

# Bringing It All Together



## What HIV Providers Need To Know About Integrated Treatment

TRAINER'S NAME

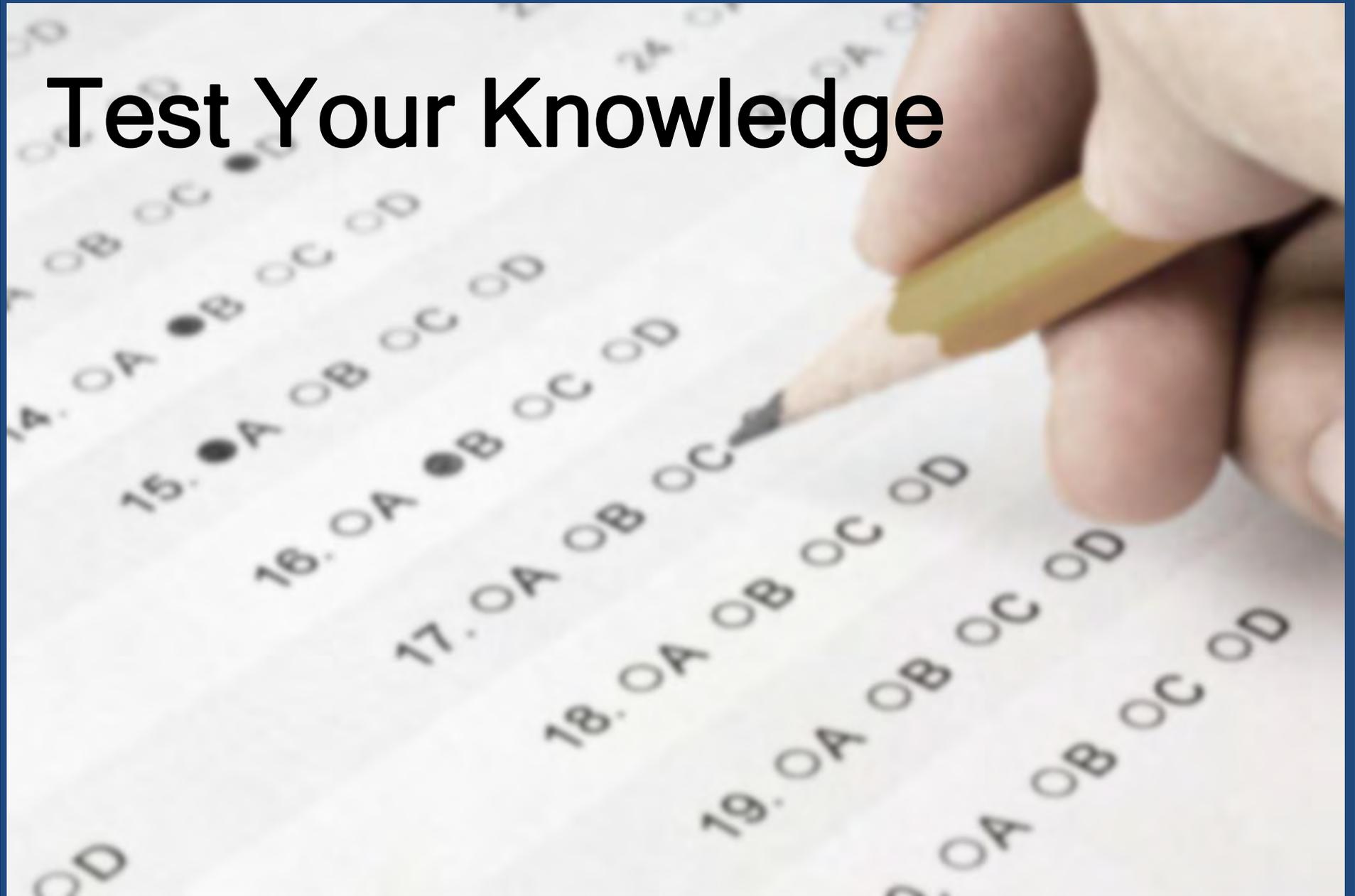
TRAINING DATE

TRAINING LOCATION

# Training Collaborators

- Pacific AIDS Education and Training Center
  - Charles R. Drew University of Medicine and Science
  - University of California, Los Angeles
- Pacific Southwest Addiction Technology Transfer Center
- UCLA Integrated Substance Abuse Programs

# Test Your Knowledge



# Test Your Knowledge

1. What proportion of people living with HIV have a substance use disorder?
  - a. Between  $1/20$  and  $1/10$
  - b. Between  $1/9$  and  $1/5$
  - c. Between  $1/4$  and  $1/2$
  - d. Between  $1/2$  and  $2/3$

# Test Your Knowledge

## 2. Integrated Services for HIV care can include...

- a. Screening for mental health and substance use disorders
- b. Conducting hour long mental health assessments for all clients
- c. Adaptation of mental health treatment techniques for use with HIV clients
- d. A and C
- e. A, B, and C

# Test Your Knowledge

## 3. Healthcare reform will do the following:

- a. Extend health insurance coverage to some people with HIV who are currently uninsured
- b. Provide better coverage to help some people pay for their HIV medications
- c. Place limits on mental health and substance abuse services for people living with HIV
- d. A and B
- e. A and C

# Introductions

- What is your name?
- Where do you work and what do you do there?
- Who is your favorite musician or performer?
- What is one reason you decided to attend this training session?

# Educational Objectives

At the end of this training session, participants will be able to:

1. Describe the impact of mental health and substance use disorders on people living with HIV/AIDS.
2. Discuss why is important to integrate mental health and substance abuse services with medical care for people living with HIV/AIDS.

# Educational Objectives

At the end of this training session, participants will be able to:

3. Describe at least two (2) models for integrating mental health and substance abuse services with medical care for people living with HIV.
4. Discuss concrete steps that organizations can take to integrate mental health and substance abuse services into HIV care.
5. Explain how changes in policy and funding will encourage the integration of services for patients living with HIV.

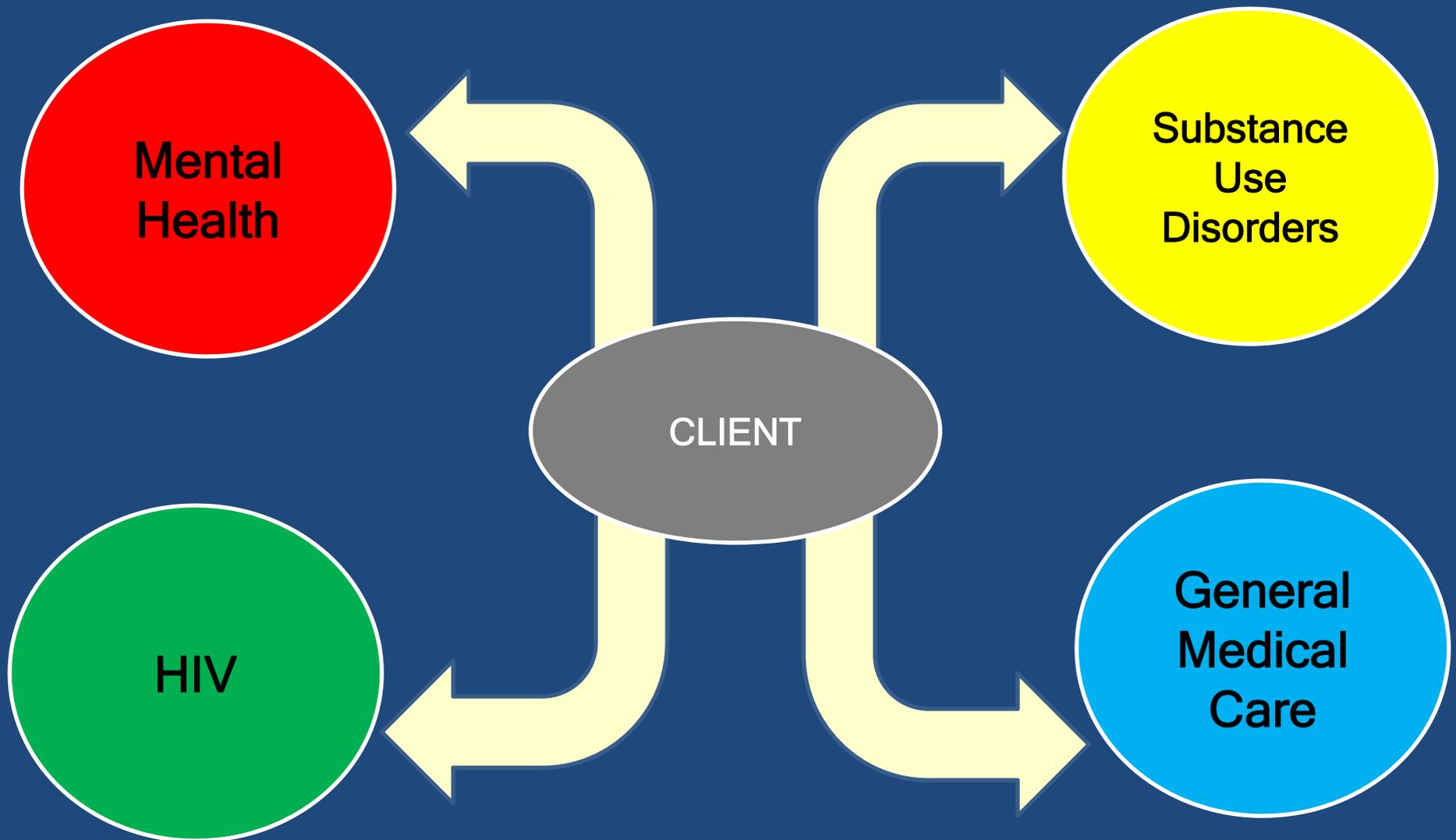
# Roadmap for the Training

- **Part 1: Silos and Their Impact on People Living with HIV**
- **Part 2: Integration at the System, Clinic, and Provider Levels**
- **Part 3: Integrated Care, Tools and Models**
- **Part 4: HIV, Integration, and Healthcare Reform**

