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HRSA Service Category:	Medical Case Management
Local Service Category:	Clinical Case Management (CCM)
Budget Type:	Fee for Service
Budget Requirements or Restrictions:	Not applicable.
HRSA Service Category Definition:	<i>Medical Case Management services (including treatment adherence)</i> are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client’s and other key family members’ needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
Local Service Category Definition:	Clinical Case Management: Identifying and screening clients who are accessing HIV-related services from a clinical delivery system that provides Mental Health treatment/counseling and/or Substance Abuse treatment services; assessing each client’s medical and psychosocial history and current service needs; developing and regularly updating a clinical service plan based upon the client’s needs and choices; implementing the plan in a timely manner; providing information, referrals and assistance with linkage to medical and psychosocial services as needed; monitoring the efficacy and quality of services through periodic reevaluation; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services will be available to eligible HIV-infected clients residing in the Houston EMA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color,

	<p>religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling (i.e. professional counseling), substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility.</p> <p><i>Clinical Case Management</i> is intended to serve eligible clients, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.</p>
<p>Services to be Provided:</p>	<p>Provision of Clinical Case Management activities performed by the Clinical Case Manager.</p> <p><i>Clinical Case Management</i> is a working agreement between a client and a Clinical Case Manager for a defined period of time based on the client's assessed needs. <i>Clinical Case Management</i> services include performing a comprehensive assessment and developing a clinical service plan for each client; monitoring plan to ensure its implementation; and educating client regarding wellness, medication and health care compliance in order to maximize benefit of mental health and/or substance abuse treatment services. The <i>Clinical Case Manager</i> serves as an advocate for the client and as a liaison with mental health, substance abuse and medical treatment providers on behalf of the client. The Clinical Case Manager ensures linkage to mental health, substance abuse, primary medical care and other client services as indicated by the clinical service plan. The Clinical Case Manager will perform <i>Mental Health</i> and <i>Substance Abuse/Use Assessments</i> in accordance with RWGA Quality Management guidelines. Service plan must reflect an ongoing discussion of mental health treatment and/or substance abuse treatment, primary medical care and medication adherence, per client need. <i>Clinical Case Management</i> is both office and community-based. Clinical Case Managers will interface with the primary medical care delivery system as necessary to ensure services are integrated with, and complimentary to, a client's medical treatment plan.</p>
<p>Service Unit Definition(s):</p>	<p>One unit of service is defined as 15 minutes of direct client services and allowable charges.</p>

<p>Financial Eligibility:</p>	<p>Refer to the RWPC's approved <i>Financial Eligibility for Houston EMA Services</i>.</p>
<p>Client Eligibility:</p>	<p>HIV-infected individuals residing in the Houston EMA.</p>
<p>Agency Requirements:</p>	<p><i>Clinical Case Management</i> services will comply with the HCPH/RWGA published Clinical Case Management Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system.</p> <p><i>Clinical Case Management Services</i> must be provided by an agency with a documented history of, and current capacity for, providing mental health counseling services or substance abuse treatment services to PLWH/A in the Houston EMA. Subrecipient must clearly demonstrate it has provided mental health treatment services (e.g. professional counseling) or substance abuse treatment services in the previous calendar or grant year to individuals with an HIV diagnosis. Acceptable documentation for such treatment activities includes standardized reporting documentation from the County's CPCDMS or Texas Department of State Health Services' ARIES data systems, Ryan White Services Report (RSR), SAMSHA or TDSHS/SAS program reports or other verifiable <u>published</u> data. Data submitted to meet this requirement is subject to audit by HCPH/RWGA prior to an award being recommended. Agency-generated non-verifiable data is not acceptable. In addition, subrecipient must demonstrate it has the capability to continue providing mental health treatment and/or substance abuse treatment services for the duration of the contract term and any subsequent one-year contract renewals. Acceptable documentation of such continuing capability includes <u>current</u> funding from Ryan White (all Parts), TDSHS HIV-related funding (Ryan White, State Services, State-funded Substance Abuse Services), SAMSHA and other ongoing federal, state and/or public or private foundation HIV-related funding for mental health treatment and/or substance abuse treatment services. Proof of such funding must be available and is subject to independent verification by HCPH/RWGA.</p> <p>Loss of funding and corresponding loss of capacity to provide mental health counseling or substance abuse treatment services as applicable may result in the termination of Clinical Case Management Services awarded under this service category. Continuing eligibility for Clinical Case Management Services funding is explicitly contingent on subrecipient maintaining verifiable capacity to provide mental health counseling or substance abuse treatment services as applicable to PLWH/A during the contract term.</p> <p>Subrecipient must be Medicaid and Medicare Certified.</p>
<p>Staff Requirements:</p>	<p>Clinical Case Managers must spend at least 42% (867 hours per FTE) of their time providing direct case management services. Direct case management services include any activities with a client (face-to-face or by</p>

