NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Integration of Mental Health Treatment into HIV Medical Care

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Disclosures

Presenters have no financial interest to disclose.

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Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Articulate prevalence rates of mental health disorders among people living with HIV and impact on HIV health outcomes.
2. Describe strategies to integrate mental health disorder treatment into HIV medical care.
3. Suggest ways to measure and report client outcomes related to treatment adherence and viral suppression.

Obtaining CME/CE Credit

If you would like to receive continuing education credit for this activity, please visit:

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Mental Health/Substance Use Disorders in the U.S. - Prevalence

- In 2014, about 1 in 5 adults aged 18 or older (18.1 percent, or 43.6 million adults) reported having 'any' mental illness in the past year, and 4.1 percent (9.8 million adults) had serious mental illness.

  National Survey of Drug Use and Health, 2014

- In 2014, about 1 in 10 youths aged 12 to 17 (11.4 percent, or 2.8 million adolescents) had a major depressive episode.

National Survey of Drug Use and Health, 2014

US Prevalence of Mental Health and Substance Use Disorders

- Approximately 21.5 million people aged ≥ 12 in 2014 reported having a substance use disorder in the past year
  - 17.0 million people reported an alcohol use disorder
  - 7.1 million reported an illicit drug use disorder
  - 2.6 million reported both an alcohol use and an illicit drug use disorder.

National Survey of Drug Use and Health, 2014

Mental Health and Substance Use Disorders and HIV

People living with HIV have higher rates of mental illness than the general public. Too often, conditions go undiagnosed and untreated, which creates barriers to care and cause interruptions in HIV treatment.

HRSA, 2014

Mental Health and Substance Use Disorders and HIV

- Groups at greater risk for HIV—African-American men and women, gay and bisexual men of all races—may have higher risk for depression, which may lead to increased risk behavior.

  American Psychiatric Association, 2014

- Injection drug use is one of the causes of HIV in the United States and is responsible for approximately 10% of HIV cases annually.

  AIDS.GOV, 2014

Mental Health/Substance Use Disorders and HIV

- General anxiety disorders are estimated to occur in approximately 16% of PLWH, compared with 2.1% of the general population.

  HRSA, 2015

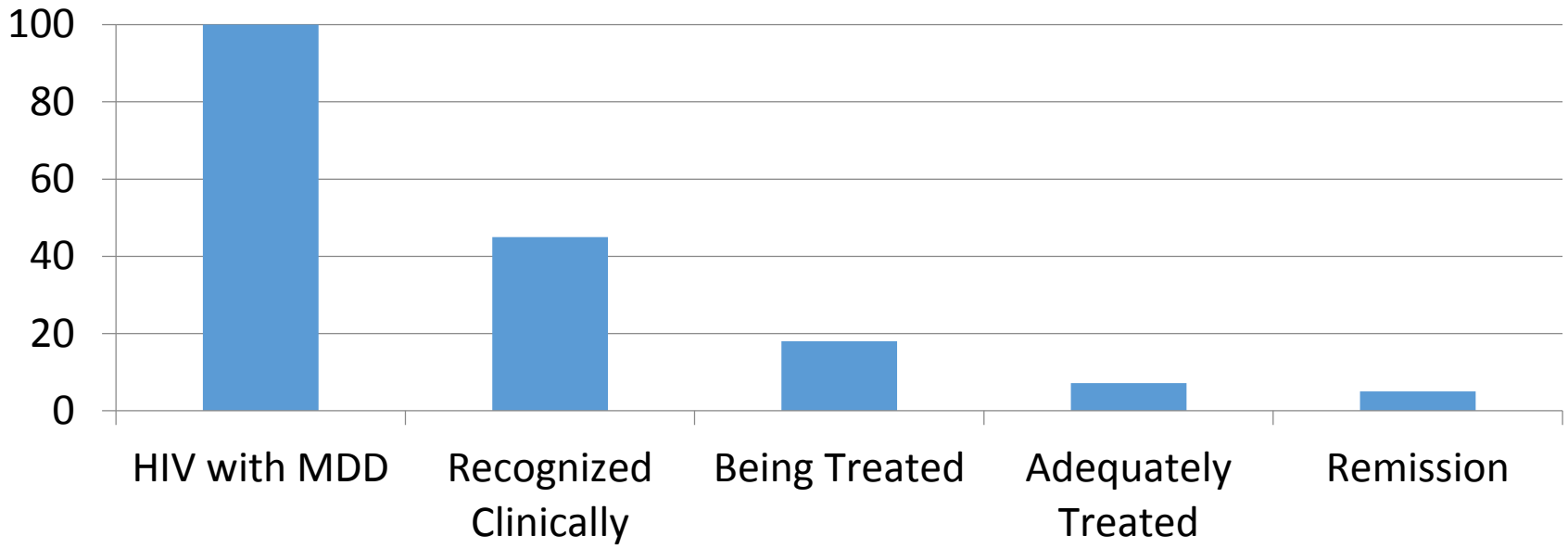
- An estimated 20% to 40% of PLWH will suffer from depression during their lifetime, more than twice the rate of the general population.

