AETC AIDS Education & Training Center Program
Southeast Regional Conference 2022

Tools for Integrating Substance Use Disorder and Other Behavioral Health Care into HIV Care Services

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John Nelson, PhD, CNS, CPNP
FXB Center, Rutgers School of Nursing

Learning Objectives

By the end of this session, each participant will be able to:

1) Identify the differences between the AETC Program *Mental Health/Substance Use Care: Clinic/Health Center Readiness Assessment Tool* and the *Integrating Mental Health and Substance Use Care into HIV Primary Care Toolkit*.

2) Summarize the purpose of the *Implementing Substance Use Disorder (SUD) Services in HIV Care Settings.*

3) Identify ways of destigmatizing substance use disorder and behavioral health and normalizing the screening, diagnosis, and care of behavioral health disorders in HIV care settings.

Disclosures

I have no relevant disclosures.

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Behavioral Health and HIV

- Depression, anxiety, and substance use disorders occur significantly more frequently among people with HIV (PWH) than among those without HIV[1,2]
- PWH with a behavioral health (BH) disorder are significantly more likely to drop out of HIV care if compared to PWH without a BH disorder[3]
- PWH and a BH disorder are significantly more likely to remain in HIV care if receiving mental health services[3]

[1]Remien RH, Stirratt MJ, Nguyen N, Robbins RN, Pala AN, Mellins CA. Mental health and HIV/AIDS: the need for an integrated response. AIDS. 2019 Jul 15;33(9):1411-1420.

[2]Cook, J. A., et al. *Prevalence, Comorbidity, and Correlates of Psychiatric and Substance Use Disorders and Associations with HIV Risk Behaviors in a Multisite Cohort of Women Living with HIV*. AIDS and Behavior. 2018; 22(10): 3141-3154.

[3]Rooks-Peck CR, Adegbite AH, Wichser ME, et al. *Mental health and retention in HIV care: A systematic review and meta-analysis*. Health Psychol. 2018 Jun;37(6):574-585.

More BH and HIV Findings

- In one study[1] of 18-29 years old Black MSM with HIV, only 19.6% of those identified to have a behavioral health concern engaged (at least 2 visits after an initial linkage visit) in recommended mental health services over a 2-year period (pre-COVID-19 pandemic).
- Among adults with HIV, viral nonsuppression has been linked to untreated, symptomatic depression, and treatment of the depression with viral suppression.[2]

[1]Hussen SA, Camp DM, Wondmeneh SB, Doraivelu K, Holbrook N, Moore SJ, Colasanti JA, Ali MK, Farber EW. Mental Health Service Utilization Among Young Black Gay, Bisexual, and Other Men Who Have Sex with Men in HIV Care: A Retrospective Cohort Study. AIDS Patient Care STDS. 2021 Jan;35(1):9-14.

[2]Lesko CR, Hutton HE, Fojo AT, Shen NM, Moore RD, Chander G. Depression and HIV viral nonsuppression among people engaged in HIV care in an urban clinic, 2014-2019. AIDS. 2021 Oct 1;35(12):2017-2024.

High Levels of Behavioral Health Need, Low Levels of Behavioral Health Services

- Despite the high need of behavioral health services, the levels of screening, diagnosis, linkage to services, and engagement in therapy (psychotherapy and/or medication assisted) are lower.
- Stigma (internalized and externalized) plays a major role in the gap of accessing behavioral health services
- Clinical care teams can reduce stigma by making behavioral health screening, diagnosis, treatment, and follow-up a routine part of the care for all individuals.
- Making the clinic a “welcoming” space for people with behavioral health concerns or needs is essential while providing a united clinical team to work collaboratively in routine behavioral health screening, diagnosis, treatment, and follow-up.

Mental Health/Substance Use Care: Clinic/Health Center Readiness Assessment

- Staff/Clinical Team Readiness
- Patient Screening Readiness
- Capacity Readiness
- Community Readiness
- Support Readiness
- Continuous Quality Improvement (CQI) Readiness

https://aidsetc.org/toolkit/mental-health

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Mental Health/Substance Use Care[1]

Clinic/Health Center Readiness Assessment[2]

The following checklist contains information about recommended capacities to consider in implementing mental health/ substance use care strategies in a clinic or health center. Services to address these conditions are often referred to as behavioral health. In the blank spaces provided, indicate which statement is the **best fit** for the given statement. This assessment may be completed individually by each member of your clinic team or collectively as a group to assist your team in planning and providing best practice mental health/substance use care for persons living with HIV (PLWH) in your program. Since every clinic and every client population is different, there is no single best-practice. Providing best-practice care is an ongoing process of evaluation, implementation, and re-evaluation. For help using this tool in your clinic, please email info@aidsetc.org.

