WEBINAR VIDEO TRANSCRIPT

DHHS / Health Resources and Services Administration (HRSA)

A Trauma-Informed Approach for Integrating HIV Primary Care and Behavioral Health

29 October 2024

ANGEL JOHNSON: Hello, everyone, and welcome to the Integrating Innovative Practices webinar on Replicating Innovative HIV Care strategies in the Ryan White HIV/AIDS Program. Today's webinar features an intervention focused on a trauma-informed approach to integrating HIV primary care and behavioral health services.

I'm Angel Johnson with the MayaTech Corporation, and I'll be moderating this webinar.

Before we meet our presenters, we're going to do a little housekeeping, and go over the webinar logistics and the agenda, and get a brief overview of the SPNS IHIP project from our project director, Shelly Kowalczyk.

Before we hear from our presenters, Shelly will give a brief overview about the SPNS IHIP project. Next, our presenters will talk about their intervention. Following the presentation, we'll take questions. And finally, how to give your feedback on today's presentation. Shelly.

SHELLY KOWALCZYK: Great. Thank you, Angel.

Hi, everyone. Thanks so much for joining today's webinar.

The Integrating HIV Innovative Practices or IHIP project, it was funded through the Ryan White HIV/AIDS program, Part F-- Special Projects of National Significance. And it is administered by HABS Division of Policy and Data.

We do work in partnership with Impact Marketing and Communications on this contract. And the IHIP project really is to support the coordination, replication, and dissemination of innovative HIV care strategies in the Ryan White HIV/AIDS program. And we do that through the development and dissemination of implementation tools and resources.

So the IHIP project does align with the third component of the SPNS framework, as we do focus on developing tools and resources to assist Ryan White and other HIV providers in the replication and integration of innovative strategies. And we also coordinate with the best practices compilation to ensure that our tools and resources that IHIP develops can be accessed through the compilation for any of the interventions that we feature.

So in terms of the type of support that we provide, we do create tools and resources featuring the interventions that are again implemented by Ryan White recipients, subrecipients. This includes intervention implementation guides. We have fact sheets, video spotlights for some of the interventions, as well.

And then we also provide opportunities, such as this webinar today, to provide capacity building technical assistance on our featured interventions facilitated by the interventionists themselves, to talk about their implementation.

And then we support those of you interested in developing and disseminating your own tools and resources. So we provide webinars. Angel will mention one later during the presentation about an upcoming webinar we have in this area. But also if you have any interest in developing your own tools and resources, we can provide that type of assistance. You just need to send an email to ihiphelpdesk@mayatech.com.

And for all of our tools and resources, as well as to sign up for the IHIP e-newsletter to learn about new opportunities, webinars, resources, you can go to TargetHIV.org/IHIP.

Thank you.

ANGEL JOHNSON: Please note that the opinions expressed during this presentation are those of the presenter, and do not necessarily represent the views of the webinar sponsors and planners. And information presented is not meant to serve as a guideline for patient management. Additionally, our presenters have nothing to disclose, and no conflicts of interest.

Let's meet our presenters Mr. Timothy Thompson is a resident of Fort Lauderdale, Florida, and a native Floridian. He is the Senior Program Project Coordinator responsible for developing and overseeing the Part A-funded Clinical Quality of Care program for the Health Care Services section.

Tim has over 15 years of experience in quality management, compliance, behavioral health, and monitoring. His expertise includes managing programs and projects, developing and implementing QI initiatives, monitoring subrecipients, and data analysis. Mr. Thompson holds a master's degree in psychology.

Brianne Miller resides in Fort Lauderdale, Florida, and is a Program Project Coordinator of the Broward County Ryan White Part A program. She utilizes her public health knowledge in program design, evaluation, and data analysis to identify gaps and improve the health outcomes for people living with HIV. As a certified health education specialist, Brianne uses her talents in community organizing to amplify the voices of community members, especially those who are the most underserved.

Welcome, Tim.

TIMOTHY THOMPSON: Thank you very much.

So this is our Primary Care and Behavioral Services Building a Trauma-informed Approach.

As mentioned and introduced, my name is Timothy Thompson. I will be reading a majority of the slides and doing part of the presentation.

Disclaimer. We have nothing to disclose at this moment in time.

So this is the overview of how our presentation is going to go. This original implementation of our trauma-informed integrated primary care and behavioral health approach took place back in 2017 and 2018. A majority of the slides in the beginning of the presentation are going to go over the

implementation process, and how that process went on during those years, where we were just getting off the ground.