# Part 1: Silos and Their Impact on People Living With HIV



# Our Current System: Silos



# The Trouble With Silos

- Access
  - Restrictive criteria to receive services in specialty systems
  - Long waits to access specialty care
  - Inflexible financial resources
- Coordination
  - Providers in different systems rarely communicate
  - Limits on what each system can do
  - Clients may have difficulty coordinating services, medications, etc.
- Each system only addresses part of clients' overall health needs
- Care divided into silos is not holistic

# The Trouble With Silos and HIV

- It is rare for people living with HIV to need only HIV services...
  - Nearly half meet diagnostic criteria for anxiety or depression
  - 25%-45% have a substance use disorder
  - 25% are infected with Hepatitis C
- If HIV care is its own silo, clients' other health needs may not be adequately addressed

# The Trouble With Silos and HIV

- HIV, mental health problems, substance abuse, and other medical conditions interact and exacerbate each other
- Neglecting conditions other than HIV leads to worse health and premature death for people living with HIV
- Providers should be able to identify/treat both HIV and other conditions that put people living with HIV at risk

# HIV

## (Human Immunodeficiency Virus)

- A virus that attacks CD4 cells, which the body uses to fight off infections and disease
- Transmitted through sexual contact or blood
- If HIV is untreated, destruction of CD4 cells leads to Acquired Immunodeficiency Syndrome (AIDS)
- AIDS leaves body vulnerable to life-threatening infections and cancers

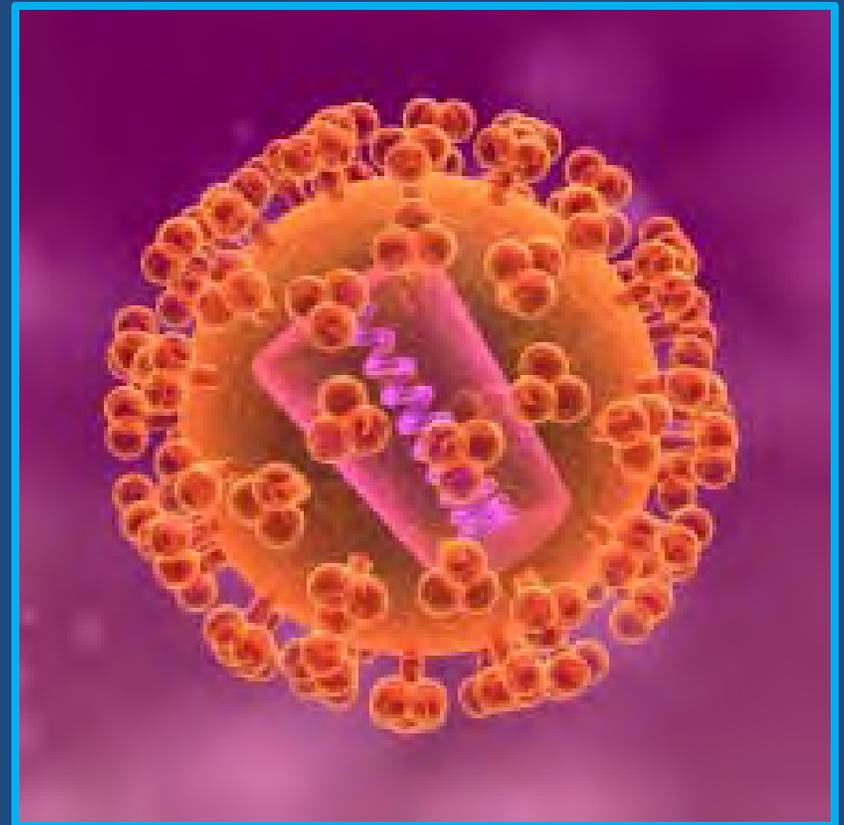


IMAGE SOURCE: National Institutes of Health

# HIV Treatment

- There is no “cure” for HIV, but it can be managed with antiretroviral therapy (ART)
  - Involves taking 3+ anti-HIV medications from two different drug classes daily
  - Prevents HIV from multiplying and attacking CD4 cells
  - Reduces viral load (amount of HIV in blood) and increases CD4 cell count
  - Helps body fight off infections/cancers, prevents advancement from HIV to AIDS
  - Reduces risk of transmitting HIV to others
  - Helps people to live longer and healthier lives with HIV

# HIV Treatment: Adherence

- Strict adherence to ART is essential for people living with HIV
  - Need to take correct dose of each medication as prescribed
  - Skipping even occasionally gives HIV opportunity to multiply
  - Missed doses increase likelihood HIV will mutate and become resistant to ART
- 95% medication adherence is optimal
- Improving ART adherence 10% can improve HIV outcomes

# Conditions that Increase Risk for People Living With HIV

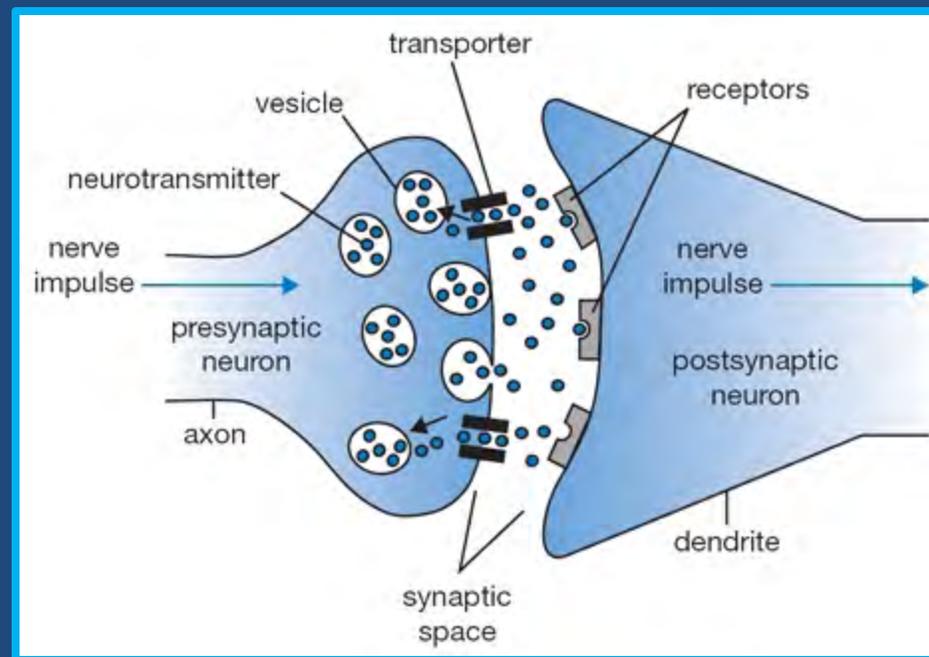
- Conditions that decrease adherence to ART
  - Mental Health Disorders
  - Substance Use Disorders
- Conditions that are complicated by HIV
  - Tuberculosis
  - Hepatitis

# Decreased Adherence to ART: Mental Health Disorders (MHD)

- Conditions marked by significant changes in cognition, mood, perception, and behavior
  - Anxiety disorders
  - Mood disorders (depression, bipolar)
  - Adjustment Disorders
  - Schizophrenia

# Biology of Mental Health Disorders

- Neurotransmitters: Chemical messengers within the central nervous system
- Changes to neurotransmission occur in behavioral health disorders



