THE CASE FOR BEHAVIORAL HEALTH SCREENING IN HIV CARE SETTINGS

SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

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The Case for Behavioral Health Screening in HIV Care Settings

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

SUBSTANCE USE AND HIV/AIDS

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

Consider these facts about the connections between HIV/AIDS, mental illness, substance use and trauma.
- People living with HIV have high rates of past or current history of alcohol or substance use disorders (SUDs).[i,ii,iii]
- 66 percent have used illicit drugs and 16.5 percent have a history of intravenous drug use.[ii]
- 24 percent report receiving treatment for SUDs.[iii]

MENTAL ILLNESS AND HIV/AIDS

People living with HIV experience mental illness at significantly higher rates than the general popu-lation. A 2008 study stated that the rate of co-occurring mental illnesses in people with HIV was so high that "having a single mental health diagnosis was the exception rather than the rule."[iv] Specifi-cally, people living with HIV have:
- Two to five times higher rates of depression.[v,vi]
- Up to four times higher rates of depression among women with HIV than women who do not have HIV.[vii]
- Higher rates of anxiety.[viii,ix,x,xi]

TRAUMA AND HIV/AIDS

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

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

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

IMPACT OF BEHAVIORAL HEALTH CONDITIONS ON HIV CARE

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

THE PROBLEM: SCREENING IS INCONSISTENT

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

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

WHAT SCREENING FORMS ARE AVAILABLE?

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

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

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

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

SCREENING FOR BEHAVIORAL HEALTH: CRITICAL BUT UNDERUSED

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

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

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

REPORT FROM THE FIELD

ABOUT THIS REPORT

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

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

WHAT IS SBIRT?

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

The Three Steps of SBIRT:

1 **Screening —** A health care professional assesses a person for risky substance use behaviors through standardized screening tools.

2 **Brief Intervention —** A short nonjudgmental conversation between a health care professional and patient exhibiting risky substance use behaviors, including feedback and advice.

3 **Referral to Treatment —** For patients whose screening results indicate the need for specialty services, a health care professional provides a referral for additional treatment.

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

For more information on SBIRT in HIV care settings, see http://aidsetc.org/sites/default/files/resources_files/sbirt.pdf
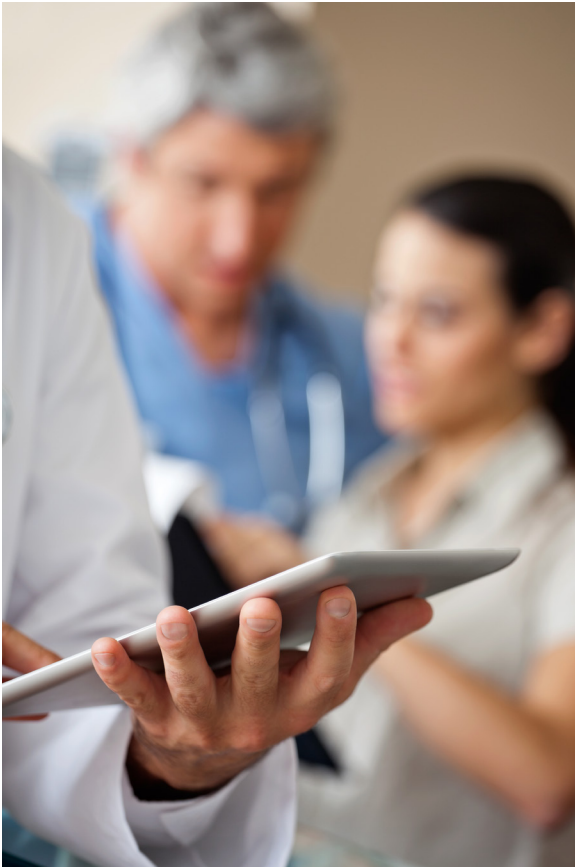
WHO SCREENS, WHEN AND WITH WHAT TOOLS?

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

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

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

TIPS FOR IMPLEMENTING SCREENING FOR BEHAVIORAL HEALTH

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

ORGANIZATIONAL CULTURE

EXPECT AND SHARE POSITIVE PATIENT OUTCOMES.

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

- Several participants reported that their organizations believed strongly that screening and treatment for SUDs and mental illnesses improves adherence to ART and better health outcomes.

- Programs ensure that staff are well aware of the link between behavioral health and good health outcomes for people living with HIV and use this knowledge as motivation for conducting the screening and referral to treatment.

- Many of the integrated facilities reported that since they began universal screening, viral suppression of those with behavioral health disorders was reduced to be the same as those

TECHNOLOGY-BASED SCREENING

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

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

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

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

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

FOSTER COLLABORATION BETWEEN PRIMARY AND BEHAVIORAL HEALTH PROFESSIONALS.