	<p>telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the Centralized Patient Care Data Management System (CPCDMS) according to CPCDMS business rules.</p> <p><i>Must comply with applicable HCPH/RWGA Houston EMA/HSDA Part A/B Ryan White Standards of Care:</i></p> <p><u>Minimum Qualifications:</u></p> <p>Clinical Case Managers must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences and have a current and in good standing State of Texas license (LBSW, LSW, LMSW, LCSW, LPC, LPC-I, LMFT, LMFT-A or higher level of licensure). The Clinical Case Manager may supervise the Service Linkage Worker. CCM targeting Hispanic PLWHA must demonstrate both written and verbal fluency in Spanish.</p> <p><u>Supervision:</u></p> <p>The Clinical Case Manager (CCM) must function with the clinical infrastructure of the subrecipient and receive supervision in accordance with the CCM's licensure requirements. At a minimum, the CCM must receive ongoing supervision that meets or exceeds HCPH/RWGA published Ryan White Part A/B Standards of Care for Clinical Case Management. If subrecipient also has Service Linkage Workers funded under Ryan White Part A the CCM may supervise the Service Linkage Worker(s). Supervision provided by a CCM that is <u>not</u> client specific is considered indirect time and is not billable.</p>
<p>Special Requirements:</p>	<p>Subrecipient must employ full-time Clinical Case Managers. Prior approval must be obtained from RWGA to split full-time equivalent (FTE) CCM positions among other contracts or to employ part-time staff. Subrecipient must provide to RWGA the names of each Clinical Case Manager and the program supervisor no later than 3/30/17. Subrecipient must inform RWGA in writing of any changes in personnel assigned to contract within seven (7) business days of change.</p> <p>Subrecipient must comply with CPCDMS data system business rules and procedures.</p> <p>Subrecipient must perform CPCDMS new client registrations and registration updates for clients needing ongoing case management services as well as those clients who may only need to establish system of care eligibility. Subrecipient must issue bus pass vouchers in accordance with HCPHES/RWGA policies and procedures.</p>

FY 2018 RWPC “How to Best Meet the Need” Decision Process

Step in Process: Council		Date: 06/08/17
Recommendations:	Approved: Y_____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Steering Committee		Date: 06/01/17
Recommendations:	Approved: Y_____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Quality Assurance Committee		Date: 05/18/17
Recommendations:	Approved: Y_____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: HTBMTN Workgroup		Date: 04/25/17
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

SUMMARY FOR HOW TO BEST MEET THE NEED



**RYAN WHITE PART A QUALITY MANAGEMENT PROGRAM
HOUSTON EMA
CLIENT SATISFACTION REPORT, 2016
PREPARED BY HARRIS COUNTY PUBLIC HEALTH
RYAN WHITE GRANT ADMINISTRATION**

MARCH 2017

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CLIENT SATISFACTION SURVEY SERVICE CATEGORY SUMMARY

There were 252 respondents for case management services and the general consensus was favorable. See the *Attachments* section for the comprehensive output for case management services.

CASE MANAGEMENT SERVICES

<i>HOW OFTEN</i>	ALWAYS	MOST OF THE TIME	SOMETIMES	NOT VERY OFTEN	NEVER	NOT APPLICABLE	TOTAL
does your case manager treat you with dignity and respect?	231 92%	9 4%	4 2%	0 0%	1 0%	7 3%	252
are your meetings with your case manager at times and locations that are based on your preferences? (How often do you have a “say so” on when and where you meet?)	162 65%	47 19%	16 6%	3 1%	9 4%	11 4%	248
does the staff ask if you have other problems or needs that are not being addressed?	168 69%	45 18%	18 7%	4 2%	8 3%	1 0%	244
do you find the information provided to you by the staff to be correct and helpful?	180 72%	46 19%	10 4%	5 2%	0 0%	0 0%	241
<i>HOW SATISFIED</i>	VERY SATISFIED	SATISFIED	NOT SATISFIED	VERY UNSATISFIED	NOT APPLICABLE		TOTAL
are you with your case manager’s knowledge of community services and	193 78%	43 17%	5 2%	1 0%	5 2%		247

his/her ability to connect you with those services?							
are you with the staff's efforts to make sure that all of your personal information stays confidential?	206 85%	30 12%	1 0%	2 1%	3 1%		242
are you with the quality of the service you receive from this agency overall?	192 80%	42 18%	2 1%	0 0%	4 2%		240
<i>CULTURAL COMPETENCY</i>	VERY MUCH	A LOT	SOME	A LITTLE	NOT AT ALL	NOT APPLICABLE	TOTAL
How would you rate the staff's understanding and respect of your cultural / ethnic background and/or your lifestyle?	178 72%	48 20%	9 4%	4 2%	3 1%	4 2%	246
If English is not your primary language, how well does the staff communicate with you in your language?	89 37%	24 10%	6 3%	1 0%	0 0%	118 50%	238
<i>HELPFULNESS</i>	VERY MUCH	SOME	A LITTLE	NOT AT ALL	NOT APPLICABLE		TOTAL