A little bit later in the presentation, we're going to talk more about where we're at-- where we are at now, and how far we have come.

So initially, we're going to go over integrated primary care, behavioral health, what it is, and why it is essential. Then we'll talk about integration efforts and the efforts made for the Broward County Ryan White Part A.

We'll talk about revisions. We had to revise service delivery models and standards of care in general. Preparing providers for integrations in this new approach, and assessing and evaluating, which is a majority of what we're doing in the current time frame.

So back in 2016, 2017, this was our original structure. We had the Part A program. We funded primary medical care, we funded mental health services, we funded substance use services, and we funded medical case management.

Today, we also fund medical nutrition therapy. We do fund mental health services for standalone mental health providers, but obviously, for the bulk of primary care, primary care is integrated into mental health services. And we'll talk a little bit more about what that may look for providers who wish to do business with Broward County to serve the HIV population.

So this is a chat question, which I will turn over to Brianne Miller.

BRIANNE MILLER: Awesome. Hi, everyone. Good afternoon.

So our first question is going to be what types of primary care and/or integrated behavioral health services are provided where you work?

So if you could please put your responses in the chat, and we will read them out. And then, of course, we'll give some time for people to respond. But once again, the question is what types of primary care and/or integrated behavioral health services do you currently provide where you work?

And I see a couple coming in.

So Jennifer said mental health, substance use disorder, HIV treatment bridge care.

Kathleen said couple, individual, and family therapy. Again, I see-- Darby says substance use. I see psychiatry.

We have lovely, lovely answers. Outpatient health services, mental health. Referrals. Medical case management. Danielle said school-based mental health services.

We also have substance use services, family-based and community engagement. We see legal, so we see a bunch of stuff. So thank you, everyone, that's answering right now.

And I see some more answers coming in, as well. So I definitely see a theme. We have substance use, we have mental health counseling, Emma says supervised funding across Arizona for behavioral health

services, such as treatment for SUD and mental health within our integrated care system. And that they also can be used for TB and HIV early intervention, so that's really interesting. Thank you.

We also have Mary that's saying primary care and SCI visits, short-term counseling, and referrals. So sounds pretty good, so I'll pass it over back to you, Tim.

TIMOTHY THOMPSON: All right. Thank you so very much for all your responses. Definitely, a theme that we are seeing here.

It should be noted, I didn't say this specifically, but the mental health services we integrated was outpatient mental health services. So we did-- that's what we had, integrated.

And we do have standalone substance use, but we do offer some substance use counseling with integrated model. And seeing as I've seen a lot of responses around SUD, I'll try to highlight that a little later on in the presentation, about the challenges and barriers we face around that. So thank you so very much for all your responses.

So integrated primary care and behavioral health, what is it, and why is it essential? Integrated primary care and behavioral health is the care that results from a practice team of primary care and behavioral health clinicians working together with patients and families, using a systemic and cost effective approach to provide patient-centered care for a defined population.

In Broward County, our outpatient ambulatory providers must provide mental health services in order to contract under that category in Broward County. And that's basically what this model went towards, and you'll hear me reference, this more later on in the presentation.

But the integrated primary care health model is ultimately bridging primary care and mental health where we attempt to reduce stigma, we tend to reduce the cost, multiple appointments, and we'll talk a little bit more about that later on in the presentation.

So we're going to talk about our integration efforts. These are efforts made for the Broward County Part A program. We're going to go ahead and just jump to the next slide.

Our initiative is thoughtfully aligned with the Broward County Commission's Values of delivering human services in a collaborative and compassionate manner, particularly focusing on the most vulnerable populations. One of the key motivations behind this initiative was the need to address unique challenges faced by the specialized population.

Comprehensive, community-driven needs assessments were conducted through Broward County Ryan White system of care networks, and internal work groups have consistently highlighted the need for mental health and primary care. By responding to the assessments, we had aimed to ensure that our services are not only effective, but also, equitable and tailored to meet the specific needs of those that we serve.

So back during this time when we were running our annual needs assessment, mental health kept popping up as a need. And I kept saying, clients/patients at the time were stating, hey, we're having a really hard time accessing mental health. We're having a very difficult time getting to our mental health appointments.

And even when we did it for our providers, providers are saying, we have clients that we're referring for mental health, and they're just not going to their appointments. So we had this disparity, and at the time, we're like, OK, we need to come to a solution, and the solution was the integrated model.

And we are going to do a brief poll, which I will turn this once again over to Brianne to handle the polling questions.

