

# Philadelphia Integrative Behavioral Health Initiative: Improved Retention in HIV/AIDS Care

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# Learning Objectives

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

1. The learner will be able to describe successful integration of behavioral health into HIV specialty care with a colocated, integrated behavioral health specialist.
2. The learner will be able to identify effective strategies for retention in HIV medical care.
3. The learner will be able to discuss sustaining behavioral health care services with a variety of funding sources, specific for behavioral health in integrated care settings.



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# Agenda

- 1) MAI-TCE Program
- 2) Philadelphia and HIV -Program Significance
- 3) Program Goals
- 4) The Primary Care Model for Behavioral Health Consulting
- 5) Mental Health and Substance Use Clinical Presentations
- 6) Program Impact
- 7) Program Evaluation and Outcomes
- 8) Behavioral Health Consultant Perspective
- 9) Psychological Services and HIV – Sustaining Services

# MAI-TCE Program Overview

**Ilze L. Ruditis, MSW**

SAMHSA, Center for Mental Health Services

# Minority AIDS Initiative (MAI)-Targeted Capacity Expansion (TCE)

Minority AIDS Initiative Targeted Capacity Expansion (MAI –TCE): Integrated Behavioral Health/Primary Care Network Cooperative Agreements (FOA SM 11-006)

Project Period - FY2011 -2013

## Purpose

The purpose of the MAI-TCE program was to facilitate the development and expansion of culturally competent and effective integrated behavioral health and primary care networks, which include HIV services and medical treatment, within racial and ethnic minority communities in 11 of the Metropolitan Statistical Areas (MSAs) and Metropolitan Divisions (MDs) most impacted by HIV/AIDS. The expected outcomes for the program included reducing the impact of behavioral health problems, HIV risk and incidence, and HIV-related health disparities, in these areas.



# MAI-TCE - 11 Metropolitan Areas:

*With Philadelphia, projects were in 11 Metropolitan Areas:*

Atlanta

Baltimore

Chicago

Dallas

Los Angeles

Miami

New York City

San Francisco

Washington, DC

San Juan, Puerto Rico



# SAMHSA MAI in 3 Centers

- First SAMHSA project with triply braided funding under the MAI funds - with Center for Mental Health Services, Center for Substance Abuse Treatment, and Center for Substance Abuse Prevention
- Developed in response to plans under the CDC Enhanced Comprehensive HIV Prevention Plans (ECHHP) and HHS 12 Cities Project, collaboratively under the NHAS
- First SAMHSA project to City and State Health Departments which were CDC ECHPP grantees/Public Health Departments

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# Acknowledgements

Jane Baker, Philadelphia Department of Public Health (PDPH)

Coleman Terrell, PDPH, AIDS Activities Coordinating Office (AACO)

Kathleen Brady, AACO

Tanner Nassau, AACO

Drexel University Department of Psychiatry

Mental Health Association of Southeastern Pennsylvania

Health Federation of Philadelphia

SAMHSA

# Program Significance - HIV

## HIV Prevention and Treatment

- 20K Philadelphians live with HIV
- 49% of HIV+ Philadelphians with mental illness (Yehia et al, 2015)\*
- Significant disparities in access and adherence
- Successful treatment leads to suppressed viral load, improved patient health and decreased transmission