How much would you say that the case management you receive from this agency has helped you to improve the problems, feelings, or situations that brought you here?	203 83%	28 11%	8 3%	5 2%	2 1%		246
WAIT TIME	VERY MUCH	A LOT	SOME	A LITTLE	NONE	NOT APPLICABLE	TOTAL
How much time usually passes between the time of your appointment, and the time you actually receive service?	135 56%	70 29%	19 8%	6 2%	5 2%	5 2%	240
CONVENIENCE	VERY OFTEN	A LOT	SOMETIMES	NOT OFTEN	NOT AT ALL	NOT APPLICABLE	TOTAL
If you make appointments, how often are you able to get them scheduled for a reasonable date and during hours that are convenient for you?	155 64%	61 25%	16 7%	4 2%	0 0%	6 2%	242
RECOMMEND	VERY HIGHLY	HIGHLY	NOT HIGHLY	RELUCTANTLY	NOT AT ALL	NOT APPLICABLE	TOTAL
How highly would you recommend this agency to others?	191 80%	40 17%	2 1%	0 0%	1 0%	5 2%	239
CONVENIENCE	VERY CONVENIENT	CONVENIENT	SOMEWHAT	A LITTLE	INCONVENIENT	NOT APPLICABLE	TOTAL
How would you rate the convenience of the office hours here?	141 58%	64 26%	25 10%	4 2%	3 1%	5 2%	242

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FY 2015 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

HCPH is the local public health agency for the Harris County, Texas jurisdiction. It provides a wide variety of public health activities and services aimed at improving the health and well-being of the Harris County community.

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Ryan White Part A
HIV Performance Measures
FY 2015 Report

Clinical Case Management
All Providers

For FY 2015 (3/1/2015 to 2/29/2016), 1,018 clients utilized Part A clinical case management.

HIV Performance Measures	FY 2014	FY 2015	Change
A minimum of 75% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing clinical case management	641 (50.6%)	402 (39.5%)	-11.1%
Percentage of clinical case management clients who utilized mental health services	298 (23.5%)	247 (24.3%)	0.8%
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	491 (74.6%)	382 (73.0%)	-1.6%
Percentage of clients identified with an active substance abuse condition who received Ryan White funded substance abuse treatment	0 (0.0%)	0 (0.0%)	0.0%
Percentage of clients who were homeless or unstably housed	411 (32.5%)	327 (32.1%)	-0.4%

According to CPCDMS, 8 (0.8%) clients utilized primary care for the first time and 57 (5.6%) clients utilized mental health services for the first time after accessing clinical case management.

Clinical Chart Review Measures	FY 2014
Percentage of HIV-infected clinical case management clients who had a case management care plan developed and/or updated two or more times in the measurement year	29%

THE CASE FOR BEHAVIORAL HEALTH SCREENING IN HIV CARE SETTINGS

SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS



integration.samhsa.gov

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ORIGINATING OFFICE

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

EFFECTIVE MEDICAL AND BEHAVIORAL HEALTH INTERVENTIONS HAVE TRANSFORMED HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) FROM A DEATH SENTENCE INTO A CHRONIC AND TREATABLE DISEASE. AS INDIVIDUALS LIVING WITH HIV LEAD LONGER LIVES AND ENJOY A GREATER SENSE OF WELL-BEING THAN EVER BEFORE, CLINICS THAT PROVIDE HIV TREATMENT SERVICES MUST BE RESPONSIVE TO THE VARIETY OF HEALTH NEEDS OF THIS POPULATION.

SUBSTANCE USE AND HIV/AIDS

The goal of HIV care is to achieve and maintain viral suppression – a very low level of HIV in the body. Yet, the health of a person living with HIV cannot be defined solely by their viral load levels. Adhering to the antiretroviral treatment (ART) that suppresses HIV and maintaining a healthy lifestyle are critical to controlling the disease and can be complicated by behavioral health conditions (mental illness and substance use disorders). People living with HIV have much higher rates of behavioral health disorders than the general population.

Consider these facts about the connections between HIV/AIDS, mental illness, substance use and trauma.