Staff/Clinical Team Readiness	Not a current priority (indicate already addressed or not able to address at this time)	We have discussed this issue	We are developing a plan to address this issue	We are implementing a plan to address this issue	We are evaluating our implemented plan to address this issue	We are making adjustments to our plan to better address this issue	AIDS Education & Training Center services requested
1. There is ALL STAFF recognition of the need for Mental Health/Substance Use Care services in our clinic.							
2. Our clinic staff knows what Mental Health/ Substance Use Care includes (Screening, Diagnosing, Treatment, and Follow-up - including referral to other services as needed).							
3. Our clinic has leadership buy-in to increase our Mental Health/Substance Use Care activities.							
4. Our clinic has identified an available Mental Health/Substance Use Care champion.							
5. All of our clinic staff is invested in improving our patient Mental Health/Substance Use Care.							

1 "Mental Health/Substance Use Care" refers to an evidence-based, comprehensive plan of care that efficiently and effectively identifies those with untreated mental illness including substance use disorders, engages them into evaluation, diagnosis, treatment, and follow-up to best manage their illness and improve their overall quality of life.

2 Based on a template from: Centers for Disease Control and Prevention (2005). Anti-Retroviral Treatment and Access to Services (ARTAS):An individual-level, multi-session intervention for people who are recently diagnosed with HIV: Implementation Manual. Retrieved from: www.cdc.gov/hiv/topics/cba/pdf/artas_implementation_manual.pdf

Assessment Readiness	Not a current priority (indicate already addressed or not able to address at this time)	We have discussed this issue	We are developing a plan to address this issue	We are implementing a plan to address this issue	We are evaluating our implemented plan to address this issue	We are making adjustments to our plan to better address this issue	AIDS Education & Training Center services requested
1. Our clinic routinely uses a validated, standardized tool to screen all PLWH for depression.							
2. Our clinic routinely uses a validated, standardized tool to screen all PLWH for substance use disorders.							
3. Our clinic routinely uses a validated, standardized tool to screen all PLWH for other commonly occurring mental health conditions (e.g., anxiety, PTSD).							
4. Our clinic has a system in place to respond immediately to patients who screen positive for depression or substance use disorders (including a protocol for patients who are actively suicidal or homicidal).**							
5. Our clinic has a mechanism for focusing behavioral health interventions on more vulnerable populations (e.g., those not ready for needed substance use care or those with population-specific needs such as children, adolescents, pregnant women, the elderly, and those who are homeless).							
6. Our clinic formally assesses cultural and health beliefs regarding Mental Health/ Substance Use and accessing services.							

Capacity Readiness	Not a current priority (Indicate already addressed or not able to address at this time)	We have discussed this issue	We are developing a plan to address this issue	We are implementing a plan to address this issue	We are evaluating our implemented plan to address this issue	We are making adjustments to our plan to better address this issue	AIDS Education & Training Center services requested
1. Our clinic has the capacity to assign services to clients based on acuity (the greater the acuity, the sooner the service).							
2. Our clinic has an onsite behavioral health specialist available for consultation when a client screens positive for depression.							
3. Our clinic has an onsite behavioral health specialist available for consultation when a patient screens positive for substance use disorder.							
4. Our clinic has a waiting list to see a behavioral health specialist.							
5. If a waiting list is used, the wait at our clinic to see a behavioral health specialist is usually LESS than one week.							
6. Our clinic has a prescribing clinician who is not a behavioral health specialist but is willing to medically monitor and prescribe psychotropics as needed in consultation with a psychiatrist.							
7. Our clinic refers clients needing a behavioral health evaluation to a behavioral health specialist outside the clinic.							
8. Our clinic has an assistance and follow-up plan to help clients make and keep referral appointments.							
9. Resources are available in our clinic to assist clients with obtaining needed, prescribed psychotropic medications (i.e., for those without insurance or for those whose prescription is not on formulary of ADAP or insurance plan).							