  HRSA, 2015

- Mental illness and substance abuse among HIV positive individuals impacts their quality of life, diminishes medical adherence and leads to negative health outcomes.

  Roundtree, et al, 2010

The Depression Treatment Cascade



Depression affects 20-30% of those engaged in HIV care, poses challenges to effective medical care at multiple points along the treatment cascade, and has been associated with HIV transmission risk behavior

Pence BW, et al. AIDS. 2012; 26(5): 656-8.
Tsai, et al. AIDS and Behavior. 2013; 17(8): 2765-72.

Challenges - Treatment

- No treatment model gives equal emphasis to the treatment of both mental health and addictions.

  Webber & Kelly, 2016

- Significant barriers continue to exist for people with comorbid conditions presenting to health services.

  Webber & Kelly, 2016

Mental Health Treatment Needs Assessment - Texas

- Barriers
  - Client not ready to enter treatment
  - Appointments not readily available – long wait times
  - Lack of mental health providers with knowledge of HIV
  - Stigma
  - Limited insurance coverage options
  - Inconvenient hours
  - Needing to see multiple providers
  - Lack of transportation
  - Lack of financial support
- Facilitators
  - Integrated care providers
  - Client-provider relationship, rapport
  - Effective therapeutic techniques
  - Internal motivation

Substance Abuse Treatment Needs Assessment - Texas

- Barriers
  - Client not ready to enter treatment
  - Inadequate providers who understand HIV
  - Stigma
  - Limited insurance coverage options
  - Inconvenient hours
  - Lack of family support
  - Housing
  - Limited community resources
- Facilitators
  - Harm reduction versus abstinence
  - Provider understanding of client circumstances, rapport

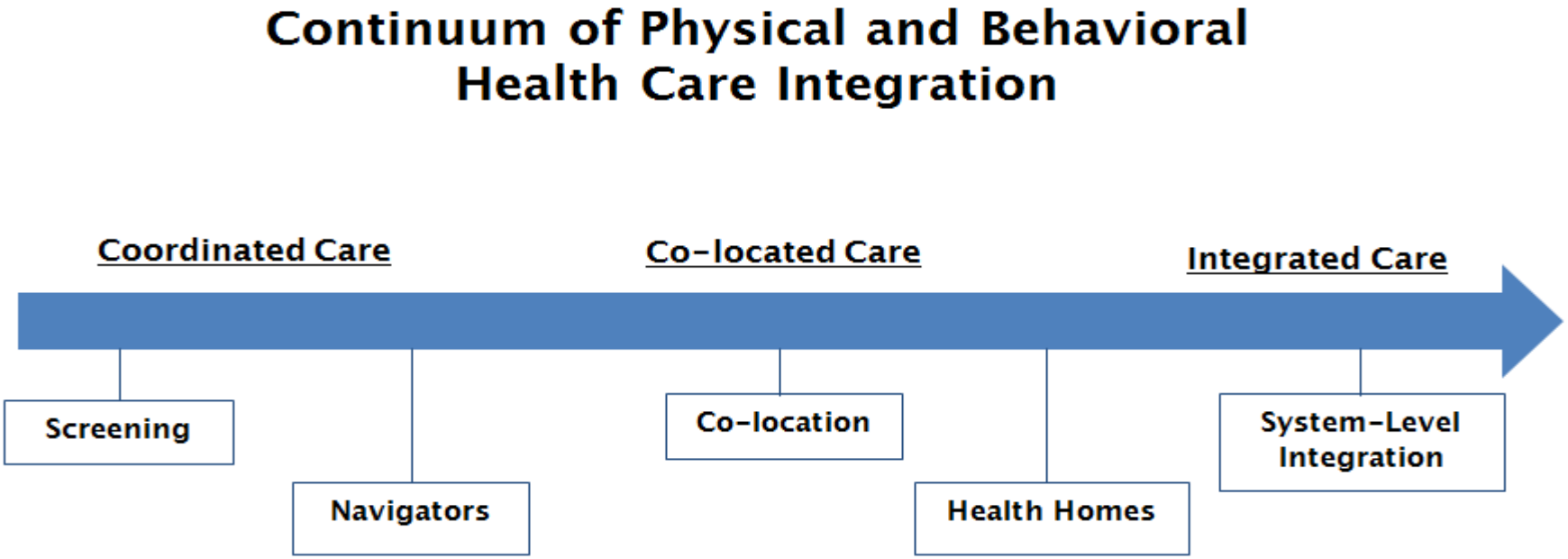
What is Behavioral Health Integration?