- People living with HIV have high rates of past or current history of alcohol or substance use disorders (SUDs).^{i,ii,iii}
- 66 percent have used illicit drugs and 16.5 percent have a history of intravenous drug use.ⁱⁱ
- 24 percent report receiving treatment for SUDs.ⁱⁱⁱ

MENTAL ILLNESS AND HIV/AIDS

People living with HIV experience mental illness at significantly higher rates than the general population. A 2008 study stated that the rate of co-occurring mental illnesses in people with HIV was so high that “having a single mental health diagnosis was the exception rather than the rule.”^{iv} Specifically, people living with HIV have:

- Two to five times higher rates of depression.^{v,vi}
- Up to four times higher rates of depression among women with HIV than women who do not have HIV.^{vii}
- Higher rates of anxiety.^{viii,ix,x,xi}

TRAUMA AND HIV/AIDS

People living with HIV are more likely to have a history of trauma.

- A person who has experienced trauma and has a serious mental illness has an increased likelihood of having an HIV infection.^{vi}
- The prevalence of traumatic experiences among those with HIV can be as high as 42 percent for women^{xii} and up to 70 percent for all people living with HIV – which means that people with HIV are as much as twenty times more likely to have experienced trauma than the general population.^{xiii,xiv}

HOW LIKELY IS IT THAT PEOPLE WITH HIV/AIDS HAVE MULTIPLE CO-OCCURRING MENTAL ILLNESSES AND SUBSTANCE USE DISORDERS?

An estimated 10-28 percent of people with HIV have co-occurring SUDs and mental illnesses.^{xv} Many people living with HIV and with depression had several other mental health disorders, including 78 percent with anxiety disorders and 61 percent with SUDs.^{xvi}

IMPACT OF BEHAVIORAL HEALTH CONDITIONS ON HIV CARE

The prevalence of mental illness among people living with HIV poses a threat to the health of the individual and has a profound effect on physical wellness. For example, people with depression and HIV are more likely to have higher viral loads, more symptoms of anxiety and are more likely to have a substance use problem.^{xvii} People with HIV and a co-occurring behavioral health condition may increase risky behaviors, such as unprotected sex or sharing needles, or diminish self-care, such as taking medication as prescribed and getting adequate food and rest. Other interrelated social determinants of health, including poverty, low educational attainment and housing insecurity can also complicate HIV treatment and maintenance of a healthy lifestyle. Addressing behavioral health concerns can play a critical role in the public health approach to reducing transmission of HIV. These reasons are why it is important for HIV clinics to conduct behavioral health screenings.

THE PROBLEM: SCREENING IS INCONSISTENT

Despite these compelling data, studies indicate there is insufficient screening for substance use in HIV care clinics.

- 35 percent of patients in 10 HIV care centers reported talking with their primary care provider about their alcohol use.
- 52 percent of those with more serious alcohol and other drug use reported discussing it with their primary care provider.^{xviii}
- Fewer than 50 percent of primary care providers in hospital-based HIV care programs conducted recommended screening and brief interventions for reducing alcohol use.^{xix}

SCREENING FOR BEHAVIORAL HEALTH: CRITICAL BUT UNDERUSED

A truly effective model for supporting individual and population health integrates behavioral health services (including screening, assessment and treatment) with primary HIV care. Integrating depression screening helps identify those who can benefit from combined psychotherapy and pharmacotherapy interventions.^{xx} The [Screening, Brief Intervention and Referral to Treatment \(SBIRT\)](#) model identifies risky substance use, provides brief interventions for those with lower level substance use before it becomes a problem and offers referral for those who need more intensive, specialty care. Early detection through screening can result in earlier intervention and substance abuse treatment, including [medication-assisted treatment](#), which can make a substantial difference in the health of the individual and reduce transmission of HIV by increasing medication compliance^{xxi}

WHAT SCREENING FORMS ARE AVAILABLE?

Numerous tools are available for screening both general and specific behavioral health issues, including:

- **General Wellness** — Healthy Living Questionnaire or Patient Stress Questionnaire
- **Trauma** — Life Event Checklist
- **Depression** — PHQ-9
- **Generalized Anxiety Disorder** — GAD-7
- **Substance Use Prescreen** — National Institute on Alcohol Abuse and Alcoholism's (NIAAA) 3 Question Screen or National Institute on Drug Abuse's (NIDA) quick screen
- **Substance Use In-Depth** — AUDIT or ASSIST

Visit the Center for Integrated Health Solutions (CIHS) website to learn more about these and other [screening tools](#).

Note: These tools are examples and do not include all screening forms available. This does not constitute particular recommendations or endorsements for use.