BRIANNE MILLER: Awesome. OK. So you should see a poll that will soon launch in Zoom. So the question is, what would be a benefit of the trauma-informed approach to integrating HIV primary care and behavioral health services? So we have A, improved health outcomes, B, system organization, C, reducing stigma, C, cost effective, or E, all of the above.

So we'll give you some time to put in your answers. And then afterwards, we'll end the poll, and then we'll go over the polling results.

All right. So we have the results of the question. So 5% chose A, which is improved health outcomes, zero chose B, which is system organization, 2% chose reducing stigma, and 94% chose all of the above.

TIMOTHY THOMPSON: And the answer is correct, it is all the above. So we're going to go through these and talk about the benefits of integration.

So integrating primary care and behavioral health within our program offers numerous benefits that significantly enhanced patient care. First, it led to improved health outcomes through coordinated diagnosis and treatment planning, reducing the number of appointments required for patients. This streamlined approach not only increases convenience, but also boosts treatment adherence.

Additionally, by normalizing behavioral health care, we can effectively reduce stigma, ensuring that mental health needs are prioritized and addressed alongside physical health. Moreover, a well-organized system facilitates access to patient records in one central location, minimizing the paperwork burden for both patients and providers. This streamlined communication enhances continuity of care, and it allows providers to focus more on delivering quality services.

Finally, the integration proves to be cost effective by reducing the need for overlapping lab tests and procedures, and leads to fewer ER visits and hospitalizations. Together, these elements create a more efficient and supportive health care environment that significantly improves outcomes for individuals living with HIV.

Later on in the presentation, I have a little bit of data to back up that claim, but at the time, this was the initial thought of the benefits of integration. And we can definitely see that in 2024, most, if not all, of these actually ended up being correct.

So one of the major aspects of this was the being centralized in one location. Remember how I said earlier that you have to offer mental health services in order to contract with Broward County for outpatient ambulatory? The reason being for that is, as mentioned in one of the needs assessments, one of the biggest issues that we saw was the clients getting referred for mental health services and just never going to the appointment.

Well, now we have-- we'll talk more about this later on, but about a warm handoff. So if a client/patient basically stated that they needed mental health services or through the course of their mental health--

or through their medical appointment or through assessment, deemed that mental health was definitely a service that they needed, they would be taken to the mental health professional that day. So there is no scheduling an appointment two, three, four months out, referring to a different agency, and then that agency having to do paperwork all over again.

And oftentimes, what was happening, during this time anyways, is clients or patients were going, if they did go to the mental health appointment, they would have to do all the paperwork again, and they'd walk out, because they didn't want to be bothered with paperwork that they had already filled out.

So all that being offered on site increased adherence to the appointments. And because it was being discussed by a medical professional on site, it made it easier to reduce stigma. Let them know that mental health it's perfectly normal to get assessments and get treatment for it.

Patient records are all in one place, so it was easier for a mental health services to talk to the primary care physician. So there was a feedback loop because it was all at the same agency, and it was all kept in the EHR and also in our system, which Provide Enterprise.

They didn't have to rerun labs because they were getting the labs done at the medical appointment, and the mental health provider had access to those labs. And it reduced a lot of burden on the patient, and it actually became extremely cost effective because we weren't having to pay for the same test results multiple times. We weren't having to pay for the same assessment multiple times.

So integration effort process, this isn't necessarily steps. These are, but if you notice the bars, it says one, two, three, and then it goes to five, and then it goes all the way to seven. This is effort. This is what we believed how much effort was having to be involved. So as you decide if you want to bring integration back to your system, understand that at least for us in Broward County, this is what we identified as requiring the most effort.

The integration effort, it evolved as a systemic approach designed to ensure effective delivery of combined primary care and behavioral health services. In redefining services, it was to align the comprehensive needs of our patient population, ensuring that both physical and mental health were prioritized, and then in identifying the need, we had to analyze current service gaps, and understanding the specific challenges faced by individuals living with HIV. And then we also had to establish standards of care to create clear guidelines and promote best practices to ensure consistent quality across all providers.

At the time, and this will be referenced a little bit later as well, best practices were not very easy to come by for a system like this. If you go into research now and if you even look at SAMHSA or even Target HIV or online, there actually is a lot more information about integrated models. But at the time, we didn't have a whole lot to go off of.

But then we moved-- but after all that, we had to assess and train. And assess and train providers took effort and took time. So we had to equip them with the necessary skills and knowledge to deliver integrated care effectively.

