

BEHAVIORAL HEALTH INTEGRATION within the HIV CONTINUUM OF CARE

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OVERVIEW

Behavioral health touches countless communities across the United States and has many implications for the quality of life individuals experience. From severe mental illness, to everyday anxiety, frontline providers witness a gamut of conditions that could impact the overall care and wellness of some of our most vulnerable populations. Unfortunately, many behavioral health clinics across the nation are woefully under-staffed, under-trained, over-capacity, stigmatizing to key communities, and siloed in scope. This is especially true for clinics that see a large volume of clients who are living with HIV or are at risk for HIV.¹ It is imperative for health departments to consider how their jurisdictions are uniquely impacted by this gap in care, understand how the data trends over time, and what role integration can play in alleviating common barriers.

According to the Centers for Disease Control and Prevention (CDC), people who use substances are at increased risk of contracting or transmitting HIV since drugs and/or alcohol could impair judgment and lead to increased high-risk sexual behaviors (for example, unprotected sex with several partners).¹ In addition, 10% of HIV cases annually are attributed to injection drug behavior, and one in six people living with HIV have injected an illegal drug in their lifetime.¹



Although the prevalence of HIV among people receiving behavioral health care is four times higher than the general population, their access to adequate and appropriate care still lacks significantly.¹ Among a variety of conditions, depression is the most commonly reported mental health issue and has been reported as a concern prior to as well as after HIV infection.¹ Gay men have a markedly higher chance of living with depression and continue to carry a higher risk burden of contracting HIV, as compared to other men.¹ Depression can be associated with non-adherence to HIV care, and treatment of depression can improve the health of people living with HIV significantly.¹

One of the most significant barriers that can deter people living with HIV (PLWH) from seeking appropriate health care remains compounding stigma toward mental illness and HIV status.^{1,5} Inherently, this discrimination minimizes the opportunity for better outcomes that focus on the latest methods of treatment and prevention.¹ Furthermore, when left untreated, mental illness and substance use can create additional health and psychosocial problems that go beyond non-adherence to HIV care.¹ It's clear that behavioral health care has the potential to impart significant, meaningful, and long-lasting impacts on people seeking and receiving HIV treatment.

This issue brief highlights the impact of integrating behavioral health into the HIV care continuum so that health departments are better able to identify specific options that may need to be considered to improve access, promote prevention, and maintain quality of treatment.

STATE OF INTEGRATED CARE

Across the United States, primary care settings have become the fundamental gateway for those living with HIV to receive the care and treatment they need. Integrating behavioral health care into these settings offers the most promise to jurisdictions looking to address the mental health needs of PLWH. Although many jurisdictions have just begun to explore this integration model, several are leveraging existing behavioral health organizations (BHOs) and community mental health centers as starting points for integration, while others focus on improving behavioral screening practices in existing HIV care programs as a model of integration.

STRATEGIES & OPPORTUNITIES

Although there isn't one model that fits every jurisdiction, there are some evidence-based strategies that can be considered to open more opportunities for integration and support a more robust care structure for PLWH. While systems-level approaches outlined here show the greatest potential for meaningful impact in this population, alternative approaches at the clinical-level need to also be examined down the road.

I. INTEGRATING BEHAVIORAL HEALTH INTO PRIMARY HIV CARE

A. Managed Care Organizations (MCOs)

One of the most effective approaches to integrating primary and behavioral health involves including the benefits of both in managed care contracts, as opposed to carving out behavioral health care and providing it separately.² In general, this model allows states to have accountability over a wider range of beneficiary needs, since physical and behavioral benefits, and financing are all included in the same managed care arrangement.^{2,3}

PROS

- Incentives are aligned and coordinated care is promoted
- Beneficiaries have streamlined access to all services
- Clinical data more integrated and accessible to a range of providers

CONS

- Many MCOs may not have the clinical capacity or sufficient provider networks to manage behavioral health services
- Behavioral health requires strong financial oversight
- Sub-MCO contracts can complicate original vision behind MCO by introducing competing priorities or alternative payment structures

JURISDICTION


EXAMPLE



Tennessee²

- Tennessee's Medicaid program, TennCare, integrated behavioral health services with its main managed care entities.
- State is divided into three regions that has two MCOs per region. These MCOs operate at full risk for all services rendered, including integrated primary HIV care and behavioral health care.
- MCOs can subcontract management of behavioral health, but subcontractors must stay on site of the MCO to ensure coordinated care.



