommended care, to continually check in with clients about their readiness for recommended BH care they have not yet initiated, and/or for making changes to the BH treatment plan that all HIV or primary care clinic team members need to 1. National Academies of Sciences, Engineering, and Medicine 2016. Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change.

[1]Washington, DC: The National Academies Press. Ending Discrimination Against People with Mental and Substance Use Disorders - The Evidence for Stigma Change. https://doi.org/10.17226/23442

Clinic Entry

- Does accessing the clinic feel safe and unthreatening to clients?
- Are clients asked for the name and pronoun(s) they go by? How are the name and pronoun(s) communicated to other clinical staff? Are intake/registration questions inclusive of gender non-binary individuals? Do all staff consistently use the name and pronoun(s) chosen by the client?
- Is there a clear understanding of the clinic intake process, including BH as part of whole-person care, and is this information shared with new clients in a manner that effectively orients them to this clinic?
- Is there a way for clients with anxiety, restlessness, intoxication, or other possible signs of acute BH needs to be allowed to wait in a different space (i.e., private exam room, other safe area) rather than the general waiting area with others?
- Is there clear process for HIV or primary care clinic team members to follow for de-escalating agitated clients, including those with thought disorder symptoms?
- Does the waiting room have information that routinizes behavioral health screening and evaluations? (i.e., https://1in4.info campaign matierals)

Telehealth Visits for Behavioral Health

- Do staff have telehealth capacity (devices, platforms, skills) to communicate virtually with clients (secure messaging, live streaming video and device microphone, telephone communication)?
- Do clients have telehealth utilization capacity? If not, which ones do not? If yes, where will the client be during virtual sessions? In a secure, confidential setting (alone in a closed-door room, or in an environment where others may be able to hear the conversation)? Outside or in a community setting?
- Is it clear to the client that the provider/clinical staff member is not setting that would compromise client confidentiality? It may be helpful to scan the provider's room with the webcam to show the client who is present. If not, is it clear that no identifying information will be verbally disclosed by the provider/clinical staff member during the telehealth visit?
- What is the best way to reach the person being treated if the telehealth communication stops or is disrupted before finishing the visit?
- Is there a clear process for provider/clinical staff team members to follow if there is a safety issue and a client is at risk of harm to self or others?

Behavioral Health Screening

- Are validated screening tools (e.g., PHQ-9, GAD-7, PC-PTSD-5, TICS, TAPS) routinely used and workflow for who/when/how often to administer them (e.g. administered annually or semi-annually and as needed) in place? (i.e., https://www.hiv.uw.edu/page/mental-health-screening/gad-2; https://www.drugabuse.gov/taps/#/)
- How are clients screened (e.g. a kiosk in the waiting room that connects to the electronic health record (HER); paper form; an HER-connected portal app for self-administration; an audio, computer-assisted administration; HIV or primary care clinic team member administers) and is the screening done in a private setting?
- If self-administered by clients, are language and literacy accounted for when results are shared with the client?

Behavioral Health Screening (Continued)

- Are results of the screening tool seen by the client and designated HIV or primary care clinic team member(s)? Based on the screening tool score and/or client questions or comments/behaviors, how is BH information communicated to the HIV or primary care providers and/or designated BH team member for further evaluation?
- What processes are in place for reporting observed findings suggestive of BH concern (e.g., front desk or triage nurse notices signs of acute BH need) by staff members to designated HIV or primary care clinic team member(s) for quicker intervention as needed?
- Are there HIV or primary care team member(s) designated to oversee transition to the next step for clients with a “positive screen” or clinical indicators of BH concern?

Behavioral Health Diagnosis and Treatment

- Are diagnoses documented? Who on the HIV or primary care team has access to this information?
- Is a client-centered, evidence-based treatment plan developed and documented?
- Are treatment option(s) that are available and accessible (in-clinic; same organization but different site; off-site or community-based) to the client clearly communicated to the client?
- What structures are in place to assure that communication occurs at routine intervals between all HIV or primary care clinic team members (BH and non-BH) for support and consistency in implementation of treatment plan?
- Does the follow-up plan encompass client engagement in the treatment plan? If medication was prescribed, did the client get the medication, did they start it, are they taking as prescribed, are they experiencing side effects, do they understand it may take a few weeks before medication effect is noticeable, how are they feeling in general, do they have someone who knows what they are going through right now, etc.? If a referral is made to a BH therapist who is not part of the HIV or primary care clinic, does the client have an appointment, has the client met with the therapist (in-person or telehealth) and if so, what is the follow-up plan?
- Does the client have an individualized crisis plan? If yes, does the client have a copy and is the plan documented in the chart?

Behavioral Health Evaluation

- Is the BH evaluation conducted by one or more BH specialists (e.g., LCSW, psychologist, mental health nurse practitioner or clinical nurse specialist, psychiatrist).
- If more than one BH provider is involved, is communication between BH providers occurring consistently and documented?
- How much patient/client voice is incorporated into the treatment plan?
- Are diagnosis and treatment plan documents shared with the patient/client?
- Are next steps and the treatment plan shared among BH and/or HIV or primary care team members?
- Who is the designated team member for coordinating the next steps (setting follow-up appointments, completing off-site therapist appointments, seeing off-site psychiatrist, arranging for transportation as needed, providing ongoing emotional support, etc.)? Does everyone on the team know whose responsibility this is?

Warm Off-Site Referrals

- Does the client agree with the plan for off-site BH service(s)?
- Does the HIV or primary care clinic take responsibility for making the off-site appointment and sharing insurance information with the client and the referral site? Whose responsibility is it to make the appointment and assure the client is prepared with what they need?
- What information on BH services location, practices, and contact information and on ways to access crisis support if needed before first appointment (i.e., needs to reschedule or BH symptoms escalating out of control) is provided to the client?
- What arrangements are made for support services to assist in completing scheduled appointment(s)– i.e., transportation to and from appointment; the HIV or primary care clinic patient navigator (if available) offers to escort?
- If BH medications are prescribed, have the options for mail order vs. in-person pick-up of the medications been provided to the client and the BH therapist (clients may prefer to have mail ordered BH medication if needed along with their HIV-related medications)?
- How will the HIV or primary care clinic team member(s), BH therapist/team and the client stay informed of updates (e.g., BH, HIV, and other medical information release form signed by client and each organization; virtual case conferences or ECHO sessions set-up for monthly updates)?

Key Success Ingredients

- **Welcoming** atmosphere
- Routine BH **screening**
- Everyone knows their **roles/responsibilities**
- Clear, timely **documentation**
- Structures in place for **routinized communication** among team members and with client
- Structures in place for **warm hand-offs** between HIV or primary care team members to external providers

Action Steps

- Work with your clinical team to identify what you are already doing in terms of routine BH awareness, screening, diagnosing, treating, and support - the AETC Program Mental Health Readiness Assessment Tool (https://aidsetc.org/resource/mental-healthsubstance-use-care-clinichealth-center-readiness-assessment-tool) may be helpful
- Once your team has identified what your plan will be for integrating the 6 steps into your clinical care flow, use the Coving the Bases BH Tool to identify who will be responsible for each component along with supervision and back-up
- Identify how you can bring non-stigmatizing BH awareness to your clinic environment – posters, flyers, verbal, written and body language use

Contact

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aidsetc.org/resource/integrating-behavioral-health-primary-HIV-care-covering-bases

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