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

• Programs that reported high rates of screening and referrals to treatment provided opportunities for primary and behavioral health care professionals to communicate and collaborate.

• In programs that were highly integrated, multidisciplinary communication takes place during in-person case conferences from once a week to two times per month. Some programs conduct daily morning "huddles."

• Several program managers noted that face-to-face contact is critical to building effective working relationships that support collaborative and coordinated care

• One behavioral health program emphasized recruiting for onsite primary care providers who understood that communication with the behavioral health clinicians was critical to the team.

• Another program affiliated with a teaching hospital found annual training was necessary to reinforce a culture of communication to interns and residents.

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

HELP PRIMARY CARE PROVIDERS SEE THE VALUE IN SCREENING.

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

- A state health program that implemented SBIRT in all of its contracted HIV clinics observed that some primary care providers incorrectly believe that they already identify individuals with risky substance use or mental health problems without screening.

- A few programs questioned the value of screening, because they believed an effective medical provider should be able to identify behavioral health problems based on their clinical judgment and knowledge of a particular patient. However, research shows that primary care providers recognize depression only 50 to 70 percent of the time.[xx]

- A large HIV clinic using electronic screening methods captured reports of mental health or substance use problems that were previously missed or undocumented by primary care providers for a significant number of patients.[xxiii] Nurses in that clinic are trained to treat the results of screening as "another vital sign," like blood pressure or heart rate.

INFRASTRUCTURE AND IMPLEMENTATION

SCREEN ALL PATIENTS, NOT JUST THOSE WITH HIV.

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

- In a state that conducts SBIRT throughout its HIV clinics, providers learned to shift their thinking from identifying disorders and referring to treatment only those that they perceive as "high risk" to identifying risk factors and intervening among all patients.

- One program reported that patients sometimes leave a number of questions blank at the end of the PHQ-9 because of fear of hospitalization if there are too many "yes" responses. In those situations, staff recommends a follow-up conversation with the primary care provider or a warm hand-off to a behavioral health professional.

PLAN THE ROLLOUT OF SCREENING CAREFULLY.

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

- Carefully selecting validated screening tools and a workflow analysis.

- Implementing screening instruments based on clinic workflow and adjusting as necessary.

- Training all employees in the screening process, including how to conduct screening and respond to results.

- Defining project success to all employees by transparently communicating outcomes.

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

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

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

CONNECTING PATIENTS TO COMPLEX SYSTEMS OF CARE

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

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

GET BUY-IN FROM KEY STAKEHOLDERS.

- A large urban clinic that uses technology-based screening (see box, page 8) began its rollout slowly, starting with a "champion" on one floor. This early adopter communicated success to others, which paved the way for implementation to the rest of that floor. Program managers studied problems with clinic flow, refined the process and rolled it out on another floor, then another.

- The statewide SBIRT program also used champions within a primary care provider system to support implementation.

FACILITATE COMMUNICATION BETWEEN PRIMARY AND BEHAVIORAL HEALTH CARE PROVIDERS.

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

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

PROVIDE SUPPORTS THAT MAKE REFERRAL TO TREATMENT STICK.

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

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

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

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

PEOPLE AND PLACES

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

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

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

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

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

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

HIRE ENOUGH BEHAVIORAL HEALTH PROVIDERS.

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

- A program that reported having enough behavioral health clinicians to be flexible and easily available worried about retaining these positions when the state grant funding that supports their salaries runs out. The growing workforce of peer providers is emerging as an important resource for programs.[xxvi,xxvii]

- Unrealistic workload expectations may affect employee retention and continuity of care. One program reported that its social worker who had a caseload of 190 HIV-positive patients also conducted all the annual assessments, leaving little time for short- or longer-term interventions. The clinic reported high turnover among social workers and struggles with fully integrating behavioral health.

TRAIN, TRAIN, TRAIN.

Retraining capabilities should be built into all training programs.

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

CONSIDER PHYSICAL LOCATION.

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

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

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

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

- A program reported a 50 percent rate of follow-through when its behavioral health services were 1.5 miles away. Follow-through on referrals increased when services were co-located.

- Co-location itself does not guarantee a warm hand-off. A clinic with a contracted behavioral health clinician was co-located on a floor with primary HIV care; however, the behavioral health clinician — who must bill his/her time — is often behind closed doors, making it difficult to connect patients to him/her.

- Three highly integrated programs report that appropriate scheduling allows their behavioral health clinicians to be available 50 percent of the time for warm hand-offs, detailed assessments, brief interventions, crisis stabilization and other related activities.

- For many programs, grants and other fundraising enables clinicians to be scheduled for non-billable time.

STATEWIDE IMPLEMENTATION OF SBIRT

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

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

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

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

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

CONCLUSION

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

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