And then in evaluation, which is something we do consistently, we had to monitor outcomes, we had to gather feedback, we had to make continuous improvements to the integration efforts, and we had to have a structured support of our services to not only be comprehensive, but responsive to the evolving needs of the community. This happened all back in 2016, 2017, 2018, the whole ballpark area.

COVID changed a lot. COVID changed a lot of our processes, as I'm sure it did for almost everyone on this call that's in attendance. COVID altered the landscape of how we provided care.

And we were able to navigate that. And honestly, the integrated model helped us consistently, where we heard from other jurisdictions, where they had clients who were falling out of care, or clients didn't want to come to medical appointments, clients were falling out of mental health care.

It was a lot easier. We adopted-- this a little bit unrelated-- we adopted telehealth early, and in adopting that, we also, because it was all under-- in one agency, the mental health and the primary care was able to be addressed more effectively because of this model.

So we're talking about revising the service delivery and the standards of care, which have a table to discuss, which is right here. So reintegration, so prior to this integration, services were provided separately and individually funded. We didn't-- there was no regular assessment for behavioral health.

Point of interest, we have health services through referrals were from support services. You had case managers referring for mental health. You had other agencies referring to other agencies. And it became-- it was a very clear barrier, both identified in the needs assessment and what we were hearing, because clients were like, I have a barrier with transportation, I have to take the bus, and to take a bus in the same day and take off work and to go to my primary care and then go to the mental health provider, it was a barrier. And it was causing people to fall out of care because of it.

After we integrated-- my apologies, my phone keeps ringing-- after integration, mental health, substance use, and medical case management funded as wraparound services for primary medical care. And providers-- and this is what I mentioned before-- providers applying for integrated primary care behavioral health funding had to provide behavioral health services and medical case management on site.

So primary medical care acts as a point of entry behavioral health services. So after integration, I talked about this a little bit before, it was a lot easier with everything being under one roof. So it was easier for clients to go from the primary care, get their labs done, get an assessment-- which you'll hear us talk about, the PHQ-2 and the PHQ-9, which are both health questionnaires, which is what we had implemented as a primary assessment, which was done in the beginning at every medical visit.

So they would get the PHQ-2. If they scored positive on the PHQ-2, they got a PHQ-9. If they scored on that, then they were referred to mental health services.

And through that we did see an increase in mental health retention. We saw an increase in mental health service utilization, as well as substance use treatment, as well. So I'm going to talk a little bit about that since I have seen in the chat a lot of agencies providing substance use.

So one of the biggest barriers with substance use can be-- well, there's two that I can think of. So you have clients/patients who, number one, don't think they have-- don't have a substance use problem, so that's one.

Two, they have a high-- they have a high treatment adherence barrier rate. So individuals in substance use, when we have this integrated model, it made it a lot easier to bring a therapist on board. It made it a lot easier to have case managers on board. Peers, we fund a lot of peers.

So there was a lot of support for somebody in substance use, and made it easier for them to accept certain things and to get to treatment a little sooner.

One of our providers has a therapist that literally has an office in the lobby, and their sole purpose is to sit there in case somebody needs mental health services, that they are ready and willing to take them immediately.

Identify the Need. So there was an assessment that was done between February 2013 and August 2015. At the time, there was 5,968 individuals included in the analysis.

It was found that there was an under-utilization of mental health services in the system, limited mental health screening by medical and non-medical case managers and substance use providers, and a lack of communication between primary care and mental health and disease case management providers.

So a lot of post-integration, we saw that this had changed, and we saw a lot of communication between mental health therapists and their MD, DO, or ARNP counterparts. We saw a lot more communication between case managers bridging the connection and also connecting and assisting in the warm handoff.

We saw a lot more utilization of mental health services. At the time, I think I have this in a later slide towards the end, I think there was only, like, 900 or so clients during this time period that were accessing mental health services. And I think now we are closer to 1,700, 1,800, or so. We're pretty high up there now, but we'll talk about that when I get to that slide.

Then we talked about establishing standards of care. So we established standards of care using public health service clinical guidelines for the treatment of AIDS-related disease, HRSA HAB HIV performance measures, and national, local guidelines. And best practices, which can tell you, those best practices were fairly limited on what we could find.

Our new standards was-- you remember I mentioned the PHQ-- PHQ-9, and they must complete the Patient Health Questionnaire 2/9 at every primary medical care visit. I will tell you that as of 2024, this is no longer the case. Now it's as medically indicated.

So most of the time new patients always have it done. And then if they have a change in their situation or if their presiding physician feels like they need to have another one done, then they get another one done. There's sort of a needs assessment that sort of a barrier to be having this done every single medical visit. But they're required to have it done at least annually, or as more as in medically indicated.