Behavioral Health integration is the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

The Academy, 2013

Three Primary Levels of Integration

Figure 1



The Kaiser Commission, 2014

Importance of Integrated Model of Care for PLWH

Not addressing behavioral health as part of comprehensive HIV clinical management can:

- compromise adherence to HIV treatment
- contribute to missed medical appointments
- adversely affect HIV disease progression

American Psychological Association, 2012

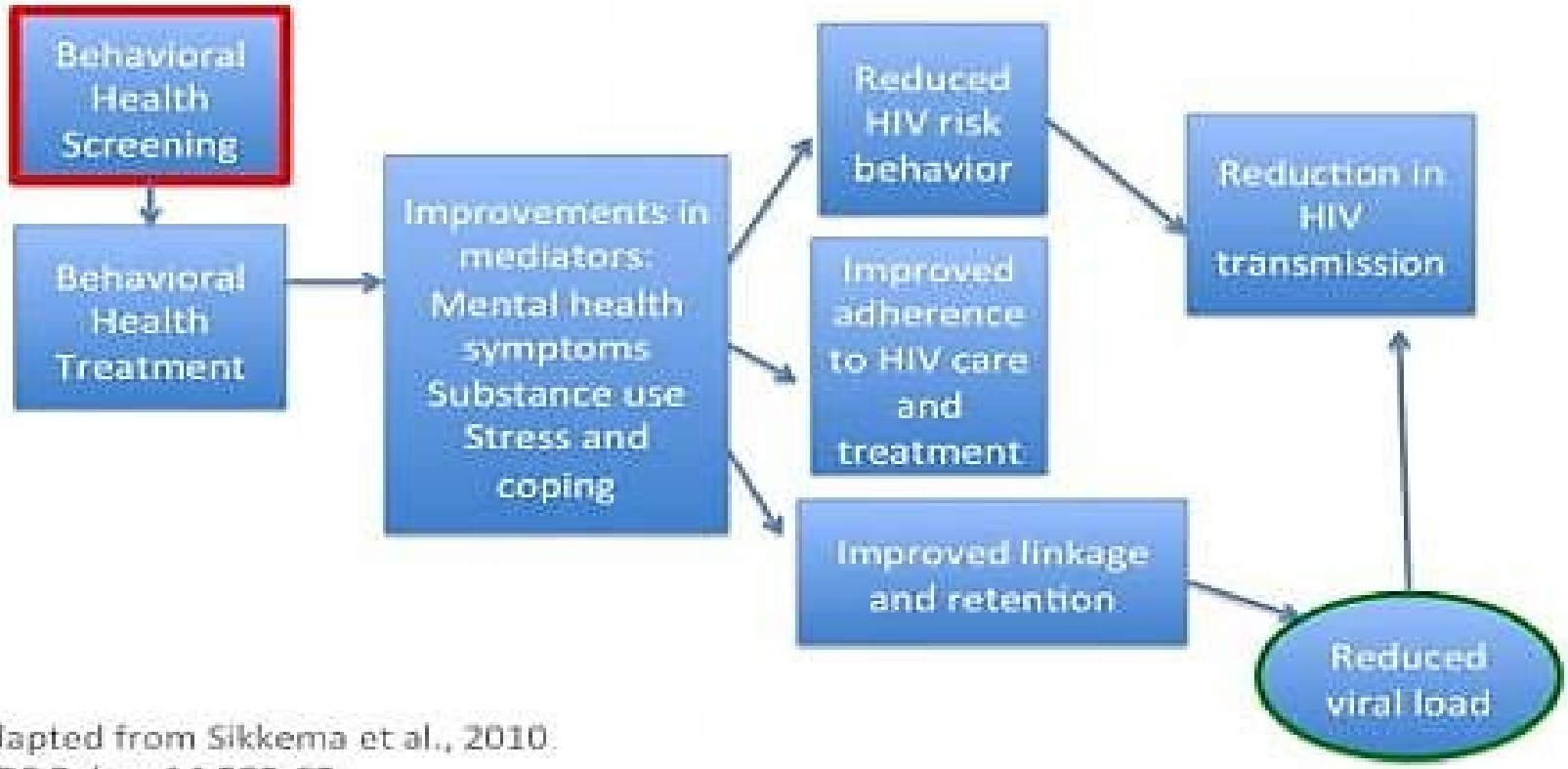
Importance of Integrated Model of Care for PLWH