Integrated primary HIV and behavioral health care improves physical health outcomes and leads to increased savings in health care costs through reduced emergency room use, increased efficiency, reimbursable use of staff time and other means of cost-savings.^{xxii}

Many Federal grant-funded programs require routine or universal screening for a range of health conditions. The [Ryan White HIV/AIDS Treatment Extension Act of 2009](#) requires funded organizations to follow the [HHS Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents](#), which includes screening for clinical depression and substance use and, if they are identified, developing a follow-up plan to address these issues. This emphasis on screening for behavioral health conditions helps Ryan White-funded organizations ensure that it is a routine part of coordinated care.

REPORT FROM THE FIELD

ABOUT THIS REPORT

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) conducted interviews with direct care HIV provider organizations across the United States and an interview with a public health program supporting the statewide implementation of SBIRT for HIV provider organizations. Several of these programs are health centers that include primary HIV medical care, although one program primarily focuses on behavioral health treatment that includes primary care for people living with HIV.

The provider organizations interviewed were at varying levels of integration, ranging from partial co-location of some behavioral health staff and services to fully integrated. Even the most integrated programs referred patients externally for residential treatment, some referred for detox and/or medication-assisted treatment for addiction and others referred for treatment of serious mental illness.

WHAT IS SBIRT?

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce and prevent problematic substance use, abuse and dependence on alcohol and illicit drugs. The SBIRT model responds to a recommendation by the Institute of Medicine for community-based screening of health risk behaviors, including substance use.

The Three Steps of SBIRT:

- 1 **Screening** — A health care professional assesses a person for risky substance use behaviors through standardized screening tools.
- 2 **Brief Intervention** — A short nonjudgmental conversation between a health care professional and patient exhibiting risky substance use behaviors, including feedback and advice.
- 3 **Referral to Treatment** — For patients whose screening results indicate the need for specialty services, a health care professional provides a referral for additional treatment.

Learn more about SBIRT at www.integration.samhsa.gov/clinical-practice/SBIRT and at www.samhsa.gov/SBIRT.

For more information on SBIRT in HIV care settings, see http://aidsetc.org/sites/default/files/resources_files/sbirt.pdf



WHO SCREENS, WHEN AND WITH WHAT TOOLS?

Almost all of the programs interviewed reported screening between 80 to nearly 100 percent of their patients with HIV for mental health problems, but were less likely to offer universal screening for substance use.

The most commonly used screening instrument was the Patient Health Questionnaire (PHQ-2 and PHQ-9), which screens for depression. Programs who did regularly screen for substance use (or for co-occurring substance use and mental illness) used the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) or other tools. Typically, individuals respond to screening questions and self-report answers using a pen and paper or a tablet computer. Some programs ask patients to fill out a written screening form in the waiting room, while others have medical assistants/technologists, case managers, patient or peer navigators or health educators conduct the screening in the exam room.

Written responses are included in a patient's medical chart. Screenings administered on tablets or other technologies allow responses to go directly to the electronic health record (EHR).

TIPS FOR IMPLEMENTING SCREENING FOR BEHAVIORAL HEALTH

Based on the key informant interviews, the following recommendations are offered as ways HIV clinics can establish consistent behavioral health screening.

ORGANIZATIONAL CULTURE

EXPECT AND SHARE POSITIVE PATIENT OUTCOMES.

"We're committed to it. We saw what a difference it made in the lives of our patients." – Senior Program Manager

- Several participants reported that their organizations believed strongly that screening and treatment for SUDs and mental illnesses improves adherence to ART and better health outcomes.
- Programs ensure that staff are well aware of the link between behavioral health and good health outcomes for people living with HIV and use this knowledge as motivation for conducting the screening and referral to treatment.
- Many of the integrated facilities reported that since they began universal screening, viral suppression of those with behavioral health disorders was reduced to be the same as those

TECHNOLOGY-BASED SCREENING

Electronic Patient Recorded Outcomes (ePRO) is a web-based system that allows patients to complete screenings on a tablet at the beginning of their visit. The ePRO system screens for depression, tobacco, intimate partner violence, learning needs, drug and alcohol use, anxiety, sexual risk behavior, medication adherence, health-related quality of life and physical activity and includes a symptom index.

The software can determine which surveys are appropriate for each visit based on set criteria and determines what issues are most important for each visit based on the results of a brief five-minute screening. Screening results flow directly into the EHR so that they are immediately available to the team of providers. This streamlines documentation workflow, supports data-driven evaluation of individual and group outcomes and monitors for quality assurance.