\* <http://bmcinfectdis.biomedcentral.com/articles/10.1186/s12879-015-0990-0>



# Program Significance – Systems

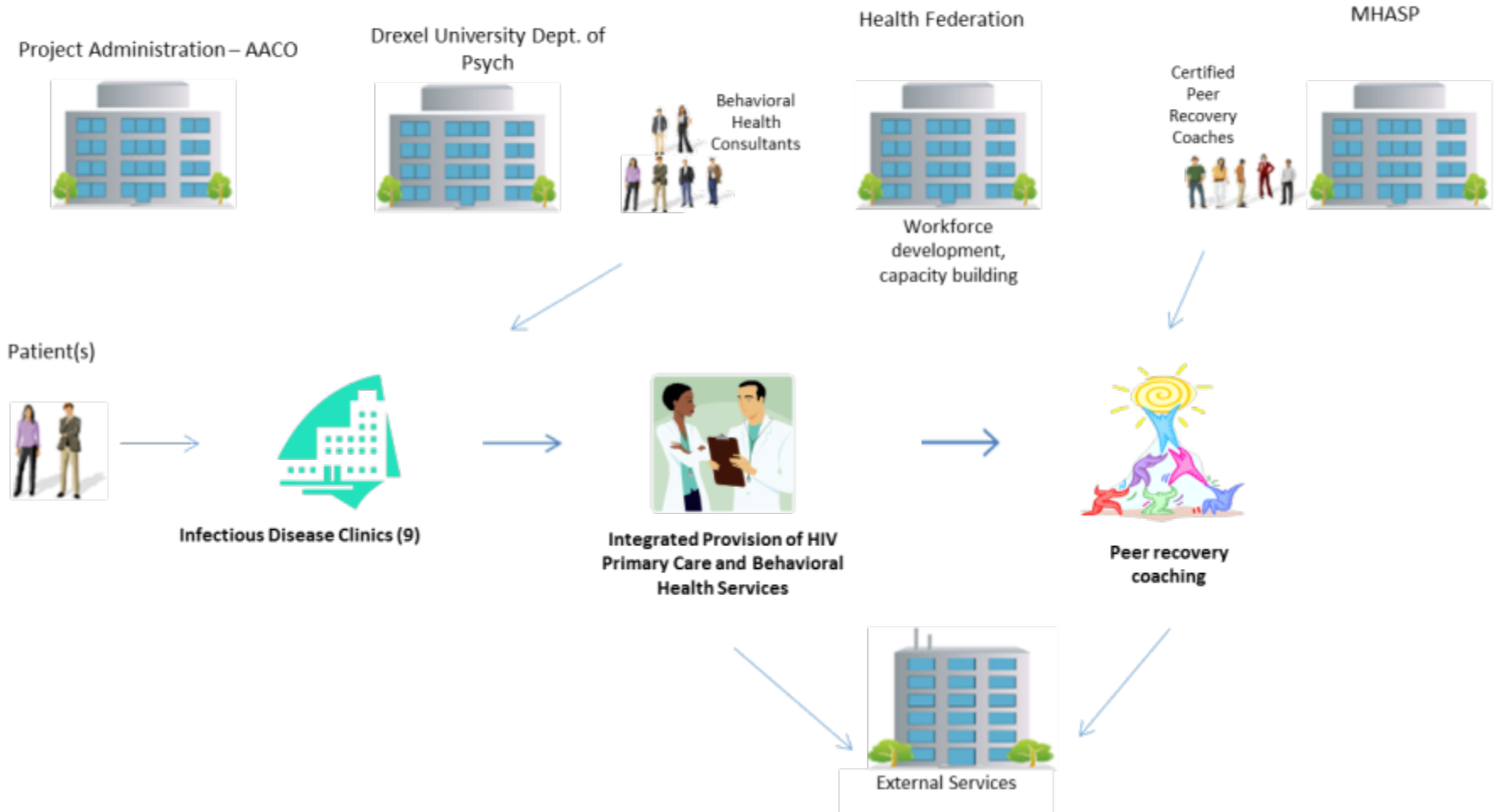
- Initiated integration of behavioral health and primary care
- Increased access to behavioral health services by integration into HIV medical care
- Provided immediate access to behavioral health services
- Improved patient readiness for and support referrals out to external behavioral health services

# A Population Based Behavioral Health Intervention: Program Goals

- **Service Integration**
- **Increase Access**
- **Improve**
  - Retention
  - Viral load suppression
  - Quality of life
- **Reduce**
  - Impact of psychosocial comorbidities
  - New HIV infections

# The Philadelphia Integrative Behavioral Health Initiative

## Organizational Structure



# Behavioral Health Consulting Model

- Goal is to promote integration of behavioral health services within a primary care team
- Delivers high volume, problem focused care delivered in brief sessions
- Capacity to treat any behaviorally based problem
- Provides immediate feedback to the Primary Care Provider (PCP) on patient behavioral health difficulties
- Seeks to achieve key changes, supporting patients in large numbers
- Improve PCP management of behavioral health care issues