Failure to recognize and appropriately treat behavioral health conditions can impact health outcomes and costs:

- Increased use of medical resources
- Increased likelihood of hospitalization
- More frequent hospital readmissions

The Commonwealth Fund, 2016

Behavioral health treatment to reduce HIV transmission risk behavior and improve adherence, linkage, and retention



Adapted from Sikkema et al., 2010
AIDS Behav 14:252-62

Instituting Integrated Care

Key Steps:

- Engage stakeholders – internal and external
- Conduct a needs assessment
- Articulate talking points
- Develop model including specific outcome measures, evaluation and reporting processes
- Obtain funding
- Implement program
- Keep all stakeholders informed:
  - progress
  - outcomes
  - challenges

Development and implementation - Challenges

- Complete system redesign
- Blending of separate practice cultures
- Shared medical records
- New workflows
- Team based approach to treatment
- Review and develop reimbursement options

Strategies to Integrate Mental Health and HIV medical care

- Leadership and Mission
- Strategy
- Technology
- Clinical Workflows

Integrating Mental Health and HIV Medical Care - Considerations

- Financing
- Billing
- Health homes
- Ongoing quality Improvement

The AIDS Arms Experience

AIDS Arms – Mission

To combat HIV/AIDS in our community by improving the health and lives of individuals living with the disease and preventing its spread.

AIDS Arms - Services

Primary Focus - Integrated programs and effective collaboration to:

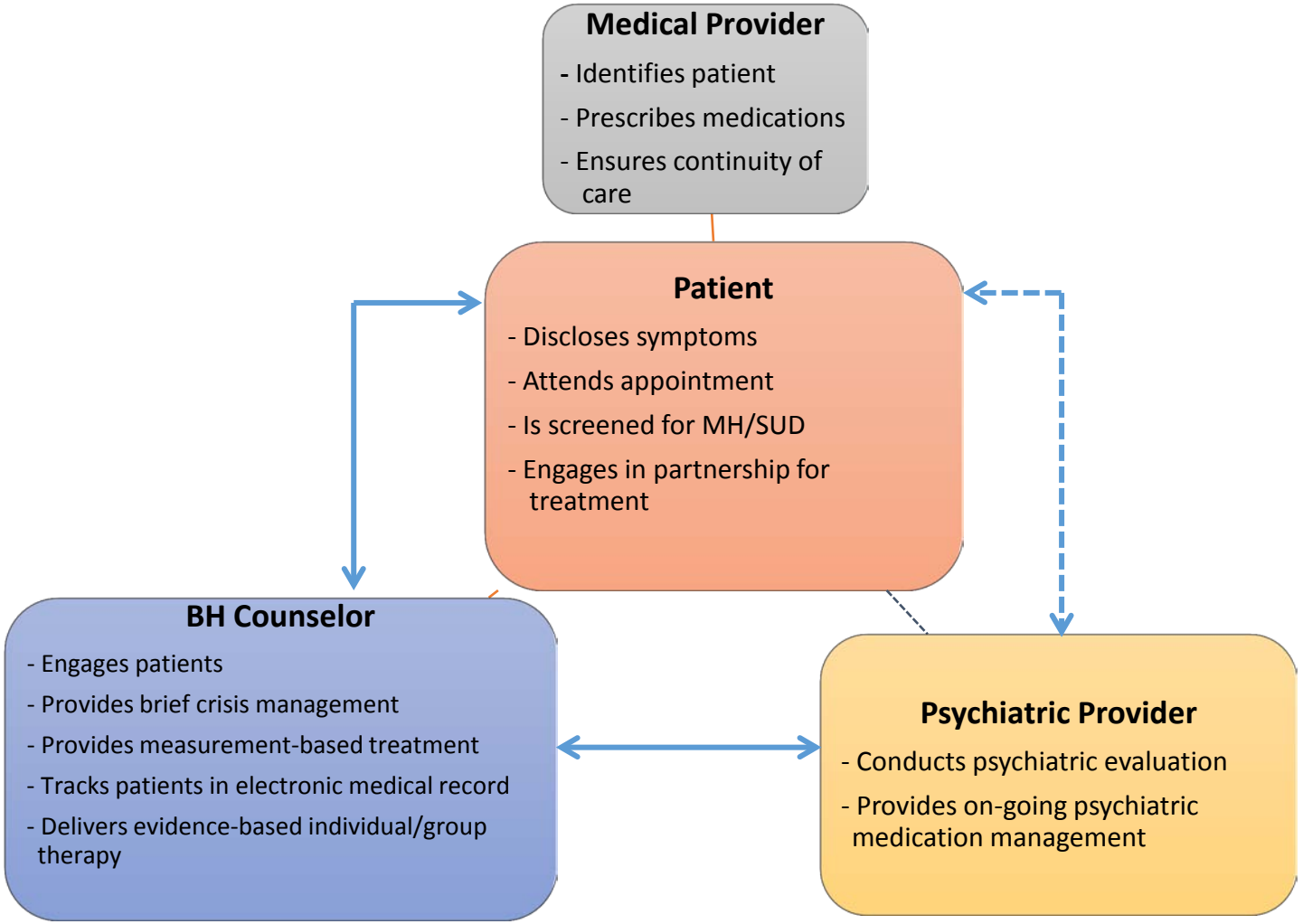
- Outreach to and test those at high risk for HIV
- Provide education about HIV/STI prevention, risk reduction and treatment
- Link HIV positive people to medical care and psychosocial services; promote retention
- Provide medical care, psychosocial support services
- Ensure that HIV people are engaged, maintained in care
- Build/sustain collaborations with partner agencies to ensure respectful care for clients

AIDS Arms - Behavioral Health

Funded by grant from Texas Department of State Health Services (DSHS) and other sources

- **Staff:**
  - Behavioral Health Director
  - Behavioral Health Counselors - 2
  - Psychiatric Nurse Practitioner -16 hours per week w/Supervising Psychiatrist
  - Psychiatrist - 26 hours per month
- **Program Components:**
  - HIV medical providers refer patients who screen positive for mental health and/or substance use disorders to BHC.
  - BHCs screen/assess patients for mental health and substance use.
  - BHCs provide support for adherence to medical/psychiatric care and treatment.
  - BHCs provide brief psycho-therapeutic interventions
  - Individual/group counseling provided if necessary
  - Staff support provided by experienced psychologist
  - Psychiatric providers assess for, prescribe and manage psych medications

Behavioral Health - Flow of Services



Most Common Diagnoses

- Major Depressive Disorder
- Post Traumatic Stress Disorder
- Amphetamine-Type Substance Use Disorder

Challenges – Individual Level

Patients may:

- Be unable to accept that mental health and/or substance use should or can be addressed.
- Believe their symptoms are normal and usual.
- Have discomfort and fear related to discussing mental health concerns and substance use.
- Be concerned about the stigma of seeking treatment for a mental health and/or substance use disorder.

Providers may:

- Be unable to recognize disorders unless patient specifically mentions it.
- Label the patient as *'difficult'* rather than having a mental health or substance use disorder.

Challenges – Organizational Level

- Increased utilization of and dependence on behavioral health services by providers and patients.
- Large behavioral health caseloads can cause staff burnout, patient dissatisfaction.
- HIV medical provider discomfort with prescribing psychiatric medications.
- HIV medical providers and behavioral health care providers may follow different protocols.
- Sustaining integration – an ongoing process.