A busy federally qualified health center (FQHC) on the east coast uses the ePRO system to screen all patients. The clinic has about 40 iPads available for use – one per provider. Program evaluations indicate the technology is well received by both patients and staff. While the technology is intuitive and user-friendly, staff are trained to give a brief tutorial on using the iPad for patients who need assistance. ePRO has both English and Spanish language options; however, if a patient speaks another language or cannot use the technology, a staff member can conduct the screening verbally.

The program received a National Institutes of Health grant to study the system's effectiveness and a local health insurance company foundation supported additional iPads. Costs include web-hosting services, storage lockers to charge the iPad and programming to load information directly into the EHR.

without behavioral health disorders. These positive outcomes were shared with staff to reinforce the importance of screening and treatment for mental illnesses and addictions.

FOSTER COLLABORATION BETWEEN PRIMARY AND BEHAVIORAL HEALTH PROFESSIONALS.

"I'm there. I'm in their view. It makes it more likely that they are going to refer to me when they actually see me." — Behavioral Health Clinician

- Programs that reported high rates of screening and referrals to treatment provided opportunities for primary and behavioral health care professionals to communicate and collaborate.
- In programs that were highly integrated, multidisciplinary communication takes place during in-person case conferences from once a week to two times per month. Some programs conduct daily morning "huddles."
- Several program managers noted that face-to-face contact is critical to building effective working relationships that support collaborative and coordinated care
- One behavioral health program emphasized recruiting for onsite primary care providers who understood that communication with the behavioral health clinicians was critical to the team.
- Another program affiliated with a teaching hospital found annual training was necessary to reinforce a culture of communication to interns and residents.

- Several programs noted that both in-person communication and communication through secure EHRs were necessary to distribute critical information to the entire multidisciplinary care team.

HELP PRIMARY CARE PROVIDERS SEE THE VALUE IN SCREENING.

After implementing SBIRT statewide, the value of screening was demonstrated to primary care providers by the number of lower-level substance use issues that were effectively addressed through brief interventions by health educators before they reached the level of SUD. Examples from similar organizations like, “Using SBIRT, a busy HIV clinic like yours identified 15 percent more patients with risky substance use,” can be effective tools to demonstrate the value of screening and brief interventions to primary care providers.

- A state health program that implemented SBIRT in all of its contracted HIV clinics observed that some primary care providers incorrectly believe that they already identify individuals with risky substance use or mental health problems without screening.
- A few programs questioned the value of screening, because they believed an effective medical provider should be able to identify behavioral health problems based on their clinical judgment and knowledge of a particular patient. However, research shows that primary care providers recognize depression only 50 to 70 percent of the time.^{xx}
- A large HIV clinic using electronic screening methods captured reports of mental health or substance use problems that were previously missed or undocumented by primary care providers for a significant number of patients.^{xxiii} Nurses in that clinic are trained to treat the results of screening as “another vital sign,” like blood pressure or heart rate.

INFRASTRUCTURE AND IMPLEMENTATION

SCREEN ALL PATIENTS, NOT JUST THOSE WITH HIV.

Programs reporting high rates of screening conduct behavioral health screening on all of their patients, regardless of HIV status. This sets an institutional expectation for screening which helps staff become more comfortable with the process and allows screening to become part of workflow and quality assurance processes. Universal screening reduces the possibility of biases that might influence a decision to skip screening. For example, some programs reported that middle- and up-per-income individuals were not always screened. Anything staff can do to “normalize” behavioral health screening demonstrates to patients that it is a routine part of health care.

- In a state that conducts SBIRT throughout its HIV clinics, providers learned to shift their thinking from identifying disorders and referring to treatment only those that they perceive as “high risk” to identifying risk factors and intervening among all patients.
- One program reported that patients sometimes leave a number of questions blank at the end of the PHQ-9 because of fear of hospitalization if there are too many “yes” responses. In those situations, staff recommends a follow-up conversation with the primary care provider or a warm hand-off to a behavioral health professional.

PLAN THE ROLLOUT OF SCREENING CAREFULLY.

Planning for change in a busy primary HIV care program requires an understanding of how the change will affect the larger clinic environment. The planning process should include:

- Carefully selecting validated screening tools and a workflow analysis.
- Implementing screening instruments based on clinic workflow and adjusting as necessary.
- Training all employees in the screening process, including how to conduct screening and respond to results.
- Defining project success to all employees by transparently communicating outcomes.

A [“Plan-Do-Study-Act”](#) cycle of analysis may be effective when implementing change. A program that struggled to implement screening said primary care providers were concerned about the time it takes. The clinic — which now boasts a 97 percent screening rate — studied the workflow process and reduced the time for medical assistants to enter results into the chart to four minutes. The program is trying to reduce that time even further.

TRAIN STAFF TO CODE THE SCREENING AND/OR BRIEF INTERVENTIONS FOR BILLING.