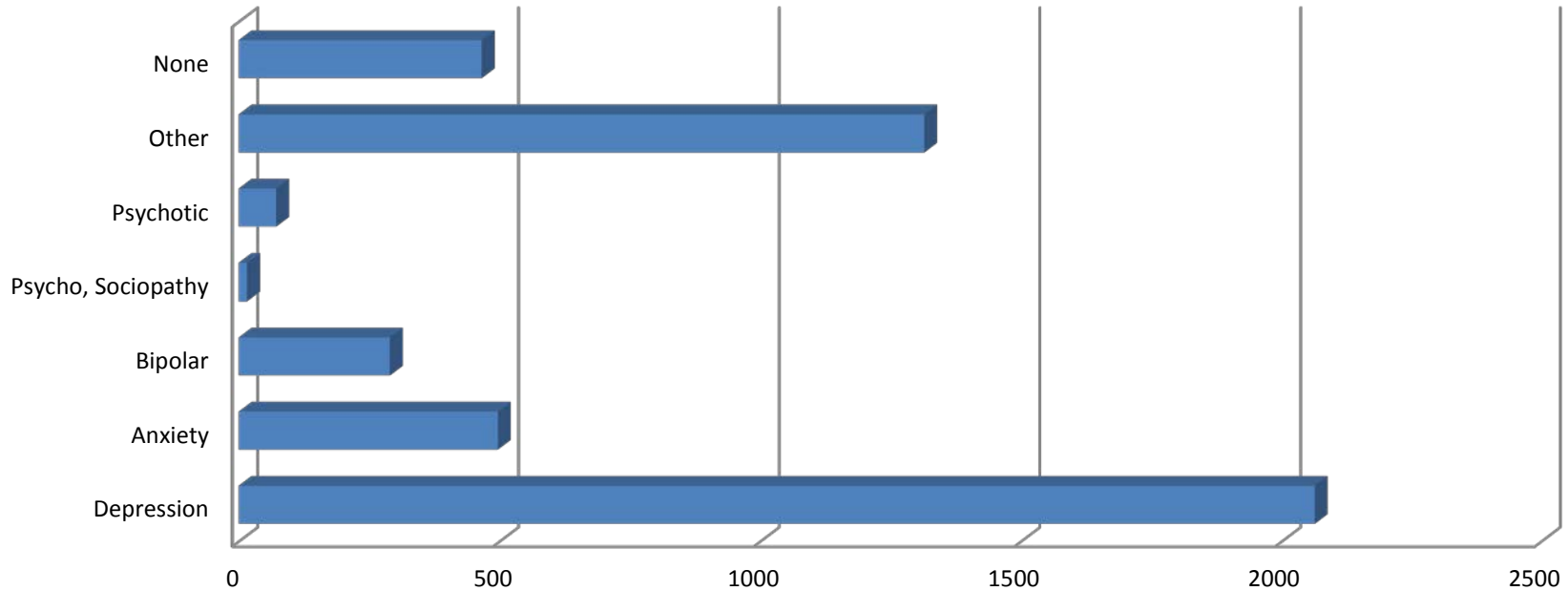


# Behavioral Health Consultant (BHC)

- Licensed, credentialed professional requiring LCSW or PhD/PsyD
- Works within a primary care clinical setting
- Must be flexible, on-demand availability
- Sees patients 'in concert' with the PCP and other providers
- 20-30 minute visits
- Not traditional therapy