STRATEGIES & OPPORTUNITIES

JURISDICTION	EXAMPLE
 <p>Washington²</p>	<ul style="list-style-type: none"> • Washington State Department of Social and Health Services (DSHS) integrated services through a sole MCO contract, known as “Molina Healthcare” • Enrollment is voluntary and follows an opt-out model for Medicaid enrollee’s and opt-in model for Alaska Natives and American Indians • Medicaid remains the largest public insurer of people getting treatment of HIV

b. Primary Care Case Management Arrangement (PCCM)


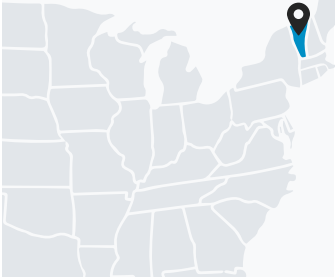
In certain states, PCCM may be a more an effective entity to integrate care for PLWH. These systems typically allow primary care providers to charge a small monthly case management fee in addition to fee-for-service reimbursement for treatment.³ Integration would involve the state directly contracting with providers, or an entity that administers the state PCCM program, instead of MCOs. Although there are many mechanisms by which integration can succeed here, most often the primary care provider is given a higher rate of service to perform more care coordination and case management.²

PROS	CONS
<ul style="list-style-type: none"> • States with PCCMs have existing structure to integrate without needing systemic overhaul • Model offer fee-for-service option if capitated payments not feasible • Potential opportunities for data sharing using Medicaid data 	<ul style="list-style-type: none"> • Integration heavily dependent on successful relationship building between PCCM and providers/entities • Implementation harder in larger, more diverse states with competing payers • Significant amount of time required if existing PCCM structure doesn't exist

JURISDICTION	EXAMPLE
 <p>North Carolina²</p>	<ul style="list-style-type: none"> • Added a “Per Member Per Month (PMPM)” payment schedule into existing PCCM, Community Care of North Carolina (CCNC) • Payment schedule supported the integration of behavioral health care into 14 existing CCNC networks in the state – hired psychiatrists, coordinators • Supported the development of flagging tools in local electronic health systems to identify persons at risk • Increased probability for PLWH to engage mental health services at the local level
 <p>Vermont²</p>	<ul style="list-style-type: none"> • “Blueprint for Health” multi-payer program included process to transform primary care practices into medical homes • Payers share cost of community health teams, which expand primary care infrastructure to include mental health providers • Primary care providers are payed a PMPM on sliding scare based on nationwide quality score • Encourages integration by focusing access to behavioral health services that were not previously there, effective follow-up on referrals, and collaborative care coordination

STRATEGIES & OPPORTUNITIES



B. Primary Care Case Management Arrangement (PCCM) *cont.*

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II. INTEGRATING PHYSICAL HEALTH INTO BEHAVIORAL HEALTH ORGANIZATIONS

A. Care Coordination & Care Management


Care coordination and care management gives behavioral health organizations (BHOs) the freedom to translate clinical and population level data to primary care providers so that appropriate referrals and timely services are rendered.³ This method of integration promotes positive relationship building between local community providers and fosters a team-based approach to care for PLWH.³

JURISDICTION	EXAMPLE
<p>Rhode Island³</p> 	<ul style="list-style-type: none"> • The Providence Center, a community mental health center, has coordinated a relationship with federally qualified health centers to develop relationships with culturally competent PCP who would support individual care with beneficiaries
<p>New Hampshire³</p> 	<ul style="list-style-type: none"> • The Greater Nashua Mental Health Center sends out a Report Card to PCPs of beneficiaries upon consent indicating physical symptoms that need to be monitored

STRATEGIES & OPPORTUNITIES


b. Navigation Services/Peer-to-Peer Support

- This model of care aims to integrate care through face-to-face navigators who support beneficiaries across a range of services from initial health assessment to personalized care planning across multiple primary care providers and settings.³ Often, but not always, these navigators serve a dual purpose as peer who would have experienced similar physical or mental health. These individuals go a step beyond care coordinators to support individuals with severe mental illness (SMI) and ensure the receipt of proper care is delivered.³

JURISDICTION	EXAMPLE
 <p>Pennsylvania³</p>	<ul style="list-style-type: none"> Montgomery County “HealthConnections” navigation program utilizes navigator teams consisting of a registered nurse and master’s level behavioral health clinician Contracted to monitor adherence to care plan for beneficiaries who are SMI

c. Co-Located or Limited Capacity Primary Care in BHOs

- In this approach of integration, BHOs contract with PCP on a local level to provide low resource or low capacity physical health services to beneficiaries already receiving behavioral health care.³ Although this middle ground is rare, it is a cost-effective alternative to many full-term contracts that lack oversight authority and require larger operating budgets.⁴ For PLWH, these services often include confidential lab work and “warm hand-offs” to providers co-habituating the space.^{3,5}