Successes

- Number of clients in behavioral health program:
  - 2012 (July-Dec): 73
  - 2013: 326
  - 2014: 472
  - 2015 (Jan-Jun): 583*
- Increased psychiatric services with addition of psychiatrist - 26 hours per month in 2015.
- Increased behavioral health services by offering individual and group counseling in 2015.

**Total # patients with at least one clinic =1914*

Successes

- Behavioral Health Director hired to manage program and create sustainability plan.
- Client participation and appreciation.
- Improved health outcomes with use of shared electronic medical record.
- Acknowledgement of need by internal and external stakeholders.
- Engagement and support at multiple levels.

Outcomes

Outcomes – Group I

Review Period: July 2012 to June 2015

Population: HIV Clinic Patients

Outcomes:

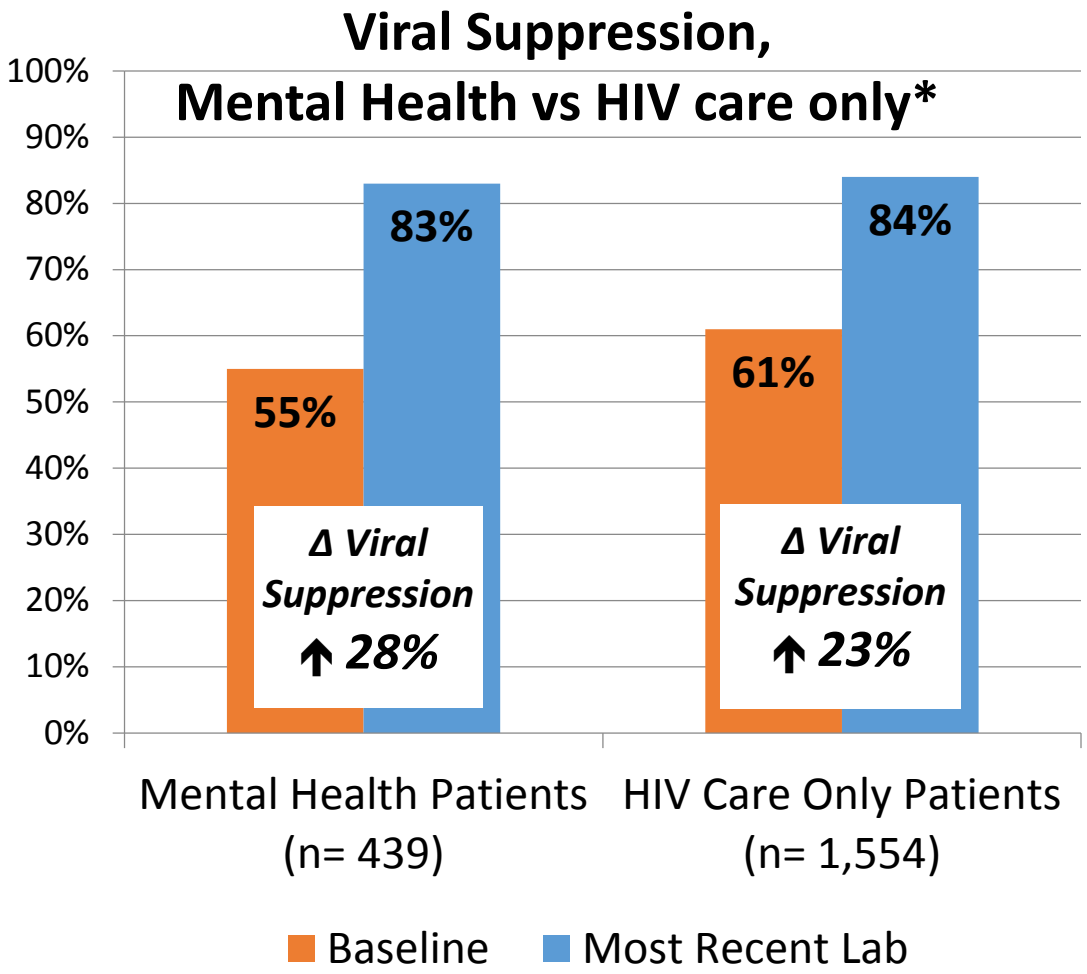
- HIV medical visit no-show rate
- Viral suppression (<400 copies/mL)

Cohorts:

1) Mental Health Program Patients (n=439)
   - *at least one mental health visit and multiple viral load tests*
2) HIV Care Only Patients (n=1,554)
   - *no mental health visits and multiple viral load tests*

Outcomes- Group I

- **Median # HIV Medical Visits**
  - Mental Health Patients: 9
  - HIV Care Only Patients: 8
- **HIV Appt No Show Rate**
  - Mental Health Patients: 23%
  - HIV Care Only Patients: 21%



** Viral suppression is defined as <400 copies/mL*

Outcomes – Group II

Review Period: July 2012 to June 2015

Population: Patients on Psych Provider caseload

Outcomes:

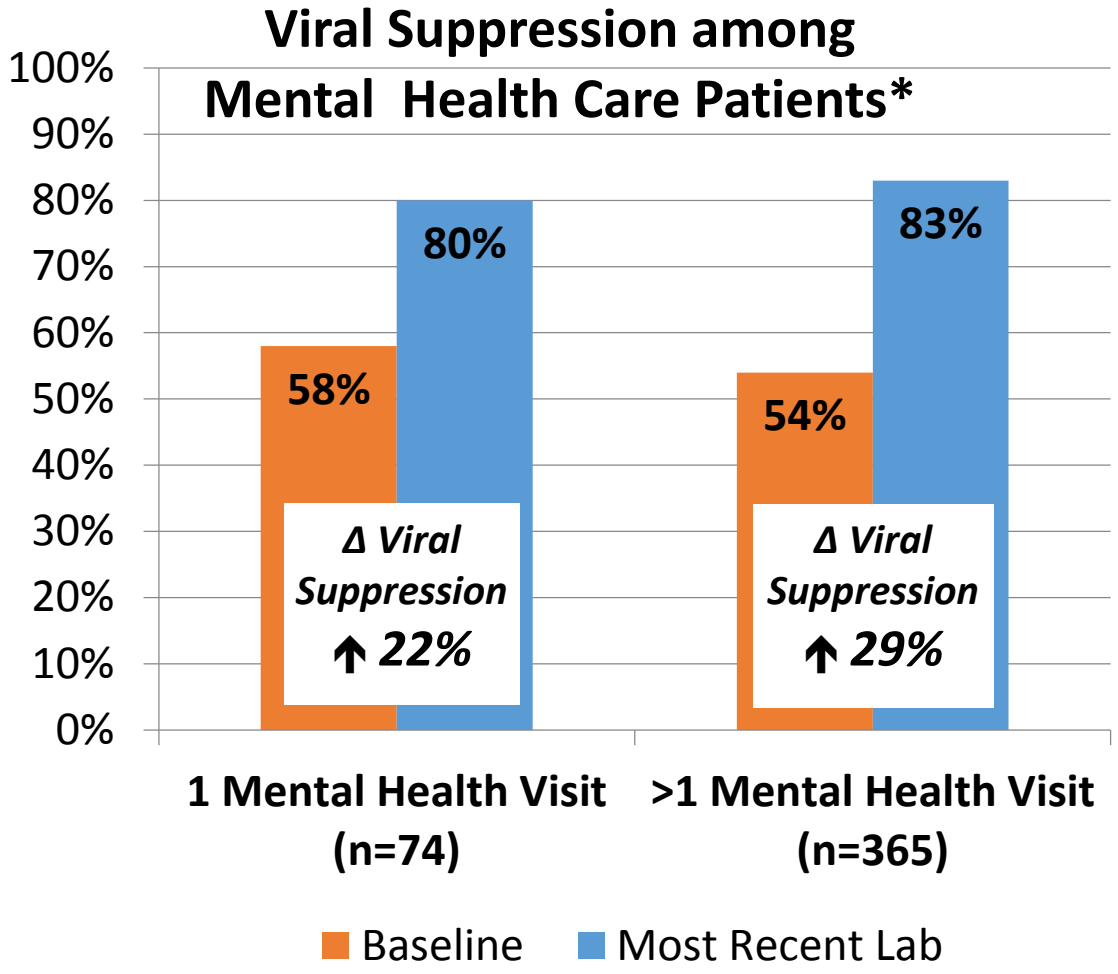
- HIV medical visit no-show rate
- Viral suppression (<400 copies/mL)

Cohorts:

1) Linked to MH Services (n=74)
   - *Only 1 onsite mental health service visit*
2) Engaged in MH Services (n=365)
   - *More than 1 onsite mental health service visit*

Outcomes- Group II

- **HIV Appt No Show Rate**
  - 1 Mental Health Visit: 42%
  - >1 Mental Health Visit: 29%



*Viral suppression is defined as having <400 copies/mL

Conclusions

- Having onsite mental health services improves HIV treatment outcomes for dually or triply diagnosed patients.
- Integrating behavioral health care into HIV primary care maximizes opportunities to lower the community's viral load.