# Risks for Mental Health Disorders

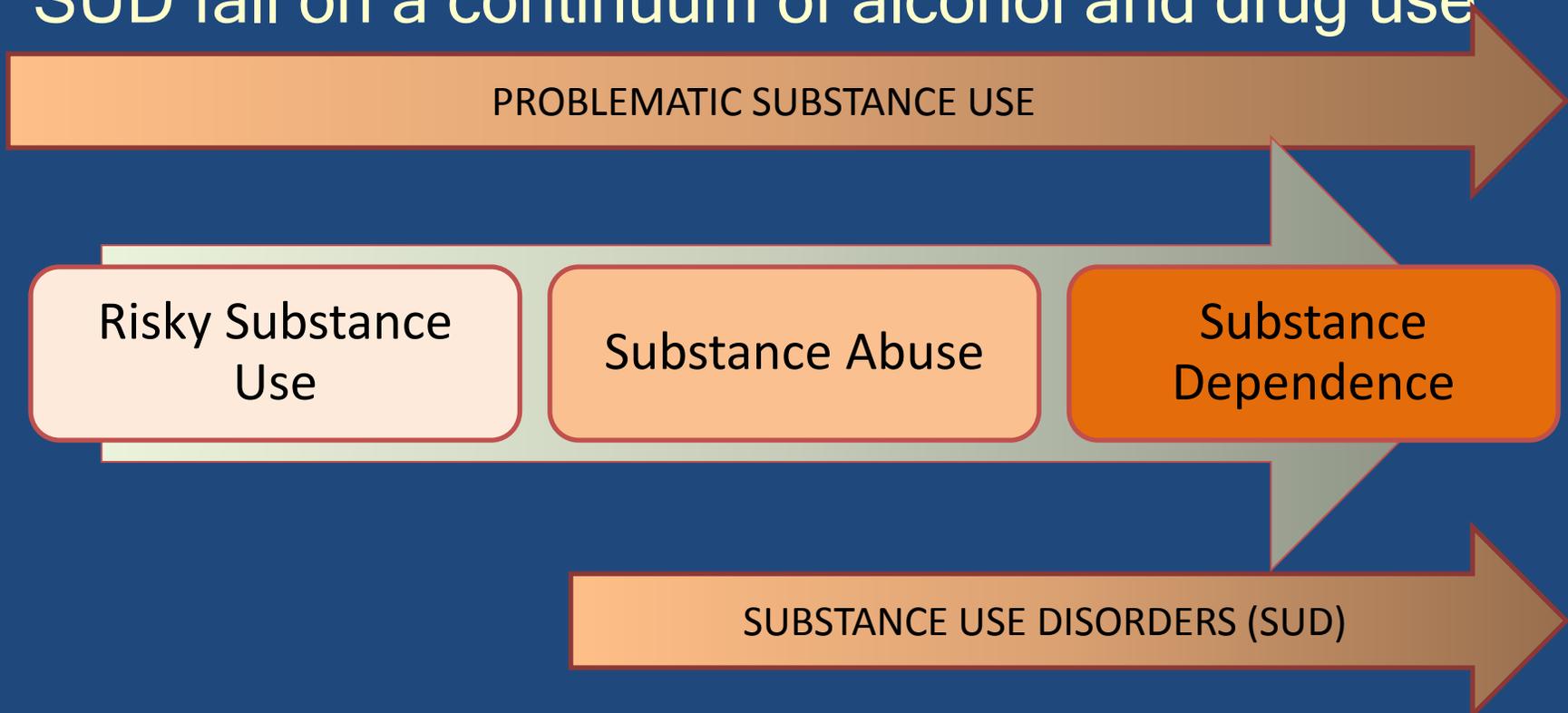
- Genetic: interaction of several genes may trigger disorders.
- Experiences: head injury, poor nutrition, exposure to toxins increase risk.
- Social factors: trauma, stress, neglect, abuse

# Mental Health Disorders: Diagnosis and Treatment

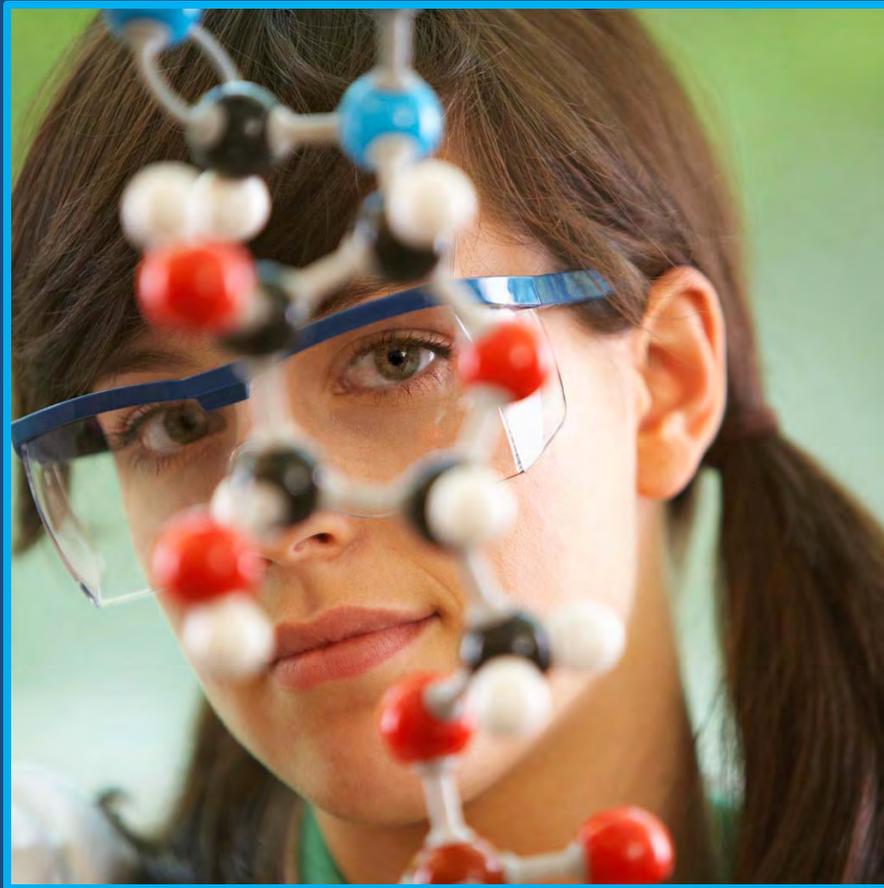
- **Diagnosis**
  - There is no biological “test”
  - Through observation and interview
  - Criteria laid out in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*
- **Treatment**
  - Psychotherapy
    - Talk to learn about condition, moods, thoughts, and behavior
    - Learn better coping and stress-management skills
  - Medications
    - Work by altering neurotransmitter activity

# Decreased Adherence to ART: Substance Use Disorders (SUD)

- Individuals with SUD consume alcohol/drugs compulsively, even when faced with negative consequences
- SUD fall on a continuum of alcohol and drug use



# How Psychoactive Substances Work



- Because of their chemical structure, alcohol and drugs have dramatic effects on neurotransmitters in CNS.
- Effects on:
  - Mental processes
  - Behavior
  - Perception
  - Alertness

# Commonly Used Psychoactive Substances

SUBSTANCE	EFFECTS
Alcohol (liquor, beer, wine)	euphoria, stimulation, relaxation, lower inhibitions, drowsiness
Cannabinoids (marijuana, hashish)	euphoria, relaxations, slowed reaction time, distorted perception
Opioids (heroin, opium, many pain meds)	euphoria, drowsiness, sedation
Stimulants (cocaine, methamphetamine)	exhilaration, energy
Club Drugs (MDMA/Ecstasy, GHB)	hallucinations, tactile sensitivity, lowered inhibition
Dissociative Drugs (Ketamine, PCP)	feel separate from body, delirium, impaired motor function
Hallucinogens (LSD, Mescaline)	hallucinations, altered perception

# Why People Use Psychoactive Substances

## Why Start?

- Experimental
- Peer Pressure
- Medical



## Why Continue?

- Relieve stress/pain
- Function better
- Have fun/relax
- Cope with mental health disorders





After repeated drug use, “deciding” to use  
drugs is no longer voluntary because

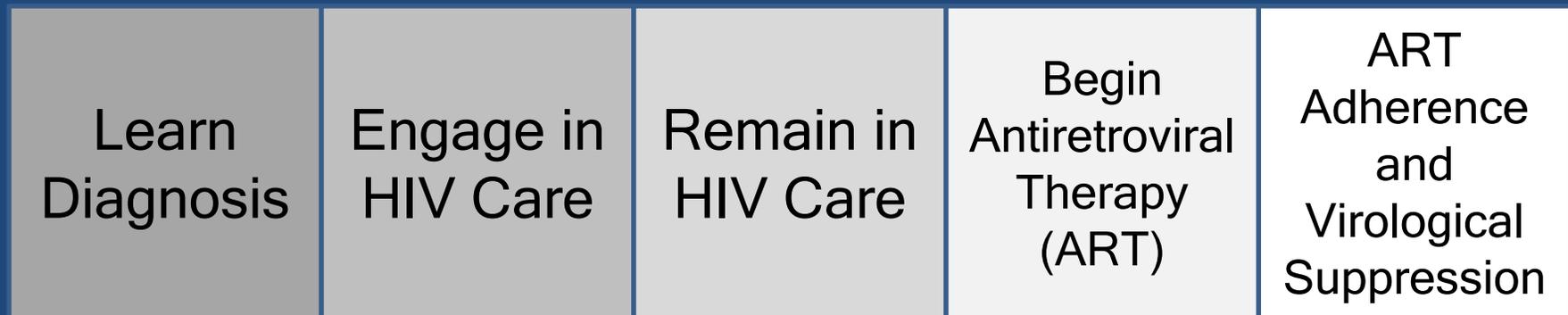
**DRUGS CHANGE THE BRAIN!**

# Substance Use Disorders: Diagnosis and Treatment

- **Diagnosis**
  - Through observation and interview
  - Criteria laid out in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*
- **Treatment**
  - Behavioral interventions
    - 12 Step Groups (AA, NA, etc.)
    - Contingency Management
    - Techniques used in treatment of mental health disorders
  - Medications
    - Can be used in treatment of alcohol and opioid dependence
    - Adjuncts to behavioral interventions

# The Impact of MHD and SUD on HIV Treatment

## The HIV Treatment Continuum: The Impact of MHD and SUD



# The Impact of MHD and SUD on HIV Treatment

Engage in HIV Care

- Decreased/delayed access to treatment associated with depression, use of alcohol and most drugs

Begin Antiretroviral Therapy (ART)

- Decreased prescription to ART associated with depression, use of alcohol and most drugs

ART Adherence and Virological Suppression

- Decreased adherence to ART associated with depression, anxiety, use of alcohol and most drugs
- Less virological suppression and slower CD4 cell response rate due to poor ART adherence

# The Impact of MHD and SUD on HIV Outcomes

- Depression associated with severity of HIV illness, CD4 cell count decline, and increased mortality.
- Early mortality among HIV clients significantly increases if they have SUD
- Among patients hospitalized for HIV/AIDS medical complications:
  - 31% have major depression
  - 19% have a substance use disorder
  - 16% have bipolar disorder
  - 13% have anxiety disorder

# Conditions Complicated by HIV: Tuberculosis

- Airborne bacterial infection caused by *Mycobacterium tuberculosis*
- 5-10% of infected persons will develop disease
- Symptoms:
  - Bad cough 3 weeks+
  - Cough up blood/mucus
  - Weakness/fatigue
  - Fever/chills
- Lethal if not treated properly (antibiotics for 6-12 months)
- Multi-drug resistant TB: Antibiotics for up to two years, poor prognosis.