Capacity Readiness	Not a current priority (Indicate already addressed or not able to address at this time)	We have discussed this issue	We are developing a plan to address this issue	We are implementing a plan to address this issue	We are evaluating our implemented plan to address this issue	We are making adjustments to our plan to better address this issue	AIDS Education & Training Center services requested
10. In our clinic, ALL staff is trained to be aware of acute needs of those exhibiting mental health/substance use symptoms (i.e., front desk staff, medical/nursing assistants who may need to get help for a patient not being seen by a clinician while in waiting room or on phone) and how to respond appropriately and safely.							
11. Our clinic has the capacity to provide Mental Health/ Substance Use Care services to those with low-literacy skills.							
12. Our clinic has the capacity to provide Mental Health/ Substance Use Care services to clients in their own language.							
13. Our clinic staff has implemented policies and procedures to allow for maximum reimbursement of behavioral health services provided in our clinic.							
14. State-of-the-science guidelines are the cornerstone of mental health and substance use disorder treatment plans used in our clinic.							

Community Readiness	Not a current priority (Indicate already addressed or not able to address at this time)	We have discussed this issue	We are developing a plan to address this issue	We are implementing a plan to address this issue	We are evaluating our implemented plan to address this issue	We are making adjustments to our plan to better address this issue	AIDS Education & Training Center services requested
1. Our clinic has relationships with community mental health clinics, community-based mental health professionals, substance use treatment specialists, or other support services (including psychiatric emergency services).							
2. Our clinic has clear, specific engagement-related roles for community partners (e.g., co-location of services, referral management dialogue).							
3. Our clinic has formal contracts and/or established referral protocols with existing community partners sufficient to meet client needs.							
4. Our clinic has identified resources in the community to secure transportation subsidies or incentives for patients.							
5. Our clinic has strong, positive, collaborative connections to community partners including community mental health facilities.							
6. Our clinic has familiarity and collaborations with health insurance marketplaces in our community, and knows the mental health coverage benefits of each.							

Support Readiness	Not a current priority (Indicate already addressed or not able to address at this time)	We have discussed this issue	We are developing a plan to address this issue	We are implementing a plan to address this issue	We are evaluating our implemented plan to address this issue	We are making adjustments to our plan to better address this issue	AIDS Education & Training Center services requested
1. Our clinic has the resources to utilize technology-based interventions to foster Mental Health/ Substance Use Care follow-up.							
2. Our clinic has the resources to provide or obtain Mental Health/Substance Use Care training and education for staff.							
3. Our clinic has the capacity to promote Mental Health/Substance Use Care strategies including Screening, Diagnosing, Treatment, and Follow-up.							
4. In our clinic, there are clear policies and procedures regarding staff member(s) responsibility in monitoring the clinical progress of patients being treated for mental illness using a standardized clinical assessment tool (if monitoring not done by a mental health professional).							

CQI Readiness	Not a current priority (Indicate already addressed or not able to address at this time)	We have discussed this issue	We are developing a plan to address this issue	We are implementing a plan to address this issue	We are evaluating our implemented plan to address this issue	We are making adjustments to our plan to better address this issue	AIDS Education & Training Center services requested
1. Our clinic uses validated, standardized Mental Health/ Substance Use Care measures for Screening, Diagnosing, Treating, and Following up.							
2. Our clinic has a process in use to evaluate patient care satisfaction and/or experiences.							
3. Our clinic has a process in use that utilizes data to create changes that will assist in continual quality improvement.							
4. Our clinic has a way to systematically monitor Mental Health/Substance Use Care Screening, Diagnosis, Treatment, and Follow-up data.							
5. Our clinic has a process in place to review and act on results from systematic monitoring on a regular basis (including success feedback to clinic staff).							
6. Our clinic works to identify barriers related to Mental Health/Substance Use Care Screening, Diagnosis, Treatment, and Follow-up, and works to reduce identified barriers for each component on the care continuum.							

Helpful resources to check out if you rated your clinic low in key areas

My clinic has staff buy-in to increase our engagement/retention in Care activities.

- Making the Connection: Promoting Engagement and Retention in HIV Medical Care among Hard-to-Reach Populations

My clinic routinely does an assessment of patient-level barriers and facilitators to Engagement in Care (i.e., finances, mental health, transportation, etc.).