# Mental Health Clinical Presentations

## Indicators - Mental Disorder



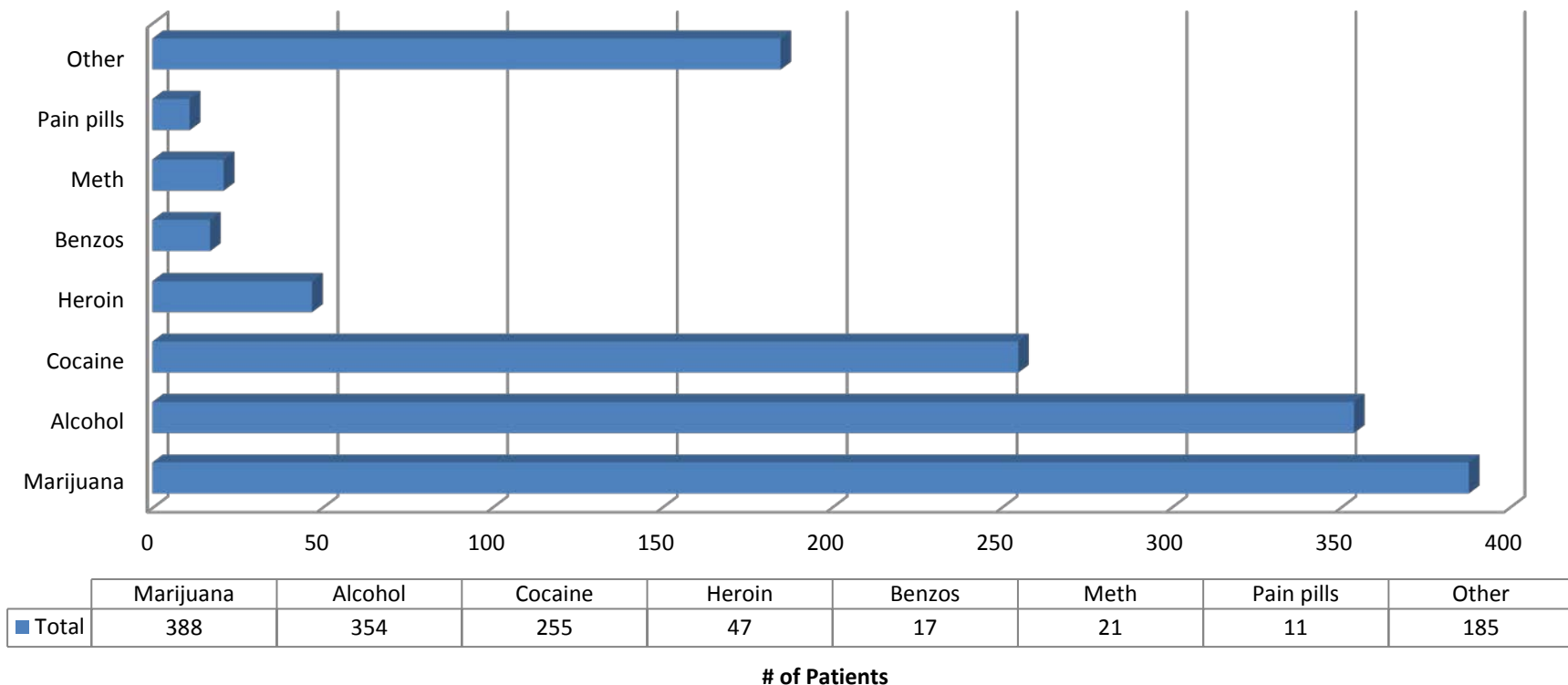
	Depression	Anxiety	Bipolar	Psycho, Sociopathy	Psychotic	Other	None
■ Total	2064	497	290	16	72	1315	466

# of Patients

Source: Total BHC patient prediagnostic MH impression at initial visit

# Substance Use Clinical Presentations

## Indicators– Substance Use Disorder



Source: BHC patient prediagnostic SUD impression at initial visit

# Final Program Services Report

	BHC Dates of Service	Patients Screened	Patients Enrolled	Referrals	Patient Sessions
ID Clinic 1*	9/18/12-5/31/14	371	156	429	726
ID Clinic 2	8/17/12-9/30/15	499	290	1919	2493
ID Clinic 3	5/18/12-9/30/15	986	543	1396	2602
ID Clinic 4	5/17/12-6/16/15	704	291	597	1657
ID Clinic 5	7/2/12-9/30/15	370	193	563	1023
ID Clinic 6**	8/10/12-9/30/14	617	299	141	1926
<b>Totals</b>		<b>3547</b>	<b>1772</b>	<b>5045</b>	<b>10,427</b>

Source: BHC report of service numbers of patients screened for MH and SUD, enrolled, referrals to external services and total patient sessions

\*BHC was on leave of absence 11/6/13 – 1/31/14

\*\* BHC rotated at 4 clinics within PDPH Ambulatory Health Centers

# Program Impact – Mental Health Care and Substance Use Disorder Treatment

- 3,547 unique HIV positive patients screened for mental health and co-occurring substance use disorders from project inception until 9/29/15
- Over 5000 referrals to substance use disorder treatment, intensive outpatient mental health services and ancillary resources
- 104 clients received peer recovery support

# Evaluation

- Inclusion Criteria
- CAREWare reporting
- Patient demographics
- HIV treatment outcomes and findings
- Limitations

# Inclusion Criteria

- HIV positive and enrolled in treatment at a RW funded clinic
- HIV outpatient/ambulatory visit prior to 1/1/12
- BHC visit from program inception – 3/31/13