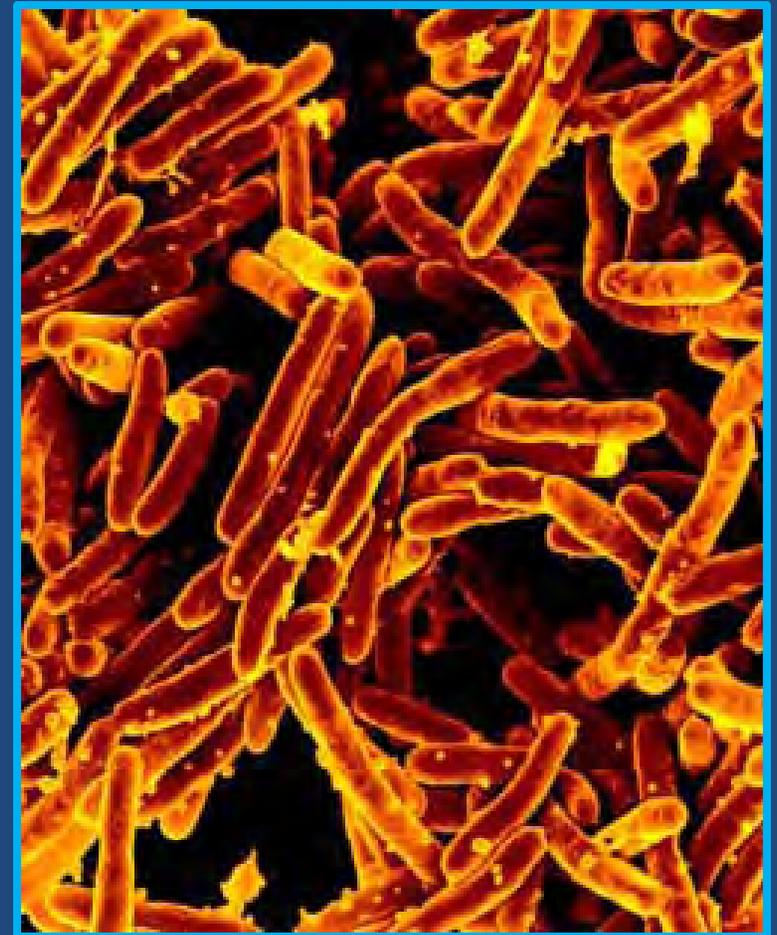


IMAGE SOURCE: National Institute of Allergy and Infectious Diseases

# Tuberculosis and HIV

- Spread person to person: Increased exposure to the bacteria in crowded settings (healthcare settings, correctional facilities)
- People with HIV are at 20-30 times the risk of having TB become active
- People with TB and HIV are more likely to die from TB than from AIDS
- HIV complicates TB diagnosis because TB tests are affected by weakened immune system

# Tuberculosis and HIV: What to Do

- Test all newly diagnosed HIV clients for TB
- Test people living with HIV for TB every year
- If TB+, start treatment ASAP
- Treatment from providers with expertise managing both conditions
- Take steps to ensure TB medication adherence
- Treatment important since it also prevents spread of the disease

# Conditions Complicated by HIV: Hepatitis

- Viruses that lead to liver inflammation, causing:
  - Abdominal Pain
  - Abdominal swelling
  - Fatigue
  - Fever
  - Loss of Appetite
  - Vomiting
- Can lead to liver cirrhosis, liver cancer
- Can be treated with antiviral medications for 24-48 weeks
- Some cases require liver transplant
- Vaccines for Hepatitis A and B



# Hepatitis and HIV

- Spread through the same vectors as HIV: sexual contact, injection drug use
- 25% of people living with HIV in US are infected with Hepatitis C (About 80% of HIV+ injection drug users)
- HIV accelerates progression of hepatitis virus, leading to high rates of liver-related health problems
- Hepatitis C contributes to development of cardiovascular disease, cognitive impairment in people living with HIV
- Hepatitis complicates HIV management, increases risk of life-threatening complications

# Hepatitis and HIV: What to Do

- Test all HIV clients for hepatitis B and hepatitis C.
- Treatment from health care providers with expertise managing both infections
- Counsel HIV clients on drug interactions and side effects of hepatitis and HIV treatments
- Provide support to help clients complete course of hepatitis treatment

# Clients Need Services beyond HIV Care, but there are Obstacles

## System Level

- Criteria to receive services based on severity, financial resources
- Restrictions on what services will be reimbursed
- Restrictions on sharing health information across systems

# Clients Need Services beyond HIV Care, but there are Obstacles

## Clinic/Provider Level

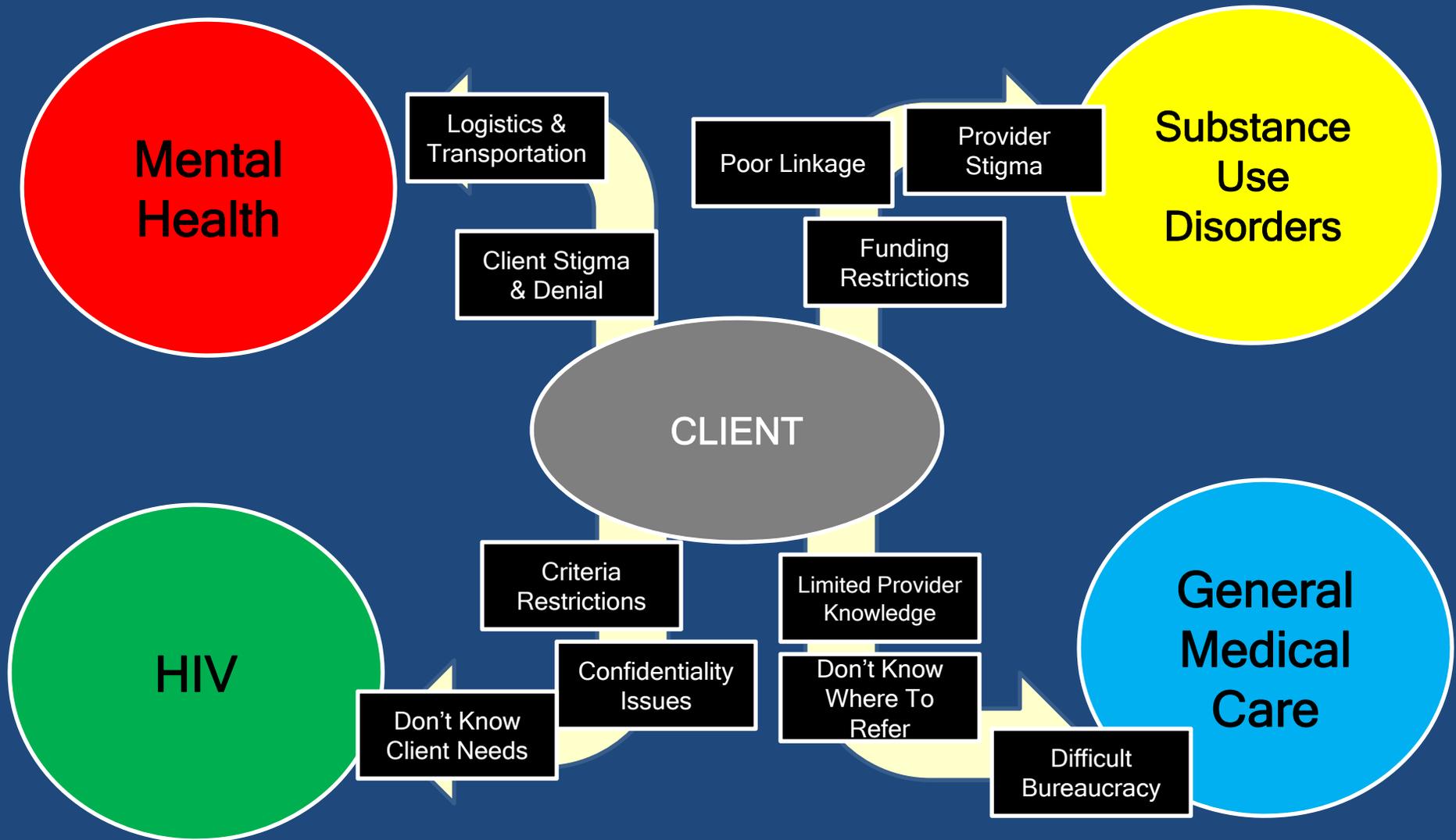
- Lack of knowledge of areas outside specialty
- Stigma
- Don't know how to identify client needs
- Don't know where to refer clients who need specialty services
- Poor linkage/follow-up mechanisms

# Clients Need Services beyond HIV Care, but there are Obstacles

## Client Level

- Difficulty navigating bureaucracy
- Logistical/transportation issues
- Stigma/reluctance to access services

# Our Current System: Barriers



# Share Your Experience

1. What has your experience been getting HIV clients appropriate services to address their...
  - a. mental health?
  - b. substance use behaviors?
  - c. general health or other physical conditions?
2. Was it difficult to figure out what their needs were? How did you get this information?
3. Did you encounter any barriers trying to get them services beyond HIV care? What were they?