Individual identified as needing behavioral health services, receiving the warm health behavior health specialist, which I've mentioned that multiple times. Medical and behavioral health treatment plans are coordinated as applicable and managed by a disease case manager. I will tell you, as of right now, that was the hope and the plan at that time. Your system may be able to utilize that more effectively. Right now, the behavioral health treatment plans are managed by the therapists right now, and those are often coordinated with the medical care specialist or doctor, or whomever it may be. If they have a case manager, the case manager is involved. But not all clients are required to have a case manager.

Care team staffing conducted for individuals experiencing problems with retention and adherence, and/or meeting treatment plan goals. So we do allow, we do cover case conferencing and a lot of providers will do case conferencing for particularly difficult individuals that may have a hard time

adhering to treatment. And it makes it a lot easier when it's all located under One Health. Not One Health, under one roof.

So funded agencies must provide coordinated, co-located or integrated primary medical care, behavioral health, and disease, case management services. They have to establish shared protocols, procedures and data collection to ensure continuity of services and retention of individuals. They have to develop formal memorandum of understanding with case management providers and other members of the individual's treatment team, if applicable.

They have to establish a crisis intervention protocol for referrals and linkages to correct receiving facilities. So I will say, we do have two facilities in our network that they are not funded by Ryan White part A, but they do have lockdown facilities and they are very easy to refer with. And I believe all of our behavioral health agencies have MOUs with those particular facilities.

Most of our providers have case management, medical case management and behavioral health services under one roof. And a lot of our larger agencies are one stop shops. But we do have individual case management agencies. We do have MOUs with our primary care providers in case their caseloads get too high.

The sharing protocols and procedures and data collection to ensure continuity of services. So our data collection requirements are pretty universal across all providers, not just under the integrated model, but all models. And a lot of that information has to be fed into our system, which, once again, is imaged as provider enterprise, which I know is very popular in the HIV world.

Trauma-informed approach-- so our mental health service category was enhanced by adopting a trauma-informed approach to care. We've done a lot of trainings with our providers over the years about this. Even our standalone mental health services is trauma informed approach. We've done trauma informed approach trainings with not just our medical providers, not just with our therapists, but also with receptionist, case managers. At this point, I think we've done trauma informed training with almost everyone in the medical services in our program.

But trauma can be caused by a single event, series of events, or a set of circumstances experienced by an individual as physically or emotionally harmful or life threatening with lasting adverse effects on the individual's function in mental, physical, social, emotional, or spiritual well-being. Given the responses I've seen in chat, I'm sure, it's not a shock to almost anybody that is in attendance. So we have to incorporating this approach to our initiative, it was a critical component in the maintenance and management of the HIV infection.

And enhancing our standards of care at that time was the screening and assessment should include trauma components, which all of our screenings do. We have the biopsychosocial and we have additional screenings and training, and screenings that address and screen for trauma. Treatment plans must be developed with consideration of identified trauma, which also is a requirement not just integrated, but also under our mental health program.

Preparing providers to integrate this new approach. So this is where we're going to go into training and the preparation of the training. This took a lot of time and it took multiple trainings. And even today, not specifically to these trainings, not particularly these training topics, but we still have trainings regularly throughout the year with our medical network. So clinical and administrative partner providers participated in a two day training to introduce integrated primary care and behavioral health. Training

topics included national and local context, integrated primary care and behavioral health. Putting in the practice, how to use the PHQ-2, the PHQ-9. Integrating it into practice.

Overview of our service and overview of our expectations as a recipient and assessing agency capacity and readiness. And that last one was very critical. And there was additional discussions, necessary training, additional discussion happened after that, which was assessing agency capacity and readiness, which if you're going to integrate this model and you're going to utilize this model in your own system, that last one is going to take probably more time than you think it will. But we'll talk a slightly bit more about that when we get to it, because we have a whole section just on assessing readiness and capacity.

So at the time we had five Ryan White party agencies who were currently implementing the three year pilot. It's not a pilot anymore, but at this time in implementation, it was a pilot. Obviously we have adopted it fully. And at the time we continue to update the client management information system, which is provided enterprise to align with integrated primary care for health service delivery process that data collection and tracking.

We still do this. So at the time we started quarterly meetings with integrated primary care for health, mental health and substance use providers to discuss implementation, challenges and accomplishments. We still have those quarterly meetings. We don't necessarily talk about implementation of integrated primary care, but we still discuss barriers, challenges, trainings. So we still have quarterly network meetings and that include these providers of these services.

