Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Clinical Case Management** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	**Medical Case Management**
Local Service Category Title:	**Clinical Case Management (CCM)**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not applicable.
HRSA Service Category Definition: **RWGA Only**	***Medical Case Management services (including treatment adherence)*** 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 HCPHS/RWGA policies.
Target Population (age,	Services will be available to eligible HIV-infected clients residing in

gender, geographic, race, ethnicity, etc.):	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, 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. *Clinical Case Management* 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.
Services to be Provided:	Provision of Clinical Case Management activities performed by the Clinical Case Manager. *Clinical Case Management* 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. *Clinical Case Management* 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 *Clinical Case Manager* 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 *Mental Health* and *Substance Abuse/Use Assessments* 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. *Clinical Case Management 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.
Service Unit Definition(s): **RWGA Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	HIV-infected individuals residing in the Houston EMA.
Agency Requirements:	*Clinical Case Management* services will comply with the HCPHS/RWGA published Clinical Case Management Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system *Clinical Case Management Services* must be provided by an agency with a documented history of, and current capacity for, providing mental health counseling services (categories b., c. and d. as listed under *Amount Available* above) or substance abuse treatment services to PLWH/A (category a. under *Amount Available* above) in the Houston EMA. Specifically, an applicant for this service category must clearly demonstrate it has provided mental health treatment services (e.g. professional counseling) or substance abuse treatment services (as applicable to the specific CCM category being applied for) 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 published data. Data submitted to meet this requirement is subject to audit by HCPHS/RWGA prior to an award being recommended. **Agency-generated non-verifiable data is not acceptable.** In addition, applicant agency 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 current 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 documented in the application and is subject to independent verification by HCPHS/RWGA prior to an award being recommended. 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 applicant agency maintaining verifiable capacity to provide mental health counseling or substance abuse treatment services as applicable to PLWH/A during the contract term. **Applicant agency must be Medicaid and Medicare Certified**.
Staff Requirements:	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 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. *Must comply with applicable HCPHS/RWGA Houston EMA/HSDA Part A/B Ryan White Standards of Care:* Minimum Qualifications: **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. Supervision: The **Clinical Case Manager** (CCM) must function with the clinical infrastructure of the applicant agency and receive supervision in accordance with the CCM's licensure requirements. At a minimum, the CCM must receive ongoing supervision that meets or exceeds HCPHS/RWGA published Ryan White Part A/B Standards of Care for Clinical Case Management. If applicant agency 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 not client specific is considered **indirect time** and is not billable.
Special Requirements: **RWGA Only**	Contractor 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. **Contractor must provide to RWGA the names of each Clinical Case Manager and the program supervisor no later than 3/30/17. Contractor must inform RWGA in writing of any**

	changes in personnel assigned to contract within seven (7) business days of change. Contractor must comply with CPCDMS data system business rules and procedures. Contractor 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. Contractor must issue bus pass vouchers in accordance with HCPHS/RWGA policies and procedures.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: No financial cap
1.	
2.	
3.	

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FY 2017 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

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Highlights from FY 2017 Performance Measures

Measures in this report are based on the 2017 Houston Ryan White Quality Management Plan, Appendix B. HIV Performance Measures.

Clinical Case Management

- During FY 2017, from 3/1/2017 through 2/28/2018, 1,265 clients utilized Part A clinical case management. According to CPCDMS, 632 (50%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing clinical case management.
- Among these clients, 328 (26%) clients accessed mental health services at least once during this time period after utilizing clinical case management.
- For clients who have lab data in CPCDMS, 71% were virally suppressed

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Clinical Case Management
All Providers