JURISDICTION	EXAMPLE
 <p>Massachusetts</p>	<ul style="list-style-type: none"> “BAGLY, Inc.”, contracts with Fenway Health, to utilize a registered nurse who conducts Screening, Brief Intervention, Referral to Treatment (SBIRT) for LGBTQ youth and young adults at high risk for HIV infection in their clinic. “AIDS Action Committee” integrated on-site behavioral health services as part of their “Access: Drug User Health Program.” Beneficiaries can obtain individual counseling or group sessions provided by an LICSW on-site, and linkage to more permanent behavioral health services at Fenway or other BHOs.



OVERALL PROS

- Coordination between two entities improves financial incentives between physical and behavioral health providers
- Beneficiaries have a larger array of services in a “one stop shop”
- Improved opportunities for coordinated population-level data on a local and state level



OVERALL CONS

- BHOs have limited experience with aspects of physical health such as prescription drugs
- Limitation with serving dual-eligible individuals – those eligible for Medicaid and Medicare
- Potential struggle over oversight authority between BHO and primary care provider – limited state experience

STRATEGIES & OPPORTUNITIES

III. BEHAVIORAL HEALTH SCREENING IN HIV CARE

In addition to systems-level changes, several primary care clinics that serve populations living with or at risk of HIV acquisition have begun to integrate behavioral health care through practice-level changes in screening. These typically include:

- **General mental illness screenings** (e.g. depression, anxiety etc.) to identify beneficiaries that could benefit from co-occurring psychotherapy and pharmacotherapy⁵
- **Screening, Brief Intervention, Referral to Treatment (SBIRT)** screening to identify beneficiaries that live with substance use, interventions for those living with mild substance use, and referrals for those with more severe indications.⁵

As screening becomes institutionalized, primary care organizations are in a unique position to detect behavioral indications early and intervene sooner.^{4,5} This can make a substantial difference in the health of PLWH and reduce transmission of HIV by increasing medication compliance.⁵

There are many options states and local communities can leverage to pilot this practice-level change, but three pillars are often key to successful uptake and sustainability:

Organizational Culture ⁵	Infrastructure & Implementation ⁵	Staffing & Location ⁵
<ul style="list-style-type: none"> • Persistent positive outcome reporting • Fostered collaboration between primary & behavioral providers • Demonstrated value in screening to medical providers & senior leadership • Express importance of screening by attaching clinical labels - screening as a “vital sign” 	<ul style="list-style-type: none"> • Within contracted SOP - screen all patients, not only HIV+ patients • Coordinate institutional roll-out of screening effectively • Train staff on billing/codes for screening • Develop relationships with community-based behavioral health programs for appropriate referral 	<ul style="list-style-type: none"> • Non-clinical staffing for screening and brief intervention • Appropriate behavioral health provider for “warm-hand-offs” from primary care provider • Physical location screening - exam rooms or designated space • Multiple opportunities to train and re-train staff so knowledge is continually transferred

DISCUSSION & RECOMMENDATIONS

Health departments are looking for innovative ways to improve the lives of people living with or at risk of HIV infection in the most efficient and effective ways given the resources they have. Many have launched “ending the epidemic” initiatives, a concept that would have been hard to imagine even a few years ago. It’s important to recognize that behavioral health plays a vital role in the mission to end the epidemic. Those at risk for and living with HIV come from a variety of lived experiences that can impact mental health status. Some may struggle with the long-term effects of trauma, while others may live with undiagnosed addiction.^{5,6} Some may have come from unforgiving family structures, or live with suicidal thoughts on a regular basis.⁷ It would misunderstand this epidemic by assuming treatment alone guarantees comprehensive care.

This issue brief is meant to encourage health departments to consider what they can do to be a part of the movement to integrate care in their jurisdiction:

1. Explore how MCO and PCCM models could operate within existing primary care systems in your jurisdiction to streamline a broader range of services.
2. Identify where integrating within BHOs could be more effective and begin to develop working relationships with existing behavioral health staff and leadership
3. Examine current practice guidelines in existing physical and behavioral care systems to determine what capacity building needs exist to institutionalize SBIRT and general screening

As providers, states, payers, and governmental agencies begin to follow an integrated model of care, it is incumbent on these entities to study the benefits, learn from the gaps that remain, and push for a system that looks at the whole individual and not just the disease.

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