And at the time our clinical quality management team was tracking performance measurement and outcomes at a three year pilot. Which we have a little bit of information on that. OK, remember I was talking about the whole side of this. Here we are. Assessing an agency's capacity and readiness. So assessment.

So it was important to assess your agent's capacity for an integrated health care system. That's critical. There actually is, although from 2015, 2016, it is still highly relevant. And that is the culture of wellness self-assessment, which is a tool that's provided by SAMHSA that assesses an organization's level of awareness of the key components of a wellness focused culture and engages a self-reflective process that assists in identifying what to keep, stop, and start doing.

All of our agencies did this. If you're going to implement this, I would highly encourage you to pull this assessment from SAMHSA and take a look at it. But things that you should need to consider, how will integration be beneficial to your agency? Does it fit with your vision, mission, and is it in a core of your business plan, strategic plan for your agency? Most, if not all of our medical providers are either hospital districts or federally qualified health care centers.

If you're running, if you have a bunch of boutique clinics in your system, it may be a little bit more challenging to integrate a model if they do not offer these services in-house. Because if you are having to refer them out, it somewhat defeats the purpose of a integrated model unless your referrals are really close, or there is a process in place to really track those referrals to the different agencies.

Needs assessment for the target population as you serve. Will integration enhance your service delivery to meet their needs? Do a needs assessment. Make this a primary focus the year prior. So let's say I was going to start this in March of 2025. All right. I would have to have already done a needs assessment this year to determine what the needs of my clients are and the needs of my system. And identify specifically

if a integrated model with mental health would in fact enhance your system, whether it be a polling question or whether it be a focus group, whether it be an interview with clients or providers.

You really want to make sure you're not going to put forth all this effort, and then find out that it doesn't really work super well for your system. So next slide. I actually have a client testimonial.

This individual is she Her name is Miss Shawn Tinsley. She actually has been receiving services in Broward County for a very long time. And she's actually a Planning Council member as well. She is a mother and grandmother who has been living with HIV for 35 years. She has received high quality care from the outstanding compassionate physicians and staff at the Broward County comprehensive care center, which is the subdivision of one of our providers.

They have helped manage her HIV care as well as her general health needs. The entire staff of the CCC has consistently provided an environment that feels like home with people who genuinely care. And she feels fortunate to have such a committed, knowledgeable, and compassionate team beside her every step of the way through the her health journey. And she says, "I want to thank each and every person who's ever been a part of my care team here in Broward. Please don't ever change. Your first person approach to care is what sets CCC apart from everyone else." And naturally, "Blessings upon blessings to you all."

So she has received very good care under our integrated primary care and behavioral health model. And am so very fortunate and thankful she was willing to share this client testimonial for you all. We're nearing the end, so we're going to talk about where were in the beginning. You've heard me talk a lot about implementation, evaluation, needs assessments, warm handoffs. Probably ad nauseum at this point.

So here's where we were in the beginning. What were our accomplishments then? Well, we increased access to a complete continuum of care for individuals in our community who are living with HIV/AIDS. We accomplished buy-in and willingness for providers to make a system change. And the five providers who at the time were providing wraparound services, integrated primary care and behavioral health, and providers expanded their overall capacity to provide integrated primary care and for health services, and increase the awareness of behavioral health throughout our provider network and our community.

But at that time, what were the challenges that we were facing very early on in implementation? Change the organizational structure and development new processes. Change takes time. No matter who you are, no matter what you're doing, even if it's not this. Systemic change takes time. Buy-in for providers and stakeholders, designing integrated primary care framework for the Ryan White Part A program.

Remember I mentioned little research available on best practices? At the time, it's true. There was very little research then. Agency researchers did provide integrated primary care health services. Some providers found out they had a higher additional staff. They need additional support staff and it was a challenge. PHQ-9 was not very routine. And at the time, isn't really a case now. But at the time there were referrals to smaller behavioral health agencies, and these were individuals who maybe didn't need to be part of the integrated model, who may just have mental health services that needed to be assessed and dealt with by a smaller agency because the primary care facility, perhaps they were at capacity or otherwise.

But this has since been removed. But at since not really been an issue. But at the time our retention and care in this was about 78%. Viral suppression was about 78% and we only had about 908 clients in mental health services.

And where we are now. So what have we accomplished since then. It is 2024. What the heck have we done since 2017, 2018? Process improvement has yielded an increase in retention and care and viral suppression. We're now on average 83% of retained in care, 91% are virally suppressed. And now we have about 1806 receiving mental health services. While our overall clients have grown, the percentage has gone up about 15%, 20%. We are seeing way more clients receiving mental health services. And more clients are improving health outcomes.