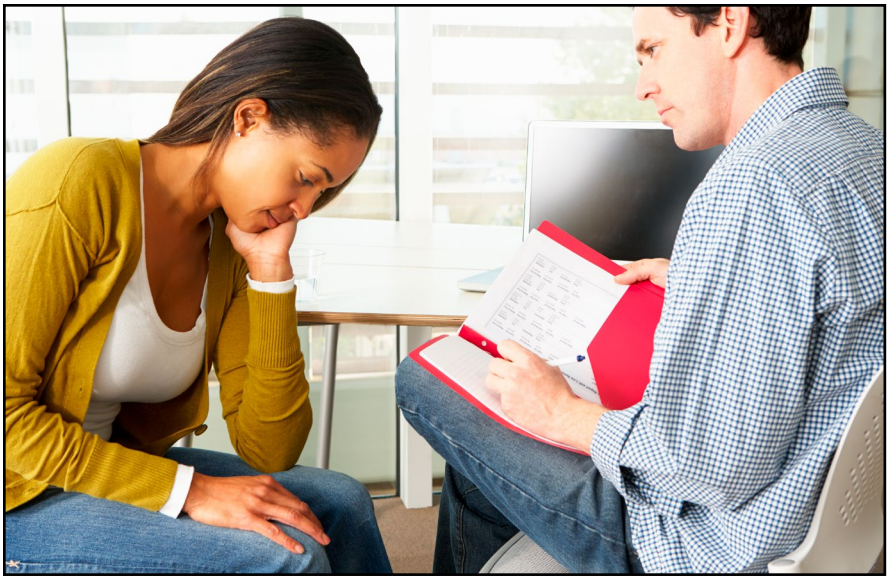
For FY 2017 (3/1/2017 to 2/28/2018), 1,265 clients utilized Part A clinical case management.

HIV Performance Measures	FY 2016	FY 2017	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	685 (48.7%)	632 (50.0%)	**1.3%**
Percentage of clinical case management clients who utilized mental health services	360 (25.6%)	328 (25.9%)	**0.3%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	501 (69.0%)	466 (71.1%)	**2.1%**
Percentage of clients who were homeless or unstably housed	322 (22.9%)	217 (17.2%)	**-5.7%**

According to CPCDMS, 27 (2.1%) clients utilized primary care for the first time and 96 (7.6%) clients utilized mental health services for the first time after accessing clinical case management.

Clinical Chart Review Measures	FY 2016
*Percentage of clinical case management clients who had a case management care plan developed and/or updated two or more times in the measurement year	41%
Percentage of clients identified with an active substance abuse condition receiving Ryan White funded substance abuse treatment	30%

*For FY 2017, due to limited data, combined clinical/medical case management plans were evaluated.



THE ROLE OF BEHAVIORAL HEALTH SERVICES IN THE RYAN WHITE HIV/AIDS PROGRAM

BEHAVIORAL HEALTH CONDITIONS AMONG PEOPLE LIVING WITH HIV

Although the ultimate goal of HIV care for people living with HIV (PLWH) is to achieve viral suppression, accessing HIV care and following treatment plans, including antiretroviral therapy, can be complicated by co-occurring behavioral health conditions. These conditions can include such mental disorders as depression and anxiety, trauma, and substance use disorders (SUDs), such as alcohol and illegal drug use. PLWH often have more than one behavioral health condition, which makes it even more difficult for them to follow HIV treatment plans and reach the goal of viral suppression. Having a behavioral health disorder also increases the likelihood of engaging in risky behaviors, such as unsafe sex and substance misuse, and often interferes with medication adherence and leads to worse health outcomes and quality of life. [1,2,3]

Mental disorders Among PLWH

Having a condition as serious as HIV is a source of stress for many PLWH and may result in the development of mental disorders, such as depression and anxiety, or complicate existing mental disorders. It has been estimated that as many as 50 percent of PLWH in care also have mental disorders. Approximately 36 percent of

DIRECTOR'S NOTE

This edition of *HRSA CAREAction* examines how integrating behavioral health services into primary care can better support the emotional, psychological, and social well-being of people living with HIV (PLWH) to achieve optimal HIV health outcomes. Behavioral health conditions, such as mental disorders and substance use disorders (SUDs), can make it more challenging for PLWH to manage their daily lives, attend medical appointments, connect with support networks, engage in healthy behaviors, and adhere to treatment plans—all of which may lead to the progression of HIV. Because of the detrimental effects of behavioral health conditions on HIV health outcomes, traditional service delivery approaches often do not provide the level of comprehensive and integrated care that PLWH who have behavioral health disorders need.

Since its implementation 27 years ago, the Health Resources and Services Administration's Ryan White HIV/AIDS Program has been addressing the comprehensive health care needs of PLWH, including behavioral health services. In 2014, almost 75 percent of Ryan White HIV/AIDS Program provider organizations provided mental health services, and 34 percent provided SUD services. Integrating behavioral health services into primary care is one of the most effective ways to care for people with multiple health care needs and improve both medical and behavioral health outcomes among PLWH. This newsletter features several Program recipients' "stories from the field," or best practices that demonstrate some of the many ways to integrate behavioral health services into HIV care.