# Part 2: Integration at the System, Clinic, and Provider Levels



# Integrated HIV Care: A Definition

*“Integrated HIV care combines HIV primary care with mental health and substance abuse services into a single coordinated treatment programme that simultaneously, rather than in parallel or sequential fashion, addresses the clinical complexities associated with having multiple needs and conditions.”*

(Soto, 2004)

# What Integration Does

- Strengthens organizational linkages between medical and behavioral health care
- Improves access by expanding availability of services and removing barriers (administrative, transportation)
- Improves coordination of services
- Identifies service needs and links clients to appropriate treatment
- Blends interventions to treat whole person rather than isolated problems or disorders



# The Four Keys to Integrated Services

- Identifying clients' needs
- Meeting their needs if you can
- Getting them to someone who can meet their needs if you can't
- Assuring that services are as coordinated or integrated as possible



# Integration Involves a Major Change to “Business As Usual”

- Requires working around silo walls...or tearing them down
- Reorienting care from specific disorders and service systems to more holistic care
  - Physical health
  - Mental health/substance abuse
  - Socioeconomic factors that impact health
- Involves change at several levels of service delivery
  - System level (federal, state, county)
  - Clinic level (service delivery organizations)
  - Provider level (doctors, nurses, social workers, case managers, etc.)

# Reorienting Services: System Level

- Tear down silos
- Broaden criteria of who can receive services where
  - Preventive care
  - Early intervention before conditions become acute or disabling
- Loosen restrictions on what services are reimbursable in different service settings
- Devise ways to share clinically important information while respecting client privacy
  - HIPAA
  - 42 CFR Part 2

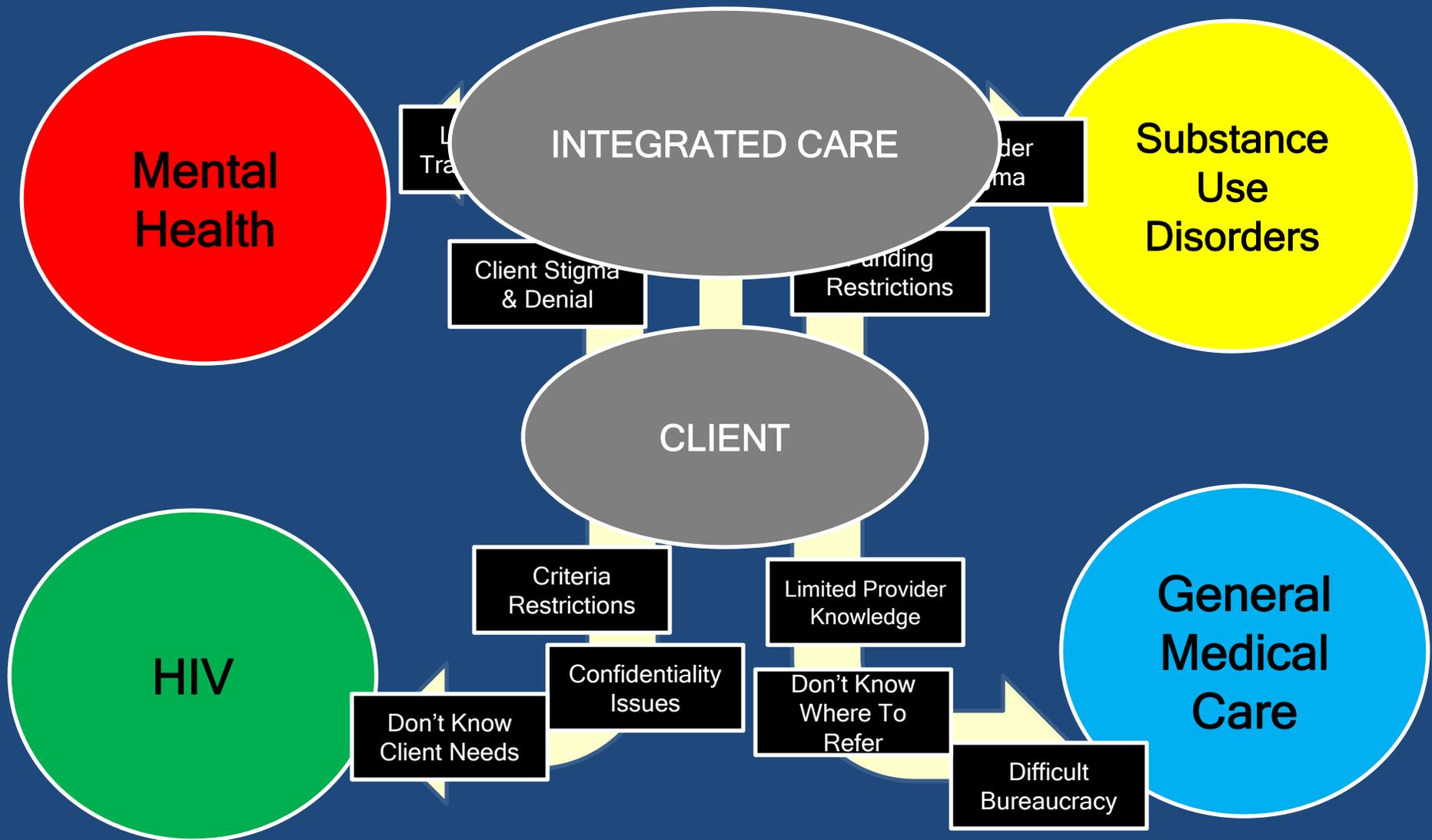
# Reorienting Services: Clinic Level

- Establish services to screen/assess for problems outside of specialty
  - Identify clients' needs in all areas of health and health-related domains
  - Offer integrated services to address client needs if possible
  - Provide effective linkage and referral services in severe/complicated cases that require specialty care
- Integrate case management into menu of services
  - Help clients navigate administrative/bureaucratic hurdles
  - Work with clients to address socioeconomic challenges that negatively impact health
  - Assist clients with logistical/transportation issues

# Reorienting Services: Provider Level

- Learn about areas outside specialty: overcome stigma and misunderstandings about certain conditions
- Learn how to effectively communicate with providers from other disciplines/backgrounds
- Learn how to screen and assess for a variety of conditions
- Learn how to provide effective brief intervention services
- Learn about resources available for clients who need specialty services
- Learn how to effectively link clients to services they need

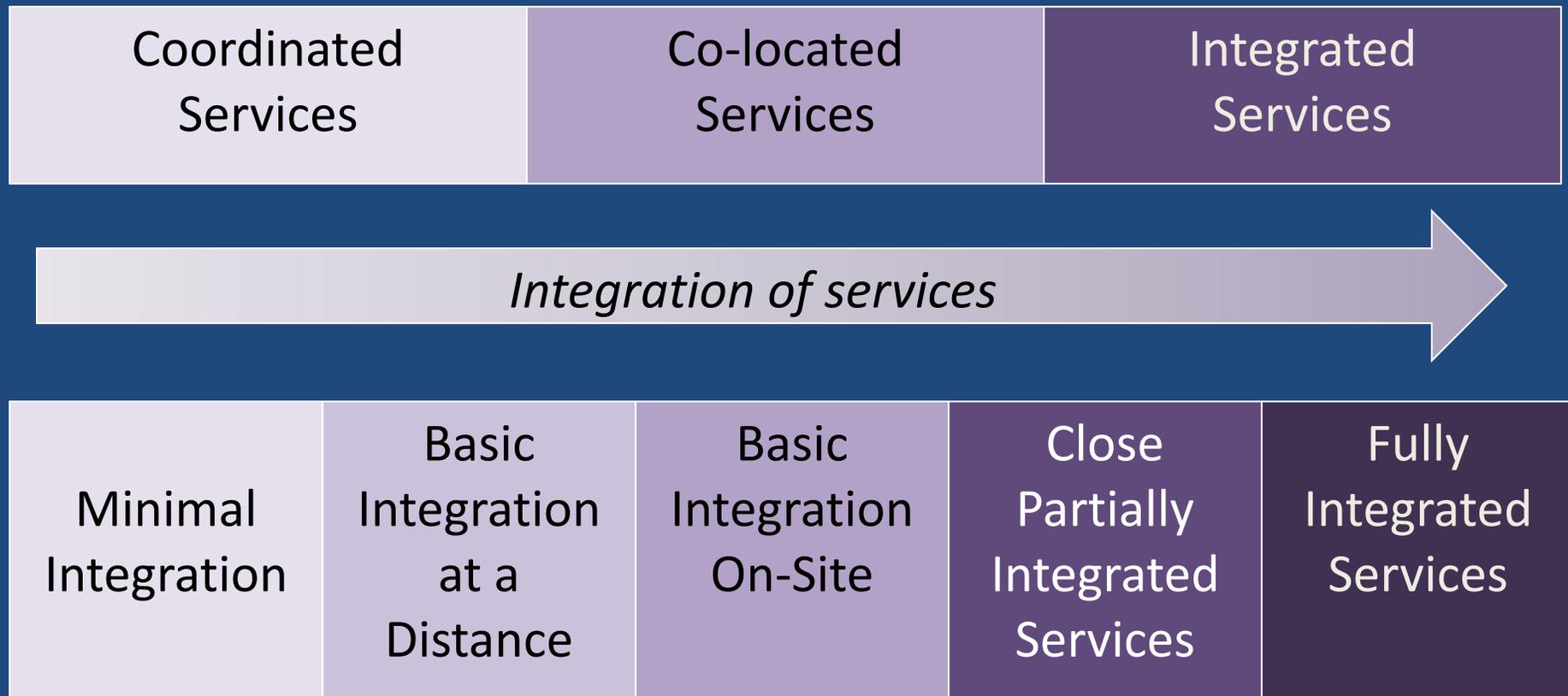
# What Can Integrating Services Do?