- Client Service Plan: Assessing needs of clients

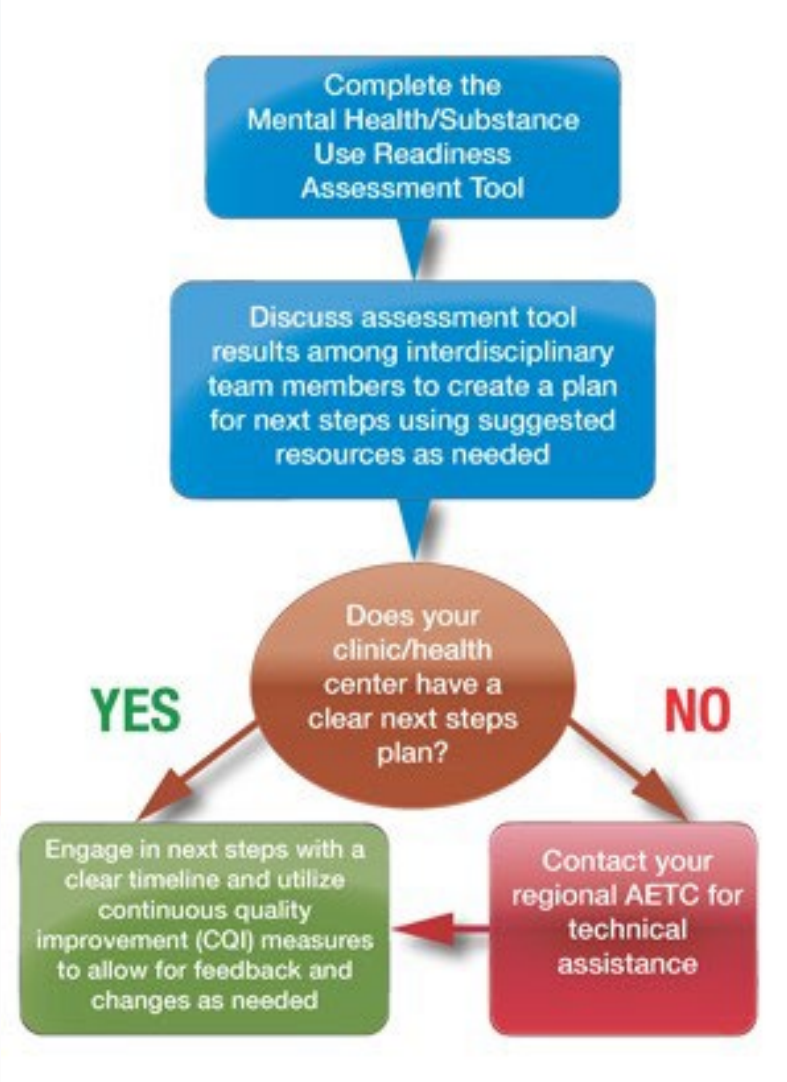
My clinic has a process to evaluate patient experiences in place.

- Patient Satisfaction Survey for HIV Ambulatory Care

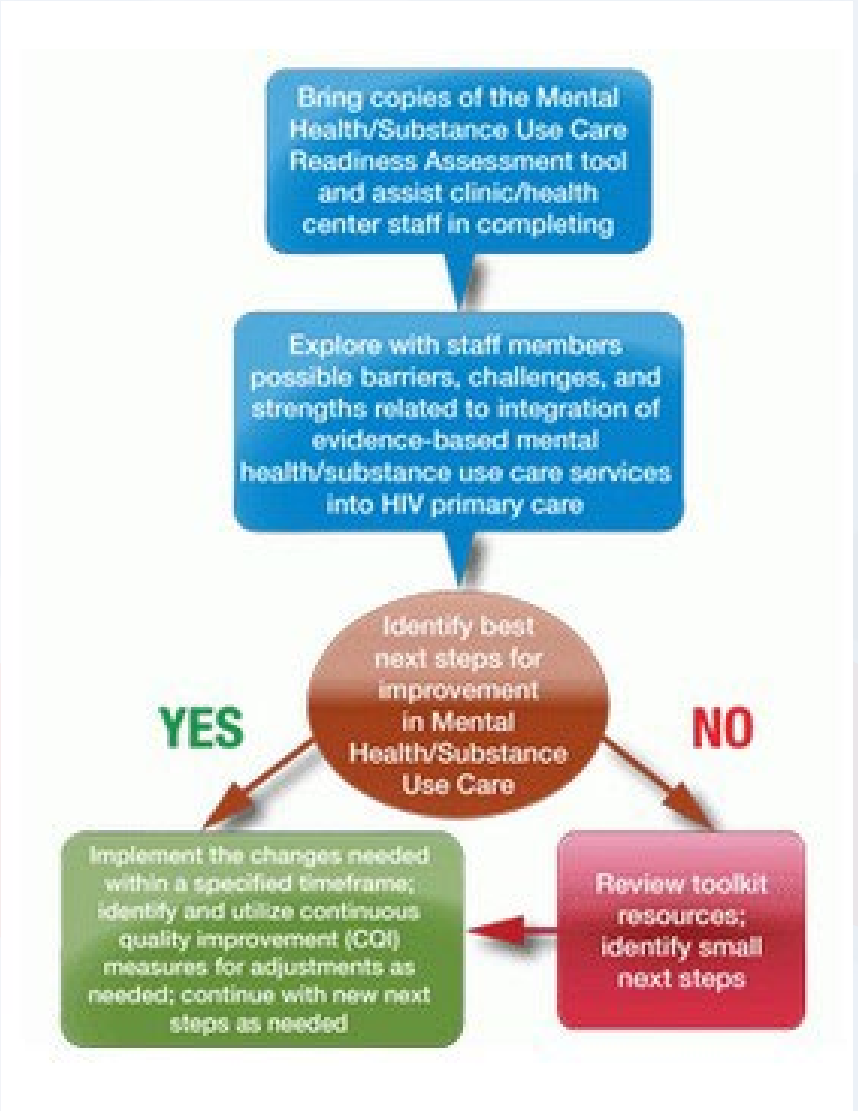
My clinic has a process in place to use data to create changes that will assist in continual improvement.