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Associate Administrator for the HIV/AIDS Bureau, Health Resources and Services Administration

these have depression, and 16 percent have anxiety.[4] A 2008 study stated that the rate of co-occurring mental disorders among PLWH was so high that "having a single mental health diagnosis was the exception rather than the rule."[5] Depression rates among PLWH receiving care are about three times higher than in the general population.[6] Anxiety symptoms are common among people with depression and can develop or recur for many reasons, including a patient's worries about HIV infection and treatment or issues unrelated to HIV. Depression, anxiety, and other mental disorders can have profound effects on the physical and mental well-being of a person living with HIV. Research shows that depression may lower immune function, increase the risk of heart disease and other comorbidities, and result in early death.[7]

Trauma Among PLWH

Many PLWH in need of behavioral health services have experienced or witnessed interpersonal and/or community-level trauma, such as physical and sexual abuse, verbal abuse or assault, neglect, bullying, and community-based violence. These experiences may lead to symptoms of posttraumatic stress disorder (PTSD), including depression and anxiety, and may worsen the overall health and function of PLWH. Trauma can also result in social isolation, feelings of anger and distrust, and SUDs. PLWH who experience trauma have higher rates of mental health conditions than the general population. Approximately 42 percent of PLWH have experienced trauma and live with PTSD. Additionally, women experience PTSD at a much higher rate than men.[8] One study found that approximately 30 percent of HIV-positive women experience PTSD—more than five times the rate of PTSD among non-HIV-positive women—and about 55 percent of HIV-positive women experience intimate partner violence, which is more than twice the national rate.[9] Among HIV-positive men who have sex with men (MSM), 35 percent report childhood sexual abuse.[10]

SUDs Among PLWH

PLWH, including those with mental disorders, have high rates of having a past or current history of a substance use disorder from alcohol or drug use. According to data from the National Survey on Drug Use and Health, approximately 28 percent of PLWH aged 12 or older reported engaging in binge alcohol use in the past month.[11] Approximately 66 percent of PLWH have used illicit drugs, 16.5 percent have a history of intravenous drug use, and 24 percent of PLWH report receiving treatment for SUDs. An estimated 10 to 28 percent of PLWH have co-occurring SUDs and mental disorders. SUDs can lead to risky sexual behaviors, such as having sex without a condom and having multiple partners, behaviors that increase the risk of HIV transmission. Having a SUD also makes it difficult for PLWH to adhere to HIV treatment and attain the goal of viral suppression.[12]

TRAUMA-INFORMED CARE APPROACH AS PART OF INTEGRATED SERVICES

Providing sensitive and safe trauma-informed care helps to ensure the best possible health outcomes for survivors of trauma. Trauma-informed care is an approach in which providers—

- Understand the effects of past or current traumas in clients' lives and paths for recovery
- Recognize the signs and symptoms of trauma
- Respond to the effects of trauma by integrating practices and procedures on an organizational and individual level to help treat, empower, and heal patients who have experienced or are experiencing trauma.

The Illinois Department of Public Health (IDPH), a Ryan White HIV/AIDS Program recipient, emphasizes trauma-informed care through training for case managers. "Internally at the health department, we have done a significant amount of work on reducing the silos within IDPH—on the work that we're doing within trauma—so that we can learn from each other and collaborate with each other," explained Elizabeth McChesney, Client Services Coordinator for IDPH's program. IDPH added questions from the Adverse Childhood Experience module in the Behavioral Risk Factor Surveillance System to its online consumer needs assessment. The data collected ultimately help inform how IDPH provides HIV care and treatment.

RYAN WHITE HIV/AIDS PROGRAM AND INTEGRATED CARE TO IMPROVE BEHAVIORAL HEALTH OUTCOMES

PLWH benefit from comprehensive and integrated HIV care that provides access, coordination and linkages to mental health, trauma, and substance use evaluation, treatment, and services within the same system or facility. PLWH may encounter numerous obstacles to accessing behavioral health services in a traditional medical care setting, as well as poor integration of behavioral health and primary care services. These obstacles may include stigma and discrimination associated with HIV, behavioral health issues, or being part of a vulnerable population—including low-income PLWH who are uninsured and underserved, ethnic/minority populations, youth, older adults, and women—which may limit access to care and services. PLWH who have behavioral health conditions also may mistrust the medical system, which may affect their willingness to receive and maintain HIV care. Additionally, receiving behavioral care in traditional medical settings with providers who are not educated about PTSD and not trained in using a trauma-informed care approach, for example, may be distressing for PLWH who have experienced trauma and may exacerbate or trigger a negative memory to the trauma. Survivors of trauma, in particular, may also have difficulty answering intimate personal questions, removing their clothing, and having a physical exam, all of which may be perceived as invasive or threatening. They also may mistrust or be intimidated by the power dynamics of the doctor-patient relationship or the gender of the health care provider.