# Demographics

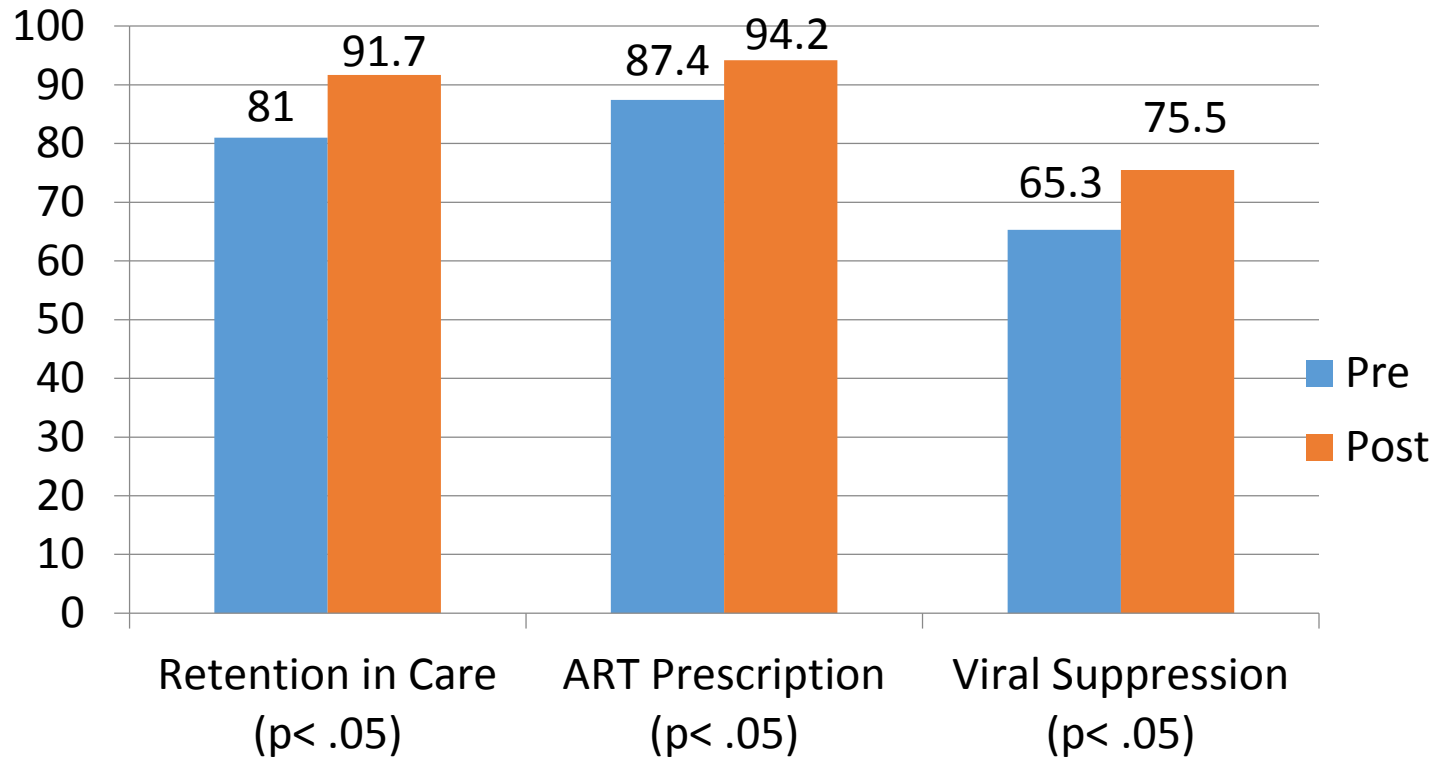
	<u>Non-BHC Pt</u>	<u>BHC Pt</u>	<u>Total</u>
<b>Race (p &lt;0.0001)</b>			
Black, non-Hispanic	4654	389	5043
White, non-Hispanic	839	40	879
Hispanic	759	36	795
Other, Unknown	170	4	174
<b>Gender (p &lt;0.0001)</b>			
Male	4049	246	4295
Female	2322	221	2543
Transgender	51	2	53
<b>Age Category (p=0.1557)</b>			
13-29	411	21	432
30-44	1667	139	1805
45-54	2376	176	2552
55+	1968	134	2102
<b>Transmission Risk (p=0.2431)</b>			
Other	274	12	286
Heterosexual	3538	260	3798
IDU	869	72	941
MSM	1741	125	1866