All providers at this point are fully integrated. Integration is now a requirement for funding. Integrated primary care for health framework has been established and we are working on expanding this and allow us to work to expanding our system integration. We are hoping, our dream is to integrate electronic health records with our Provide Enterprise system so that we have a free flow of information. So data is constantly updated and it makes it easier to track clients between appointments and to track their data outcomes.

Integrate framework-- I said that already. I apologize, I'm repeating myself. The PHQ 2/9, part of the routine screening, that every provider does it. We have some agencies that are not even in the integrated model that do it. It is done and all over our system. And we have increased access to behavioral health services, but obviously we still experience challenges, we still have barriers.

What are some of those challenges and barriers? We have cultural barriers. Behavioral referrals. This probably a big one. At that time, cultural barriers not really thought about all that much. We over the last couple years, we have seen cultural barriers as increasing challenge. I'm sure almost everyone has heard about the political turmoil going on in Haiti, and in Florida we've been seeing a large increase in high viral load clients from Haiti that are in need of mental health services. And that particular culture has a lot of barriers around behavioral health referrals. And we are slowly working through that, either utilizing peers or utilizing different approaches in our agencies to increase access to behavioral health referrals.

Warm handoffs, tracking within our Provide Enterprise. EHR, it's tracked in our provider's EHR, but we can't see our provider's EHR all the time. So when it comes to tracking data around warm handoffs, we simply don't have the bird's eye view we wish we did. And now we are trying to do a better job of tracking those handoffs, assuring that clients are staying in their appointments, and what they're being referred for.

Behavioral health data tracking. And that's something that I would encourage anyone who wants to implement this to really take into consideration. At that time, they implemented all of this, and they implemented data modalities, but they didn't really implement a really good tracking system. We've gotten better about it. That's why I was able to provide the data that I am able to provide now. But we are working on providing better data tracking for behavioral health because right now, under integrated model, because primary care is meshed in with mental health, that data gets intertwined.

So we're doing a better job of separating those out. So under integrated model, we can see how many exactly are mental health services and what their health outcomes are. So right now it's more of a manual pool as opposed to an automatic pool where we can just simply do a bird's eye glance as opposed to having to drill down the data and figure out what the information is.

Uniformity and treatment. All providers have a different way of handling mental health treatment. We have similar protocols and similar general requirements, but everybody's got a slightly different biopsychosocial. Everyone has a little bit slightly different way of providing treatment. So we're working on trying to make that more uniform, trying to get more providers buy-in into adopting uniform forms.

Problem is that we're finding some, if not most providers feel the reforms are the best. So it becomes, which one do we use. Can we do a combination? And challenges is retention and behavioral health services. And this is when talking about retention, I'm not talking about retention in medical care. I'm talking about clients that are being told that you have a six month treatment plan. And after three months they decide they no longer need treatment.

They're at least getting there. That was the initial barrier. They were not even getting to the appointment. Now they're actually getting to the appointment, do the warm handoff, but they're only going for a few sessions. And some of them are deciding they no longer wish to stay. So we're trying to figure out where that breakdown is.

But that is where we're at now. That's where we were. And here's our references. I mentioned the culture of wellness self-assessment. We also have from the American Psychology Association Behavior Health Integration Fact Sheet, and also Interventions for Integrating Behavioral Health Services and HIV Clinical Care. A Narrative review. From PMC, find it on NIH.gov. And this is where you may contact us. Our email. Our email addresses are here. Any follow up questions after the presentation. And also our website.

ANGEL JOHNSON: Thank you so much. Wonderful presentation. So we're now going to give our attendees an opportunity to ask any questions that they may have about presenters. So if you have a question, you may use the chat or QA feature or use the Raise Hand feature if you'd like to speak to them directly. So we're going to open that up right now. I do-- there was question and comment actually left by Romel Cummings that was in the Q&A. And it states, "Is it appropriate to align trauma informed approach with mental health? That's misleading as trauma informed approach should be the process in which we engage with humanity." That's one part of his comment. I'm going to go ahead and read the whole thing.

"Especially when dealing with HIV/AIDS, this makes me wonder if we're over assessing. FYI, I've been certified in trauma informed approach years before it became as popular as it is now." So I'm going to let you respond to that.

BRIANNE MILLER: And thank you for that question. So as far as trauma informed, right, I understand your thought process and in particular when it comes to our clients that we see in Broward County, we do have a diverse population. In particular, for people who are from a Caribbean and/or South American background, I myself am Jamaican, when we're talking to clients who for the first time hearing about mental health, substance use, talking to someone, there is stigma.