Unlike traditional medical systems, Ryan White HIV/AIDS Program recipients provide a comprehensive system of integrated HIV primary medical care—including specialized services using a trauma-informed care approach to respond to the effects of trauma on PLWH, case management and other essential support services, and medications—to PLWH who are uninsured and underserved. More than 550,000 people receive services through the Ryan White HIV/AIDS Program each year. Since the Program's inception 27 years ago, Ryan White HIV/AIDS Program recipients and providers have been addressing the health needs of PLWH through a patient-centered, team-based approach that integrates and coordinates behavioral and primary medical services. This integrated model of care is uniquely equipped to identify and respond to clients' behavioral health challenges because it allows providers to collaborate with one another and to assess and refer patients for specialized behavioral health disorder treatment within the same health care system or facility. It has further demonstrated improved health outcomes for PLWH because it increases accessibility to appropriate treatment and care, thus ultimately helping to achieve viral suppression. In 2016, approximately 85 percent of the Program's clients achieved viral suppression—the goal of HIV care.

Features of Integrated Behavioral Health Care

Effective, integrated behavioral health care is dependent on such features as dedicated and trained staff from multiple disciplines, co-located care services, a system for screening and referral of clients for behavioral health treatment, and ongoing communication between Ryan White HIV/AIDS Program providers and clients.[13, 14, 15]

Multidisciplinary team. The multidisciplinary care team comprises a range of providers with well-defined roles within the team, including primary medical practitioners and professionals—such as physicians and nurse practitioners—community health workers, peer navigators, social workers, psychiatrists, psychologists, addiction counselors, case managers, and medical assistants.

Co-located services. When primary and behavioral health services are located within the same medical system and facility—also known as a "one-stop shop" approach—or when linkages and referrals to behavioral health services are offered, clients are more likely to engage in and stay in care and receive appropriate treatment.

Screening and referral for behavioral health disorders. An integrated approach to HIV care enables providers to identify and evaluate patient health care needs and refer those patients with mental health conditions, trauma/PTSD, and SUDs to trained specialists for behavioral health services. See **Screening for Behavioral Health Disorders: A Critical Component of Integrated Care**.

Staff training. For behavioral health care to be most effective, the whole health team—from office receptionists and intake specialists to providers and peer navigators—benefits from regularly scheduled training. Staff training may focus on identifying patients with behavioral health conditions; how mental illness, trauma, and SUDs may affect the lives of clients; how to sensitively interact with clients who have experienced trauma/PTSD; and other relevant topics.

Patient engagement and empowerment. Ongoing engagement and communication between health care providers and clients build trust and also may improve behavioral health outcomes for PLWH. Clients are better able to make informed health care decisions when Ryan White HIV/AIDS Program providers share and discuss HIV care options and listen to what matters most to the patient. Other positive outcomes may include greater retention in HIV care, improving medical adherence, and lowering health care costs.

Communication among health care staff. Ongoing effective communication and collaboration among providers is vital to ensure that clients receive the care they need. Integrated care teams use informal face-to-face conversations between providers who may encounter each other in a hallway, for example, and more structured types of communication, such as daily "huddles" and weekly, biweekly, and monthly meetings to review clients' care, treatment plans, and clinical progress. Using this approach, primary care providers and behavioral health specialists also review one another's client notes via electronic medical records, consult with one another, and address treatment plans as needed, including medications, talk therapy, and educational interventions to help clients with HIV also manage their behavioral health conditions.