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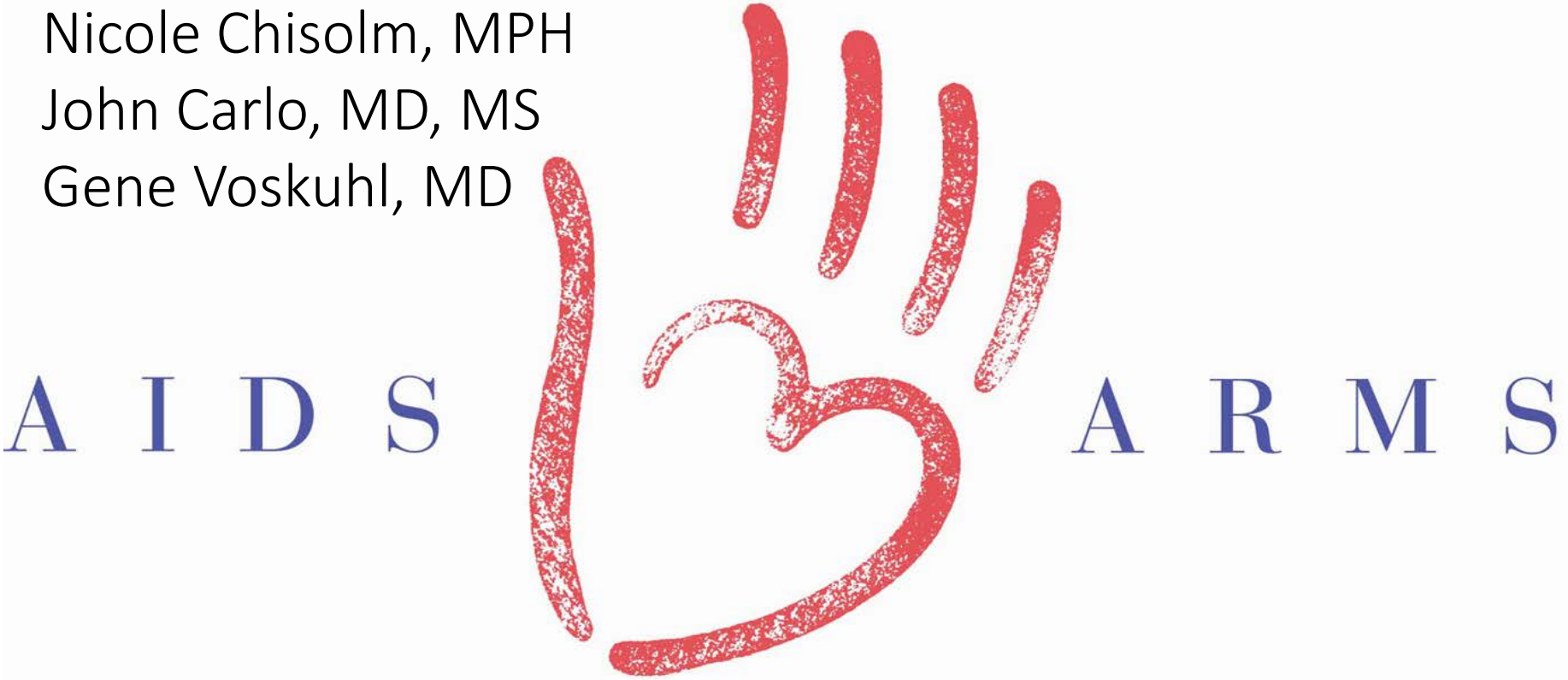
Questions, Comments, Thoughts?

Acknowledgements:

Raymond Castilleja, Jr., LMSW
Anna Pereida, LMSW
Markelse Jordan, LPC-I
Nicole Chisolm, MPH
John Carlo, MD, MS
Gene Voskuhl, MD



Thank you!