# Integrating Services for HIV Clients: The Evidence

- Improve mental health
- Reduce drug/alcohol use
- Increase retention in medical care
- Improve health-related quality of life
- Improve adherence to ART, reduce viral load, increase CD4 Count
- Lower risk of premature death

# What Do Integrated Services Look Like?



# What Do Integrated Services Look Like?

## Minimal Integration

- Providers work in separate systems, separate facilities, rarely communicate
- MH/SUD consultation with HIV providers and vice versa, but not about specific clients
- Case managers coordinate care, provide transportation



**HIV  
Care**



**MH/SUD**

# What Do Integrated Services Look Like?

## Basic Integration at a Distance

- Providers work in separate systems/facilities, but they communicate about shared clients.
- HIV provider consults with MH/SUD provider on how to serve specific clients' needs.
- Based on MH/SUD providers' input, HIV providers give screening and brief intervention services.



**HIV  
Care**

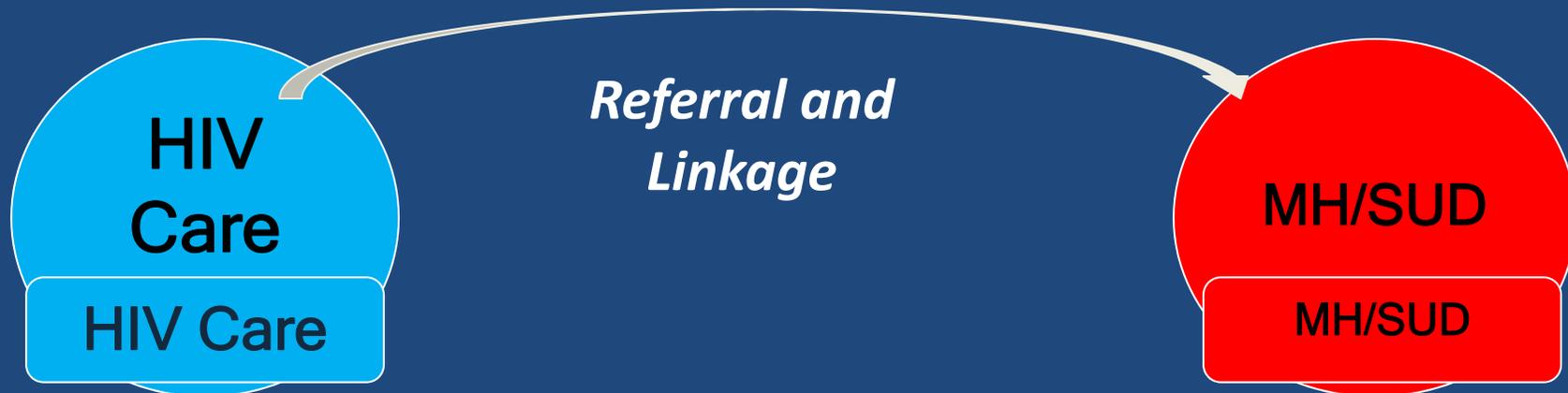


**MH/SUD**

# What Do Integrated Services Look Like?

## Basic Integration On-Site

- Providers work in separate systems, but in same facility
- Co-located MH/SUD providers deliver specialty services in HIV settings
- Co-located HIV providers deliver services in MH/SUD service settings.



# What Do Integrated Services Look Like?

## Close Partially Integrated Services

- Providers work in the same facility, and have some common systems (scheduling, medical records)
- Better communication and service collaboration.
- Case manager works with providers to develop and implement integrated treatment plan.



**HIV  
Care**

**Partially  
Integrated  
Services**

**MH/  
SUD**

# What Do Integrated Services Look Like?

## Fully Integrated Services

- MH/SUD and HIV providers work in the same facility, under the same system, and as part of the same team.
- Client may experience MH/SUD treatment as part of regular care.
- MH/SUD and HIV providers regularly consult on client care, can see clients together at the same time.



**HIV  
Care**

**Fully  
Integrated  
Services**

**MH/  
SUD**

# Making Integration a Reality: It's Not Easy

- As service integration becomes more intense, it requires more change at all levels
- Integration may require action at all levels of service delivery (system, clinic, provider)
- It may not be possible to make changes at every level at once

# Making Integration a Reality: The System Level

- Establish mechanisms to facilitate collaboration and consultation across systems/organizations
- Create integrated medical records and billing systems
- Provide funding for integrated services
- Set up mechanisms so providers can bill for integrated services

# Making Integration a Reality: The System Level

- Devise ways for providers to share health information while complying with privacy regulations
- Provide training providers need to deliver integrated services
- Provide resources providers need to build integrated service capacity

# Making Integration a Reality: The Clinic Level

- Establish partnerships with outside organizations
- Set up protocols for clinical collaboration and consultation
- Hire/train case managers
- Find space for co-located staff
- Integrate co-located staff into clinic culture and processes
- Establish effective referral and linkage protocols for clients referred to co-located services (warm handoffs)

# Making Integration a Reality: The Provider Level

- Learn to look for signs/symptoms of issues outside of area of expertise that require consultation
- Communicate effectively with providers from different backgrounds/disciplines
- Collaborate/coordinate services with case managers when necessary
- Learn screening and brief intervention methods

# Barriers to Integrated Care

*“Integrated behavioral/primary care is like a pomegranate: overwhelmingly people say they like it, but few buy it.”*

(Cummings, 2009)



# Barriers to Integrated Care

- Different priorities
  - Many challenges to address, can they all be done at once?
- Different philosophies
  - Harm reduction vs. abstinence
  - Medical vs. Behavioral
- Differences in training
- Different funding streams
- Documentation and privacy issues

# Potential Solutions

- Use case managers
- Form effective partnerships
  - Show integration is a win-win
  - Identify “champions”
  - Coordinate philosophy/principles of care
- Flexible funding
- Consent forms to share information
- Start small
- Make changes incrementally



# Barriers to Integrated Care: Group Activity

- Clinic X serves a large homeless population in a neighborhood where substance abuse is a major problem. To address clients' needs, administration brought in a substance abuse counselor to provide co-located SUD service onsite. Yet after several months, nobody was going to see the SUD counselor.
- Why wasn't anyone going to see the SUD counselor?

# Barriers to Integrated Care: What Happened at Clinic X?

- Some clinic X staff didn't know SUD services were available onsite
- Clinic X staff who knew SUD services were available didn't know...
  - where the SUD counselor's office was
  - the SUD counselor's office hours
  - how to refer clients for assessment or services
- When Clinic X staff made referrals...
  - they never received confirmation that clients went to the counselor
  - they never received progress reports on clients' substance use and recovery
- Clinic X staff was uncomfortable asking clients about substance use, so they never found out who to refer to the SUD counselor

# Barriers to Integrated Care: Small Changes Can Make a Big Difference

- Clinic X was able to address these problems at little cost:
  - Notified clinic staff of SUD services available onsite
  - Informed clinic staff of location of SUD services
  - SUD counselor posted office hours on door
  - Created disposition forms for SUD counselor to return to referring clinician
  - Educated Clinic X staff on techniques to talk about substance abuse and encourage clients to see the SUD counselor

# Part 3: Integrated Care: Tools and Models



# Tools Providers Need to Deliver Integrated Services

- **Effective communication skills**
  - Gather accurate information from clients
  - Assure clients understand information they receive
  - Communication with clients with MHD/SUD can be difficult
- **Screening and assessment**
  - Determine which clients need of integrated services
- **Brief intervention techniques**
  - Deliver integrated services for clients with mild/moderate mental health/substance use problems

# Effective Communication

- Clients with mental health or substance use disorders may have cognitive and/or emotional difficulties
  - Must be always be clear, ensure comprehension
    - Repeat key points: have clients repeat instructions in their own words
    - Teach science in simply terms
    - Use translator or sign language services if necessary
    - Use pictures and/or written material
  - Non-Judgmental
    - Gather and present information, be non-confrontational
    - Avoid value judgments

# Screening and Assessment

- Ask about mental health and substance use
- Screening Instruments Used in Primary Care:
  - MHD: BDI, PHQ, GAD
  - SUD: CAGE, AUDIT, DAST
- Recommended for HIV Clients:
  - Substance Abuse and Mental Illness Symptoms Screener (SAMISS)
  - Client Diagnostic Questionnaire (CDQ)



# Screening and Assessment

- Be Aware of Overly Literal Answers
  - Be Sure To Get Information Pertinent to Symptoms:
    - Q: Have you had trouble concentrating on things such as reading the newspaper or watching television?
    - A: That doesn't apply to me: I don't read the paper and I don't have a TV.
  - Rephrase, or come up with other way to get at point regarding concentration (*“Have you had difficulty concentrating when people are talking to you?”*)

# Screening and Assessment

- Be aware of tendency to minimize or deny socially undesirable behaviors: probe in non-confrontational manner
  - Denial may come across as inconsistent or contradictory information
  - Present follow-up probes as attempts to clarify, not as challenges to accuracy of responses.
  - Provide a non-threatening opportunity to correct or retract statements.