- HIV QUAL Workbook: Guide for Quality Improvement in HIV Care

Clinic Self-Administered Flow



Clinic Coach Administered Flow



Integrating Behavioral Health into Primary HIV Care—Covering the Bases

Purpose

Mental health and substance use disorders are highly prevalent among people with and at risk for HIV. This tool was designed to assist HIV primary care teams in a range of clinical settings to plan and carry out enhanced integration of mental health and substance use services, referred to as behavioral health (BH). Just as there is a well-known HIV care continuum, there is a BH continuum which consists of screening and diagnosis, referral and linkage, and treatment. This tool will guide you to create workflows and other processes in which responsibility for the key continuum steps is delineated. Resources for how to implement these steps are provided in the last section of the tool and include considerations for both BH specialty services for people with BH disorders as well as community-based and informal services that support people with sub-threshold BH disorder signs and symptoms.

https://aidsetc.org/resource/integrating-behavioral-health-primary-hiv-care-covering-bases

Overall Operational Considerations

- The client presents to the Primary HIV Care Clinic Team for either routine HIV care (initial or follow-up) or for an acute care issue. This may be an in-person or video/phone visit.
- For non-acute care visits, a screening process is in place to routinize behavioral health (mental health and substance use) questions and to destigmatize conversations about behavioral health. Although a similar stance is important for lab- or immunization-only visits, behavioral health (BH) screening is not typically feasible during these appointments. For clients who "screen positive" or whose scores fall within a range of concern, a process is in place to get clients to the "next step" of a behavioral health evaluation.
- For acute-care and non-acute care visits with identifiable behavioral health concerns (e.g., changes in mood or thought content that significantly affect day-to-day functioning, self-harming behaviors or urges, suicidal ideation, substance use, etc.), a process is in place to get clients to the "next step" of a BH evaluation.
- For each step, designated clinical care team members serve as facilitators to make sure the next step is taken.
- Are your HIV and/or primary care clinic space(s) and processes (in-person and virtual) "welcoming" to clients with a range of cultural meanings about behavioral health and behavioral health literacy[1]? (i.e., accessibility of posters, pamphlets, videos/tv and how successfully they communicate with all clients)
- Closed-loop communication, transparency, and oversight between each "step". A designated, skilled person (often an RN, LPN, MA, case manager, patient navigator) is helpful to support smooth transitions from one step to the next.
- Once a BH evaluation is completed and a plan developed in collaboration with the client and put into place, coordinated communications continue in a systematic way to prevent the client from falling out of recommended care, to continually check in with clients about their readiness for recommended BH care they have not yet initiated, and/or for making changes to the BH treatment plan that all HIV or primary care clinic team members need to be updated on to deliver optimal HIV care.