And we have to really acknowledge, the nuances that comes with that stigma. It can be passed down right from generational, just like language. It can be just absorbed through media. And when we're looking at a trauma informed approach, especially for people who they're dealing with, other systemic types of issues, right. Housing, right? Access to quality health care, all of the social determinants of health, it's really important for us to have that trauma informed approach because we want to be holistic.

And so when we're talking with our medical practitioners, and especially those who have day to day engagement with our clients, they add that trauma informed approach too. I understand that we want to talk about your viral load and we want to talk about your medical adherence. But how are you doing? What's going on? Do you have access to food?

We want to make sure that we're being cognizant, we're being aware, and we're also being, quite frankly, just sensitive, especially with the times that we're living in in South Florida, where there's so many things going on. And we really encourage our practitioners to continue to do research, continue to be certified, and we want them to be as educated as they can so that way they can make the best educated decisions for our clients. So I'll stop there.

TIMOTHY THOMPSON: I will add on to it. So I was thinking, because I understand the question and the statement as well, and I wanted to make it clear that while trauma informed is aligned with mental health services, it's not only aligned with mental health services. I think Brianne touched upon. We have provided, I've mentioned earlier in the presentation, we have provided training for trauma informed care to almost everybody in our system, even our dental providers. So we do align with metal health, but that's not the only place that's aligned.

ANGEL JOHNSON: Thank you both. And Romel, I hope that response was satisfactory. And if you want to open your line and speak further, that would be fine. So Kathleen Smith also provided a question. "First, thank you for the presentation. Tim mentioned that they change the implementation of the PHQ-2/9 from every visit to as medically indicated. What was the rationale for this change?"

TIMOTHY THOMPSON: So the rationale for that change was a few things. I believe, I said this, if I didn't, my apologies. It is annually, at least annually or medically indicated. The reason why it change is because we-- anyone who's new to the system is going to have it. Like if you're new to care, you have to have one regardless. But we, through our needs assessments, we had clients complaining that they were receiving too many assessments, especially clients who are going to medical visits.

And most of ours that are virally suppressed, they're retained in care, they're virally suppressed. They are routinely going to the medical appointments. They're going twice a year. And unless they have a history of mental health services or they have a history of mental health or some form of mental health diagnosis, oftentimes the physicians were saying, hey, we don't really feel like we need to be doing this every single visit. So that's really where the rationale was, and that's why that change recently happened.

And we very well may go back. We've been in this implementation for a while now, and that change was only as of this year. So there is a very high chance that in the next year or two we could revert that change back in the service delivery. But we thought that we were hearing enough from our clients and the need assessment saying they're receiving too many assessments. And we're hearing from providers that they felt like they didn't really necessarily need it. And talking to consultant-- talking to physician and consultants, we decided that medically indicated or at least or at least once a year was the path we want to go at this moment in time. But again, that was a recent change. And could be reverted.

ANGEL JOHNSON: OK. Thank you, Tim. Well, we would love to hear what you think of this webinar series and the presentation and presenters, so please use the following link to provide your feedback. And this link is also being placed in the chat so that you may copy and save it, and then send us your feedback when you have a chance.

So thank you all for attending this webinar. This concludes our webinar series on replicating innovative HIV care strategies in the Ryan White HIV/AIDS program. This webinar and all previous webinars in this series can be viewed at targethiv.org/ihip. For any capacity building technical assistance questions, you may email us at ihiphelpdesk@mayatech.com. And to access IHIP tools and resources or to join the IHIP Listserv, please go to targethiv.org/ihip.

And we do ask that for this particular webinar, you give about three weeks before it will be available at Target HIV, but you should be able to view some of the other webinars. And I appreciate all the hand clapping and and praise. OK that actually concludes our webinar. If there are no other questions, we really appreciate your time. If Tim or Brianne want to make one final comment about the webinar about anything here, then you're welcome to do so.

TIMOTHY THOMPSON: The last thing I have to say is thank you all for listening to me speak for the last like 45 minutes or so. If you have any questions about implementation of this particular model, you may more than welcome to email myself or Brianne or both of us, and we'll be more than happy to assist in some way, shape, or form or provide additional information that may not be included in this presentation. So thank you so very much.

ANGEL JOHNSON: Thank you very much, Tim. Thank you very much, Brianne. And thank you to all our attendees for all the webinars. We appreciate it. And everyone, have a great rest of your day.