# Demographics Cont..

	<u>Non-BHC Pt</u>	<u>BHC Pt</u>	<u>Total</u>
<b>Insurance (p &lt;0.0001)</b>			
None/Other	1581	38	1619
Private	967	60	1027
Medicare	814	81	895
Medicaid	3060	290	3350
<b>Poverty Level (p &lt;0.0001)</b>			
50% or Less FPL	2974	170	3144
100% FPL	2024	191	2215
200% FPL	898	69	967
300% or Greater FPL	526	39	565
<b>HIV Status (p &lt;0.0001)</b>			
HIV Positive (not AIDS)	3871	240	4111
CDC Defined AIDS	2551	229	2780
<b>Housing Status (P &lt;0.0001)</b>			
Stable/Permanent	4725	375	5100
Non-permanent/Unstable	459	61	520
Unknown/Other	1238	33	1271

# BHC Patient Cascade Pre and Post Intervention (N=469)



# BHC Intervention Findings

- Multivariate logistic regression model shows that patients derived clinical benefits, receiving behavioral health services and HIV medical care, with significant increases in retention in HIV care (10.7%), viral suppression (10.2%) and the numbers of patients receiving ART(6.8%)
- **Retention**
  - BHC patients living with CDC defined AIDS were 3.5x as likely to be retained compared to BHC patients with HIV
  - BHC patients 3x as likely to be retained compared to non-BHC pts

\* Model was adjusted for race, gender, age category, transmission risk, insurance, poverty level, HIV status and housing status\*

# BHC Intervention Findings Cont.

- ***ARV Prescription***
  - BHC patients retained at baseline were 3.8x as likely to be on ARVs compared to BHC pts not retained at baseline
- ***Viral Suppression***
  - BHC patients who were virally suppressed at baseline were 6.3x as likely to remain as compared to patients not virally suppressed at baseline
  - No statistical significance in comparison of BHC patients vs non-BHC patients

# Limitations

- Newly diagnosed HIV positive patients not included in the analysis
- Length of study period
- No BH diagnoses or treatment recommendations
- PCP uptake of BHC recommendations

# Program Sustainability

## (1) Fiscal

- *Community Behavioral Health* (quasi governmental org.)
- Ryan White
- Private insurance

## (2) Personnel

- BHC retention

## (3) Provider/Institutional Level

- Investment
- Psychiatry Departments

# Lessons Learned

- It is practical to integrate behavioral health into the HIV medical clinic setting
- Partnerships with local community based organizations facilitated hiring, training, clinical supervision, billing and sustainability
- For sustaining the program, hiring and billing occurred through the infectious disease clinic and included discussions to expand service to other clinical populations
- The HIV positive population is appropriate for service integration
- Integration takes time and investment

# Questions?





# The Behavioral Health Consultant - Roles and Perspective

**Bryce Carter, PhD**

*Behavioral Health Consultant, The University of Pennsylvania*

# Behavioral Health Consultant (BHC) Program Structure

- Integrating Care into HIV Clinics in Philadelphia's Ryan White Care Program - six clinics

# BHC Program – Integration Factors

- BHC Administrative / Hiring
- BHC Training
- Stigma
- Clinic Integration
  - **Perception of Need**
  - **Openness to change**
  - **Champion**
  - **Accessibility On-site – centrality is critical**

# BHC Program– Administrative / Hiring

- BHC Characteristics  
the need to hire mental health clinicians that are able to connect with the patient population, who are flexible, resourceful, and creative

# BHC Program – Training for BHC

- BHC Training
  - The importance of shadowing as a part of the training process
  - Shadowing and being shadowed allows the beginning BHC to become familiar with the clinic flow and procedures
  - Essential to help the beginning BHC develop a sense of the model of service delivery

# BHC Program –Addressing Stigma

- Stigma
  - subtler aspects of HIV related stigma may pervades patients' lives and impact all levels of care and treatment - from testing to engagement in care to adherence and retention in care

# BHC Program – Clinic Integration

- Clinic Integration
  - Services need as related to perception of need among staff
  - Openness to change and experimentation in the clinic staff
  - Having a **Champion among clinic leadership**

# BHC Program – Clinic Integration

- **Accessibility of BHC Services on-site -**
- Ease of access - the level of ease or difficulty to access the BHC, and the BHC's experiences in:
  - Work station
  - Credentialing
  - EMR
  - Consultative Staff (RN, MD, Case managers, Peer staff)
  - Access to Exam Rooms



# Questions?



# Psychological Services and HIV – Sustaining Services

**David J Martin, PhD, ABPP**

*American Psychological Association*

# Why Integrated Care?

- *“Healthcare for general, mental, and substance use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body.”<sup>1</sup>*
- Clinical integration is the extent to which patient care services are coordinated across people, functions, activities, and sites

<sup>1</sup>Institute of Medicine. *Improving the quality of health care for mental and substance-use conditions*. Washington, D.C.: National Academy Press, 2006.