SCREENING FOR BEHAVIORAL HEALTH DISORDERS: A CRITICAL COMPONENT OF INTEGRATED CARE

Routine screening and identifying substance use and mental disorders as early as possible are critical components of integrated care. Incorporating screenings and referrals into behavioral health services can help PLWH with behavioral health conditions stay engaged in care and improve overall treatment outcomes. For example, early detection of SUDs through screening can result in timely intervention and treatment, including medication-assisted treatment, which can make a considerable difference in outcomes. The Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB) requires Ryan White HIV/AIDS Program providers to follow the *U.S. Department of Health and Human Services (HHS) Guidelines for Use of Antiretroviral Agents in Infected Adults and Adolescents*. The guidelines include screening for clinical depression and substance use and, if identified, creating a follow-up treatment plan to help clients address and manage these issues. Ryan White HIV/AIDS Program providers and organizations have access to a wide variety of tools to screen for behavioral health conditions.

The Substance Abuse and Mental Health Services Administration (SAMHSA)-HRSA Center for Integrated Health Solutions (CIHS) and the Ryan White HIV/AIDS Program Part F AIDS Education and Training Center Program offer a variety of screening tools and resources to help Ryan White HIV/AIDS Program providers and organizations enhance their integrated HIV and behavioral health care approaches. These include the following:

- Depression: Patient Health Questionnaire 2 and 9 (PHQ 2 and PHQ 9)
- Anxiety Disorders: Generalized Anxiety Disorder 7 (GAD-7) question tool
- Substance Use Disorders: Alcohol Use Disorders Identification Test (AUDIT), CAGE AID, Drug Abuse Screen Test (DAS T-10), and other tools
- Trauma: Life Events Checklist and Primary Care PTSD (PC-PTSD) Screen

HIV providers also can incorporate the Screening, Brief Intervention and Referral to Treatment (SBIRT) model into their routine care. SBIRT is an evidence-based practice used to deliver early intervention and treatment to people with, or at risk for SUDs. SBIRT has three steps:

1. Screening for risky substance use behaviors using standardized screening tools
2. Conducting a brief intervention or conversation between health care provider and patient about risky substance use behaviors. Provider offers feedback and advice.
3. Referring patients for additional treatment based on screening results.

SBIRT was developed in response to a recommendation by the Institute of Medicine for community-based screening of behavioral health risks, including substance use.

Stories From the Field: Ryan White HIV/AIDS Program at CarePoint Health and the Center for Comprehensive Care

The Ryan White HIV/AIDS Program-funded CarePoint Health system and The Center for Comprehensive Care in Hudson County, New Jersey, provide comprehensive and integrated medical services, including behavioral health care and case management, to children, adolescents, and adults infected with HIV. CarePoint Health, which includes three area hospitals, delivers HIV health services in communities highly affected by HIV, especially among bilingual racial/ethnic minorities. CarePoint Health's client population comprises 41 percent Hispanics, 23 percent black/African Americans, and the remaining population mainly Whites. The client population at the Center for Comprehensive Care is primarily black/African American, followed by Hispanics/Latinos, Whites, and Asians.

Both CarePoint Health and The Center for Comprehensive Care offer on-site behavioral health care and treatment services. Such medical services as psychiatry, behavioral health screening and referral, counseling, and primary care, as well as laboratory services, all are located within one setting. This comprehensive and integrated approach ensures a thorough and effective process for identifying, treating, and retaining clients. Whitney Bracco, program director for the Center for Comprehensive Care, stated, "The one-stop shop is our unique feature and is responsible for our successful program. Clients like the fact that all services are available in one location, and they do not need to go outside."

Gustavo Valdes-Rivera, CarePoint Health director for the Ryan White HIV/AIDS Program, said, "Be very aware of the community you serve. Since we serve over 40 percent Hispanics, we have on-site bilingual program services." CarePoint Health also provides financial aid for transportation, medications, etc., to clients in need—which is critical for keeping patients in care and improving patient outcomes.

Patients referred to services are screened every six months for behavioral health conditions to identify such HIV co-morbidities as depression. Appropriate follow-ups and referrals are recommended to the clients by their assigned case managers based on their screening results. According to Mr. Valdes-Rivera, "Case managers are essential to the process. They stay in close contact with patients and hold bimonthly meetings with health care providers to facilitate communication and help ensure that patients receive and stay in behavioral health care." Mr. Valdes-Rivera stated that this "enhanced communication has led to increased medication adherence, engagement, and treatment rates among patients with behavioral health conditions at CarePoint Health." Ms. Bracco also emphasized that case managers are essential and added, "The Center for Comprehensive Care also owes its success to having on-site behavioral health staff, such as psychiatrists, psychiatric nurse practitioners, and counselors, as well as case managers. Our collaborative, integrated approach to HIV care further aids in identifying and addressing the clients' behavioral health disorders, making the program successful."