# Communication, Screening, Assessment: Five-Minute Role Play

1. How did it make you feel asking about these personal issues like mental health and substance use? How did it make you feel being asked?
2. If discussing these issues made you uncomfortable, how did you handle this discomfort? Did it affect the way you acted during the conversation?
3. What strategies for talking about mental health and substance abuse issues seem to work? Which don't? Why?
4. How can you incorporate this knowledge into the way you talk about these issues with your clients?

# Screening and Assessment



- Be aware of HIV-Associated Neurocognitive Disorders
  - Occur as HIV invades the brain
  - Slowing of cognitive functions
  - Behavioral Changes: Apathy, loss of motivation, low energy, withdrawal
  - Motor changes: Slowing, clumsiness, unsteadiness
- Assess using Modified HIV Dementia Scale and other tests available in *Guide for HIV/AIDS Care*

# Brief Intervention Techniques: Motivational Interviewing

- “A way of being with a client, not just a set of techniques for doing counseling” (Miller and Rollnick 2002)
- Used to help clients facilitate positive behavior change or improve adherence.
- Do not lecture or advise, but stimulate change by identifying discrepancies between client’s behavior and their goals.
- Goal is to elicit “change talk” from client

# Brief Intervention Techniques: Motivational Interviewing

- Key principles
  - Express Empathy
  - Support Self-Efficacy
  - Roll With Resistance
  - Discover Discrepancies
- Key skills (OARS)
  - Open Ended Questioning
  - Affirming
  - Reflective Listening
  - Summarizing
- More information available at <http://www.motivationalinterviewing.org>

# Brief Intervention Techniques: Cognitive Behavioral Therapy

- Structured therapy with a limited number of sessions
- Focus on increasing awareness of inaccurate or negative thinking.
- Helps clients recognize challenging situations, avoid getting into them (if possible), and cope with them more effectively.
- Helps clients view challenging situations more clearly and respond to them effectively
- More information available at <http://www.nacbt.org>

# Medications

- Mental Health Medications
  - Antidepressants
  - Mood Stabilizers
  - Anti-anxiety medications
  - Antipsychotics
- Substance Use Disorder Medications
  - Alcohol dependence (naltrexone, disulfiram, acamprosate)
  - Opioid dependence (naltrexone, methadone, buprenorphine)

# MH/SUD/HIV Medication Interactions

ARV Medication	MHD/SUD Medication	Potential Clinical Effect and Management
Efavirenz	Buprenorphine (opioid dependence)	Possible reductions in buprenorphine effects. Monitor and adjust buprenorphine
Ritonavir	Olanzapine (psychotic disorders)	Decreased olanzapine effects. Monitor and adjust olanzapine
Amprenavir, Delavirdine Ritonavir	Alprazolam (anxiety)	Increased alprazolam effects. Avoid alprazolam. Use lorazepam instead
Efavirenz, Tipranovir Lopinavir/Ritonavir	Bupropion (depression)	Decreased bupropion effects. Monitor and titrate bupropion.
Many ARV medications	Methadone (opioid dependence)	Possible reductions in methadone effects. Monitor and adjust methadone.
Delavirdine, Ritonavir	Fluoxetine (anti-depressant)	Increased ARV levels, increased medication effects. No dose adjustment needed.

- Most interactions are clinically insignificant.
- Check UCSF Database of Antiretroviral Drug Interactions: <http://hivinsite.ucsf.edu/insite?page=ar-00-02&post=7>

# Integration Example: Healthy Living Project for People Living With HIV

- Reduces substance use and risk of HIV transmission
- Cognitive behavioral approach, with facilitators working as “life coaches” with clients
- Help clients make changes in health behavior, become active participants in ongoing medical care, achieve personal goals
- Includes education, coping skills, problem solving training, and role play

# Integration Example: PATH (Preventing AIDS through Health)

- For clients with serious mental illness
- Nurse provides in-home consultations and coordinates medical and mental health services
- Nurse partners with prescribing providers, pharmacists, case managers
- Helps client overcome barriers to medication adherence and promotes self-care

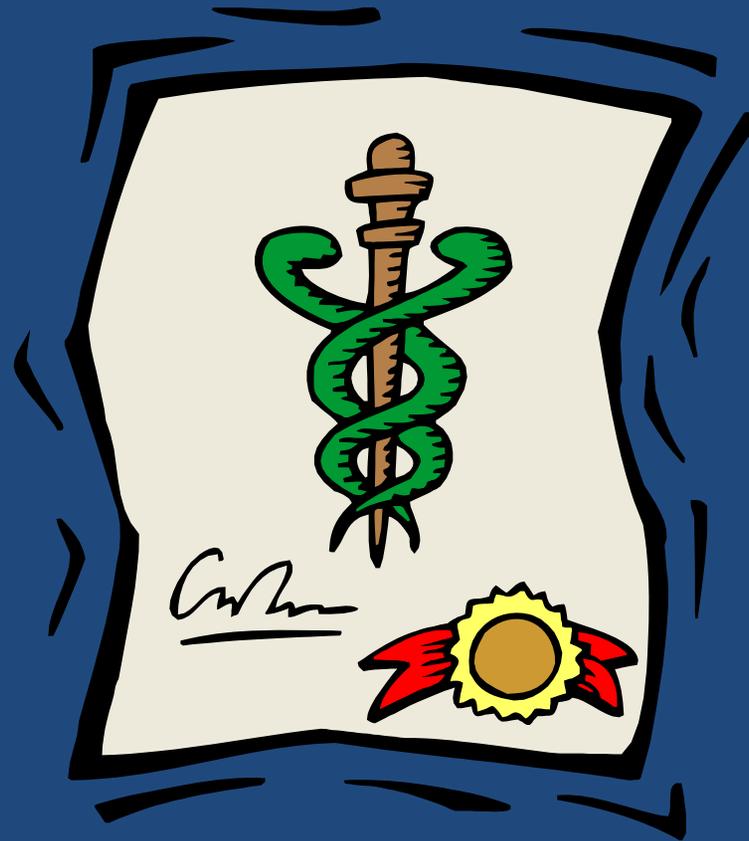
# Integration Example: SBIRT (Screening, Brief Intervention, and Referral to Treatment)

- Screen using brief screening instruments
- If at moderate risk, conduct brief intervention or brief treatment
  - Education about risks associated with substance use
  - Motivational Interviewing
- If at high risk, refer to specialty SUD services

# Integration Example: Buprenorphine and HIV Services

- Clinician prescribing ART also provides buprenorphine
- SUD specialist provides buprenorphine therapy at HIV clinic
- Hybrid model: Induction by SUD specialist and maintenance by HIV care provider

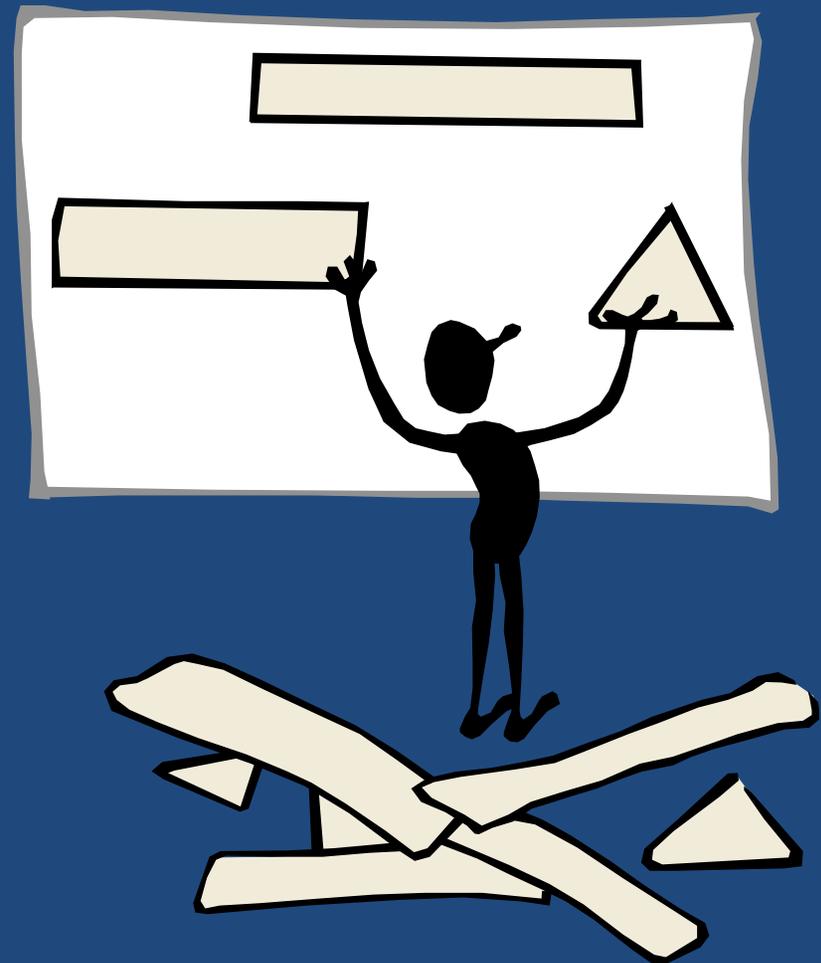
# Part 4: HIV, Integration, and Healthcare Reform\*