# Why Integrated Care?

- 54% of people with mental health issues are served in primary care<sup>2</sup>
- In public sector primary care, more patients present with mental health issues than in private sector
  - Mix of people with serious mental illness (SMI) and non SMI
- Need for behavioral medicine interventions for maladaptive health behaviors

<sup>2</sup>Wang, P., Bessler, O., Olfson, M., et al. (2006). Changing profiles of services sectors used for mental health care in the United States. *American Journal of Psychiatry*, 163, 1187 – 1198.

# Why Integrated Care?

Many health problems have behavioral components:

- 
- Diabetes
  - Hypertension
  - Obesity
  - COPD
- 
- Need for behavioral interventions to treat or prevent disease

# Factors in Sustaining Behavioral Health Services in HIV Care Settings

- Reimbursement

- Codes
- Credentialing

- Retention of Staff

Supervision

Trauma Informed Services

Training and Experience / Credentialing

Team Synergy - Coordination with Primary Care, Peers,  
Case managers, Nursing, Psychiatry Services

# Four Quadrant Clinical Integration Model

		Physical Health Risk/Status	
		Low	High
Behavioral Health Risk/Status	High	<ul style="list-style-type: none"> <li>Behavioral Health Case Manager with responsibility for coordination with primary care provider</li> <li>Primary Care provider (with standard screening tools and Behavioral Health practice guidelines)</li> <li>Specialty Behavioral Health</li> <li>Residential Behavioral Health</li> <li>Crisis/ER</li> <li>Behavioral Health Inpatient</li> <li>Other Community Supports</li> </ul>	<ul style="list-style-type: none"> <li>Primary Care Provider (with standard screening tools and Behavioral Health practice guidelines)</li> <li>Behavioral Health Case Manager with Responsibility for coordination with Primary Care Provider and Disease Manager</li> <li>Care/Disease Manager</li> <li>Specialty Medical/Surgical</li> <li>Specialty Behavioral Health</li> <li>Residential Behavioral Health</li> <li>Crisis/Emergency Room</li> <li>Behavioral Health and Medical/Surgical Inpatient</li> <li>Other Community Supports</li> </ul>
	Low	<ul style="list-style-type: none"> <li>Primary Care Provider (with standard screening tools and Behavioral Health practice guidelines)</li> <li>Primary Care Provider-based Behavioral Health</li> </ul>	<ul style="list-style-type: none"> <li>Primary Care Provider (with standard screening tools and Behavioral Health practice guidelines)</li> <li>Care/Disease Manager</li> <li>Specialty Medical/Surgical</li> <li>Primary Care Provider based Behavioral Health (or in specific specialties)</li> <li>Emergency Room</li> <li>Medical/Surgical Inpatient</li> <li>Skilled Nursing Facility/Home based care</li> <li>Other community Supports</li> </ul>

# Four Quadrant Clinical Integration Model

		Physical Health Risk/Status	
		Low	High
Behavioral Health Risk/Status	High	<ul style="list-style-type: none"> <li>Wellness Checks</li> <li>As needed medical care</li> <li>Assessment and diagnosis of mental health issues</li> <li>Referral to specialty behavioral health care</li> <li>Coordination with primary care provider</li> <li>Periodic follow up to monitor progress regarding mental health issues</li> </ul>	<ul style="list-style-type: none"> <li>Management of chronic medical illness</li> <li>Assessment and diagnosis of mental health issues</li> <li>Referral to specialty behavioral health care</li> <li>Coordination with primary care provider</li> <li>Periodic follow up to monitor progress regarding mental health issues</li> </ul>
	Low	<ul style="list-style-type: none"> <li>Wellness Checks</li> <li>As needed medical care</li> <li>Screening for common mental health issues</li> <li>Motivational interviewing to sustain healthy lifestyle</li> <li>Preventive approaches</li> </ul>	<ul style="list-style-type: none"> <li>Management of chronic medical illness</li> <li>Assessment and treatment of co morbid mental health issues</li> <li>Empowering patient to adhere to better lifestyles and medical regimen</li> </ul>



# Questions?



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