The fact that SBIRT was billable under Medicaid was one factor in achieving buy-in for the statewide implementation program. Teaching staff to [code for screening and brief interventions](#) ensured the clinic recouped some of the related expenses. Programs should review their states' Medicaid system to determine if brief interventions by paraprofessionals such as health educators or peer specialists are reimbursable.



CONNECTING PATIENTS TO COMPLEX SYSTEMS OF CARE

A west coast behavioral health program that integrated primary care into its services for patients who have HIV or AIDS created a navigation program to connect patients to care, including screenings, assistance navigating the health care system and links to behavioral and mental health service. The goals are to improve patient experiences by delivering care when it is most needed, provide access to additional behavioral health supports and improve behavioral health follow-up.

Patient navigators enhance co-located services by completing patient intake procedures, connecting their assigned patients to the correct services and “tracking” them using the EHR and other internal management information systems. For example, the program uses the PHQ-2 to identify potential depression. If patients are flagged for follow-up based on the screening, they receive medical care and are then connected to the behavioral health specialist on call. The patient navigator consults with other service providers and provides input on treatment for up to three months to ensure the patient follows through on referrals. Quality assurance is measured by assessing the number of patients assisted by the patient navigator and the percentage of patients who follow through with service appointments.

GET BUY-IN FROM KEY STAKEHOLDERS.

- A large urban clinic that uses technology-based screening (see box, page 8) began its rollout slowly, starting with a “champion” on one floor. This early adopter communicated success to others, which paved the way for implementation to the rest of that floor. Program managers studied problems with clinic flow, refined the process and rolled it out on another floor, then another.
- The statewide SBIRT program also used champions within a primary care provider system to support implementation.

FACILITATE COMMUNICATION BETWEEN PRIMARY AND BEHAVIORAL HEALTH CARE PROVIDERS.

Integrated EHRs allow providers to share notes, referrals and medications, which enhances their ability to provide informed care. A 2011 policy paper by the HIV Medicine Association and the Ryan White Medical Providers Coalition states, “EHRs are a key component of effective integrated care and medical home models.”^{xxiv} The Institute of Medicine (IOM) notes that both in-person and electronic communication facilitates [care coordination](#) among providers and are key steps in redesigning effective health systems, creating patient-centered medical homes and ensuring better outcomes.^{xxv}

- A program that allows onsite access to EHRs to only one full-time mental health clinician and not to contracted off-site behavioral health clinicians, reported significantly less communication between primary care and behavioral health providers.

PROVIDE SUPPORTS THAT MAKE REFERRAL TO TREATMENT STICK.

Successful programs with increased referrals and high levels of retention with behavioral health interventions are highly integrated, with numerous clinicians who are available to receive a “[warm hand-off](#)” from either a primary care provider or a non-medical staff member. Support resources may include

a health educator, case manager or peer/patient navigator focusing on accessing the behavioral health program, filling out paperwork and securing other support services, such as transportation.

DEVELOP EFFECTIVE LINKS TO SUBSTANCE USE DISORDER AND MENTAL HEALTH TREATMENT PROGRAMS.

Even the most integrated primary HIV care programs do not have the full continuum of behavioral health care available onsite such as detox, medication assisted treatment for addiction, intensive outpatient treatment for addiction or mental health or residential treatment. Formal partnerships that outline in a memorandum of understanding, clear roles, responsibilities and communication expectations with shared EHRs and co-location of some services in the primary care site can facilitate referrals.

PEOPLE AND PLACES

CONSIDER USING NON-CLINICAL STAFF FOR SCREENING AND BRIEF INTERVENTIONS.

Most programs use staff without advanced medical training — medical assistants, health educators, peer/patient navigators or community health workers — to conduct the brief screening such as the PHQ-2 and AUDIT-C and used behavioral health providers for longer assessments like the PHQ-9 and AUDIT.

- The state that implemented SBIRT used highly trained health educators to conduct screening and brief interventions for substance use to provide effective and nonjudgmental support and reduced cost.

CHOOSE APPROPRIATE BEHAVIORAL HEALTH CLINICIANS FOR WARM HAND-OFFS AND REFERRALS.

Behavioral health clinicians in an integrated and/or co-located program must be particularly flexible and understand the model for providing services in a primary care setting. This means being available for a warm hand-off for immediate assessment and accepting the responsibility of providing mostly short-term interventions (four to six visits). Referrals are reserved for longer-term therapy.

Not all behavioral health clinicians feel comfortable with this model. Many are used to, or prefer the predictable pace of a 50-minute session that provides the opportunity to develop longer-term relationships with clients. During the interview process, job previews – like having a prospective employee spend time in the clinic shadowing a similar behavioral health clinician or showing videos of the clinic experiences – may be helpful in creating realistic expectations.