Stories From the Field: The City of Milwaukee, WI Ryan White HIV/AIDS Program at AIDS Resource Center of Wisconsin (ARCW)

ARCW has 10 statewide offices and clinics that provide a robust array of integrated services and act as medical homes to nearly 3,600 clients in the state of Wisconsin. ARCW serves a demographic consisting of 50 percent Whites, 45 percent black/African Americans, and 5 percent other demographics, with most clients living below the poverty level. Its integrated services include co-located medical, dental, and mental health clinics, along with a pharmacy, a food pantry, legal services, an HIV prevention

program, and social work case management services, ensuring that PLWH thrive, not merely survive.

ARCW's integrated approach emphasizes the need for health care teams to include physicians, nurse practitioners, nurses, dentists, mental health therapists, lawyers, nutritionists, social workers, and case managers. Dr. Kevin Roeder, senior director of behavioral services, said, "By providing integrated medical, behavioral, and social services, along with an accessible electronic health records system, we elevate coordination of care for our clients to the highest level." The clinical liaison program ensures that a therapist for clients to talk to is available in the clinic daily. Along with screening for depression and other mental health conditions, ARCW provides neuropsychological assessments for clients aged 50 or older. Research indicates that PLWH aged 50 or older have an increased risk of neurocognitive issues associated with aging. Dr. Debra Endean, vice president and chief operating officer, emphasized the need to start with the client: "Think about your patient holistically and avoid artificial distinctions between care for the body and care for the mind: it's care for the person."

Stories From the Field: Prism Health North Texas, Dallas, TX

Prism Health North Texas provides HIV care services to a population comprised of nearly 60 percent racial and ethnic minorities. Its integrated behavioral health services program is successful as a result of co-locating services, according to Dr. Manisha Maskay, chief program director. "Most of the clients we serve like the one-stop shop approach since they do not have to go anywhere else to get services." The in-house access to behavioral health counselors, psychiatrists, and mental health providers facilitates screening, treating, and retaining clients living with HIV and behavioral health conditions. In their clinics, the most common behavioral health disorders observed are major depressive disorder, post-traumatic stress disorder, and methamphetamine use disorder, according to Dr. Maskay. "Integrating behavioral health services in our program has benefited our patients in multiple ways, including attaining 90 percent viral suppression and improved medical adherence, which is very encouraging."

Communication among the team and with the client also is very important for successful treatment and medication adherence. The staff, including the case managers and clinical providers, have regularly scheduled case conferences. Shared electronic health systems are another important aspect of the successful program. The case managers, behavioral health counselors, psychiatrists, and other team members all have access to the client's health information, leading to better patient outcomes.

Although the program is successful, one challenge that Prism Health North Texas faces is access to and availability of trained and culturally competent behavioral health counselors, including mental health providers who thoroughly understand the environment and nature of treating people living with chronic conditions like HIV. Dr. Maskay explained, "We believe in the harm-reduction approach that employs a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. This leads to improved patient outcomes."

HRSA CARE Action

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Cover: ShutterStock

Copies are available for download at www.hab.hrsa.gov.

ONLINE RESOURCES

1. *Ryan White HIV/AIDS Program Annual Client-Level Data Report, 2016*
   hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2016.pdf
2. HRSA's Behavior Health Integration with Primary Care webpage
   bphc.hrsa.gov/qualityimprovement/clinicalquality/behavioralhealth/index.html
3. SAMHSA's *Concept on Trauma and Guidance on a Trauma Informed Care Approach*
   www.traumainformedcareproject.org/resources/SAMHSA%20TIC.pdf
4. SAMHSA-HRSA Center for Integrated Health Solutions information about integrated care models, behavioral health screening tools, and information for clinical practice, including trauma-informed care
   - www.integration.samhsa.gov/integrated-care-models
   - www.integration.samhsa.gov/clinical-practice/screening-tools
   - www.integration.samhsa.gov/clinical-practice
   - www.integration.samhsa.gov/clinical-practice/trauma
5. The Agency for Healthcare Research and Quality's new report, *Implementing Medication-Assisted Treatment for Opioid Use Disorder in Rural Primary Care: Environmental Scan*
   integrationacademy.ahrq.gov/implementing-medication-assisted-treatment-opioid-use-disorder-rural-primary-care-environmental-scan

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