*\* Please note that the implementation of healthcare reform (the Affordable Care Act) may differ in some states.*

# Anticipated Effects of the 2010 Patient Protection and Affordable Care Act (ACA)

- On HIV services
- On the integration of services (in general)



# The ACA and HIV: Improved Access to Health Coverage

- Pre-ACA:
  - 17% of people living with HIV have private insurance, 30% have no insurance at all
  - Most funding from Medicaid, Medicare, Ryan White
- What ACA Will Do:
  - Insurers can no longer deny coverage to children living with HIV/AIDS
  - Pre-existing Condition Insurance Plan to cover people now considered “uninsurable”
  - In 2014, insurance companies cannot deny coverage or impose limits on coverage
  - Expand Medicaid coverage
  - Insurance subsidies for people up to 400% of poverty level

# The ACA and HIV: Covering the Medicare Part D “Donut Hole”



- Medicare Part D Standard Benefit:
  - Enrollees pay \$310 deductible plus 25% of medication expenses up to \$2,530 each year.
  - Covers 95% of medication expenses once enrollees reach \$6,445.50 in medication costs
  - No coverage from \$2,840.01-\$6,445.49
- Leaves a \$3,607.50 “donut hole” uncovered

# The ACA and HIV: Covering the Medicare Part D “Donut Hole”



- What ACA Will Do:
  - Provide rebates and discounts to help cover the donut hole
  - Will consider AIDS Drug Assistance Program benefits part of out of pocket spending, creating better coverage for medication costs.

# The ACA and Integration: Behavioral Health Coverage

- Will define “essential benefits” for insurance plans participating in exchanges.
- Among the “essential benefits” are:
  - Chronic disease management
  - Mental health services
  - Substance abuse services
- Parity: No caps on MHD/SUD spending below spending on medical services

# The ACA and Integration: Medical Homes

- Enhances coordination and integration of behavioral health, medical care, and community supports
- Interdisciplinary team interacts directly and coordinate care
  - Physicians and nurses
  - Behavioral health professionals
  - Social workers
  - Chiropractors, alternative medicine
- A “whole person” approach: identify needs and either meet them or provide linkage to someone who can.

# The ACA and Integration: Medical Homes

- Encouraged by 90% FMAP to states for first eight quarters
- For patients with:
  - Two chronic medical conditions
  - One chronic condition and risk for another
  - A serious or persistent mental health condition
- HIV providers can apply to become Health Homes. Assistance is available from the Target Center's HIV MHRC at [www.careacttarget.org/ta\\_providers.asp](http://www.careacttarget.org/ta_providers.asp).

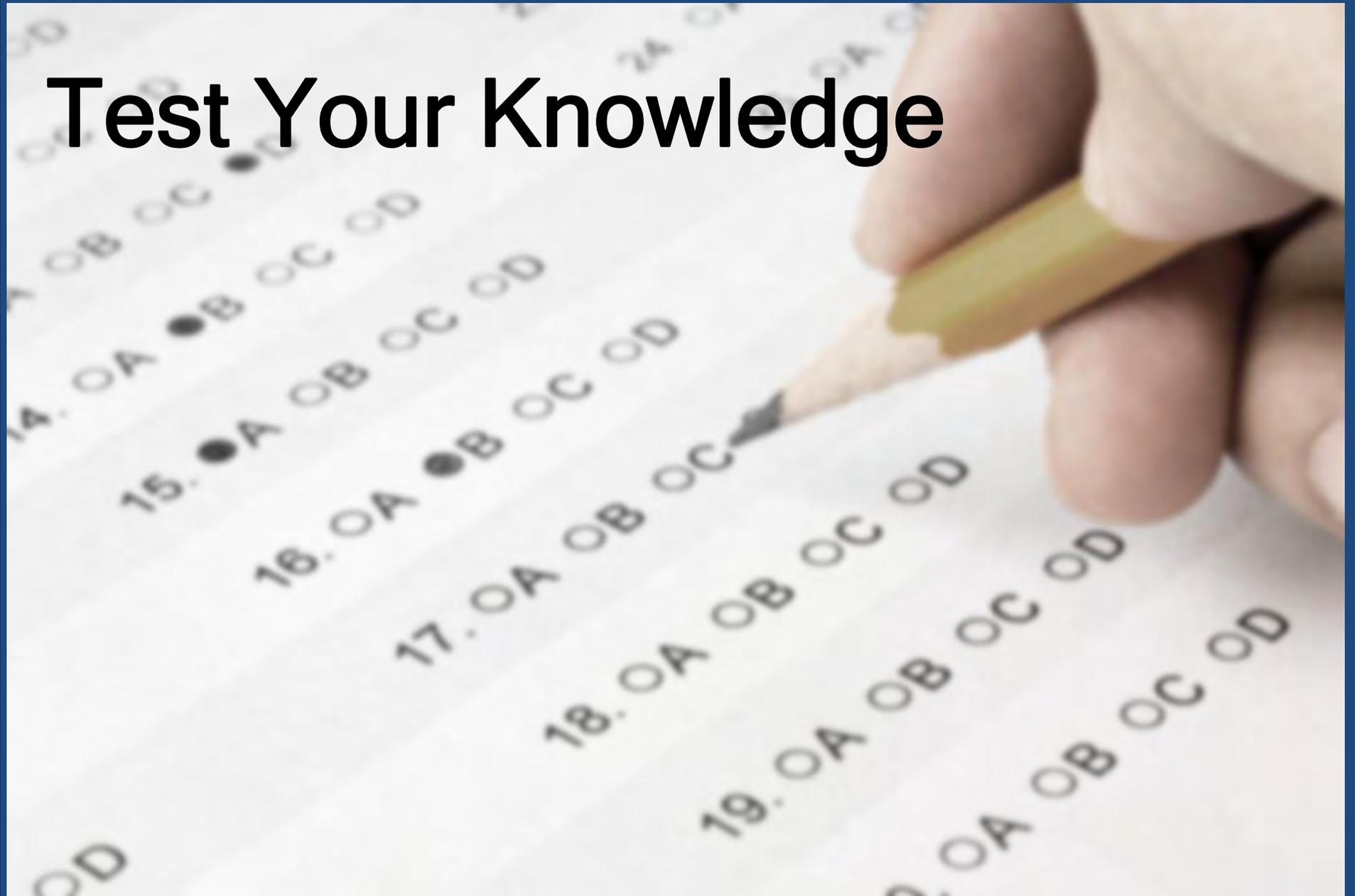
# The ACA and Integration: Innovations

- **Accountable Care Organizations**
  - Groups of healthcare providers that will enter collaborative agreements to improve quality and lower costs
  - MH/SUD treatment providers may join
- **Primary Care/Behavioral Health Co-Location Grants**
- **Home and Community-Based Services**

# Take-Home Points

- There are many conditions that affect HIV clients other than HIV, and addressing them is an essential component of HIV care
- Integrating services to address these conditions with HIV services can improve both HIV outcomes and overall health
- Integration is not always quick or easy, but the barriers to integration can be overcome
- Many providers are already integrating mental health and substance abuse services with HIV care
- Policy changes in the coming years will help facilitate service integration

# Test Your Knowledge



# Test Your Knowledge

1. What proportion of people living with HIV have a substance use disorder?
  - a. Between  $1/20$  and  $1/10$
  - b. Between  $1/9$  and  $1/5$
  - c. Between  $1/4$  and  $1/2$
  - d. Between  $1/2$  and  $2/3$

# Test Your Knowledge

## 2. Integrated Services for HIV care can include...

- a. Screening for mental health and substance use disorders
- b. Conducting hour long mental health assessments for all clients
- c. Adaptation of mental health treatment techniques for use with HIV clients
- d. A and C
- e. A, B, and C

# Test Your Knowledge

## 3. Healthcare reform will do the following:

- a. Extend health insurance coverage to some people with HIV who are currently uninsured
- b. Provide better coverage to help some people pay for their HIV medications
- c. Place limits on mental health and substance abuse services for people living with HIV
- d. A and B
- e. A and C

# Thank You For Your Time!



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