HIRE ENOUGH BEHAVIORAL HEALTH PROVIDERS.

Having enough behavioral health staff available increases the probability that further assessment, case consultation and warm hand-offs to behavioral health services will take place. One of the biggest challenges organizations face is too few internal and external behavioral health providers for referrals or case consultation, particularly with psychiatrists or psychiatric nurse practitioners for psychopharmacology.

- A program that reported having enough behavioral health clinicians to be flexible and easily available worried about retaining these positions when the state grant funding that supports their salaries runs out. The growing workforce of peer providers is emerging as an important resource for programs.^{xxvi,xxvii}
- Unrealistic workload expectations may affect employee retention and continuity of care. One program reported that its social worker who had a caseload of 190 HIV-positive patients also conducted all the annual assessments, leaving little time for short- or longer-term interventions. The clinic reported high turnover among social workers and struggles with fully integrating behavioral health.

TRAIN, TRAIN, TRAIN.

Retraining capabilities should be built into all training programs.

- One program recognized that the need for increased training to reduce the number of refusals for addiction screening, particularly from the transgender population. The number of refusals dropped among all populations after they offered additional training to screening staff, primary care providers and others.

CONSIDER PHYSICAL LOCATION.

“Space is the final frontier.” – Program Manager who successfully argued for an exam room for mental health clinicians

Physical location can influence the outcomes of both screening and subsequent assessment/referral.

- A program that uses tablets for screening conducted a study on differences in refusal rates. The refusal rates were lower when patients were screened in exam rooms compared to screenings in waiting rooms. This suggests that willingness to participate in screening depends on perceived privacy.

Physical location also influences post-screening brief interventions or treatment referral. Availability of onsite assessment and treatment referral facilitates a warm hand-off from the primary care provider to the behavioral health clinician.

- A program reported a 50 percent rate of follow-through when its behavioral health services were 1.5 miles away. Follow-through on referrals increased when services were co-located.
- Co-location itself does not guarantee a warm hand-off. A clinic with a contracted behavioral health clinician was co-located on a floor with primary HIV care; however, the behavioral health clinician — who must bill his/her time — is often behind closed doors, making it difficult to connect patients to him/her.
- Three highly integrated programs report that appropriate scheduling allows their behavioral health clinicians to be available 50 percent of the time for warm hand-offs, detailed assessments, brief interventions, crisis stabilization and other related activities.
- For many programs, grants and other fundraising enables clinicians to be scheduled for non-billable time.

STATEWIDE IMPLEMENTATION OF SBIRT

The efficacy of the SBIRT model in identifying risk of SUDs led a western state to implement it for all Ryan White programs, including clinics and AIDS service organizations. The state's public health program ensured adoption across all programs by requiring use of SBIRT in its contract.

While some SBIRT programs pose one or two questions about substance use, this state asks four key questions. Two questions focus on alcohol — the number of drinks per week and the last time four to five drinks were consumed in one day — one asked about the use of an illegal drug or a prescription drug for nonmedical reasons in the past year and one focused on tobacco use. If the results indicate a possible substance use problem, health educators use additional screens or longer assessment instruments to explore the scope of the issue.

Staff at many primary care programs were skeptical about the effectiveness of screening and worried about its effect on various clinic flow issues. Questions arose about the time it would require, who would perform the screening and brief intervention, where would it take place and finding appropriate places for referral. As training rolled out across the state and similar clinics reported success, primary care providers started to embrace SBIRT. Approximately 85 percent of patients at publicly funded clinics who are HIV-positive are screened with SBIRT at least once a year and 50 to 60 percent are screened annually for mental health concerns.

Focus groups revealed that patients appreciated the opportunity to talk with medical providers about substance use when asked in a respectful way and providers felt it gave them a more complete picture of patients' health. The SBIRT program helped normalize discussions about substance use in medical settings by demonstrating to primary care providers that those who screen positive for some risky behaviors are not necessarily addicted to alcohol or other drugs, but are part of a wider continuum of people who may need intervention.

Lessons learned about supporting SBIRT implementation included the importance of finding champions within each program and using them to develop staff support, define clear protocols that match clinic flow and improve referral systems to ensure that those who need more than a brief intervention receive additional treatment.

CONCLUSION

Behavioral health screening is an important step for health care provider organizations to increase access to quality behavioral health care. By following the steps and examples outlined, organizations can build effective behavioral health screening that supports a system of integrated care. These recommendations and lessons learned, when implemented, can result in a truly effective and more comprehensive model to meet the multiple needs of individuals living with HIV.

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