References:

1. National Academies of Sciences, Engineering, and Medicine 2016. Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Washington, DC: The National Academies Press. https://doi.org/10.17226/23442

1 Clinic Entry

Does accessing the clinic feel safe and unthreatening to clients?	RTM:* Role:
Are clients asked for the name and pronoun(s) they go by? How are the name and pronoun(s) communicated to other clinical staff? Are intake/ registration questions inclusive of gender non-binary individuals? Do all staff consistently use the name and pronoun(s) chosen by the client?	RTM: Role:
Is there a clear understanding of the clinic intake process, including BH as part of whole-person care, and is this information shared with new clients in a manner that effectively orients them to this clinic?	RTM: Role:
Is there a way for clients with anxiety, restlessness, intoxication, or other possible signs of acute BH needs to be allowed to wait in a different space (i.e., private exam room, other safe area) rather than the general waiting area with others?	RTM: Role:
Is there a clear process for HIV or primary care clinic team members to follow for de-escalating agitated clients, including those with thought disor- der symptoms?	RTM: Role:
Does the waiting room have information that routinizes behavioral health screening and evaluations? (i.e., https://1in4.info campaign materials)	RTM: Role:

2 Telehealth Visits for Behavioral Health

Do staff have telehealth capacity (devices, platforms, skills) to communicate virtually with clients (secure messaging, live streaming video and device microphone, telephone communication)?	RTM: Role:
Do clients have telehealth utilization capacity? If not, which ones do not? If yes, where will the client be during virtual sessions? In a secure, confidential setting (alone in a closed-door room, or in an environment where others may be able to hear the conversation)? Outside or in a community setting?	RTM: Role:
Is a support/IT person available who can assist if needed?	RTM: Role:
Is it clear to the client that the provider/clinical staff member is not in a setting that would compromise client confidentiality? It may be helpful to scan the provider's room with the webcam to show the client who is present. If not, is it clear that no identifying information will be verbally disclosed by the provider/clinical staff member during the telehealth visit?	RTM: Role:
What is the best way to reach the person being treated if the telehealth communication stops or is disrupted before finishing the visit?	RTM: Role:
Is there a clear process for provider/clinical staff team members to follow if there is a safety issue and a client is at risk of harm to self or others?	RTM: Role:

3 Behavioral Health Screening

Are validated screening tools (e.g., PHQ-9, GAD-7, PC-PTSD-5, TICS, TAPS) routinely used and workflow for who/when/how often to administer them (e.g., administered annually or semi-annually and as needed) in place? (i.e., https://www.hiv.uw.edu/page/mental-health-screening/gad-2; https://www.drugabuse.gov/taps/#/)	RTM: Role:
How are clients screened (e.g., a kiosk in the waiting room that connects to the electronic health record (EHR); paper form; an EHR-connected portal app for self-administration; an audio, computer-assisted administration; HIV or primary care clinic team member administers) and is the screening done in a private setting?	RTM: Role:
If self-administered by clients, are language and literacy accounted for when results are shared with the client?	RTM: Role:
Are results of the screening tool seen by the client and designated HIV or primary care clinic team member(s)? Based on the screening tool score and/or client questions or comments/behaviors, how is BH information communicated to the HIV or primary care provider and/or designated BH team member for further evaluation?	RTM: Role:
What processes are in place for reporting observed findings suggestive of BH concern (e.g., front desk or triage nurse notices signs of acute BH need) by staff members to designated HIV or primary care clinic team member(s) for quicker intervention as needed?	RTM: Role:
Are there HIV or primary care team member(s) designated to oversee transition to the next step for clients with a "positive screen" or clinical indicators of BH concern?	RTM: Role:

4 Behavioral Health Diagnosis and Treatment Plan

Are diagnoses documented? Who on the HIV or primary care team has access to this information?	RTM: Role:
Is a client-centered, evidence-based treatment plan developed and documented?	RTM: Role:
Are treatment option(s) that are available and accessible (in-clinic; same organization but different site; off-site or community-based) to the client clearly communicated to the client?	RTM: Role:
What structures are in place to assure that communication occurs at routine intervals between all HIV or primary care clinic team members (BH and non-BH) for support and consistency in implementation of treatment plan?	RTM: Role:
Does the follow-up plan encompass client engagement in the treatment plan? If medication was prescribed, did the client get the medication, did they start it, are they taking as prescribed, are they experiencing side effects, do they understand it may take a few weeks before medication effect is noticeable, how are they feeling in general, do they have someone who knows what they are going through right now, etc.? If a referral is made to a BH therapist who is not part of the HIV or primary care clinic, does the client have an appointment, has the client met with the therapist (in-person or telehealth) and if so, what is the follow-up plan?	RTM: Role:
Does the client have an individualized crisis plan? If yes, does the client have a copy and is the plan documented in the chart?	RTM: Role:

5 Behavioral Health Evaluation

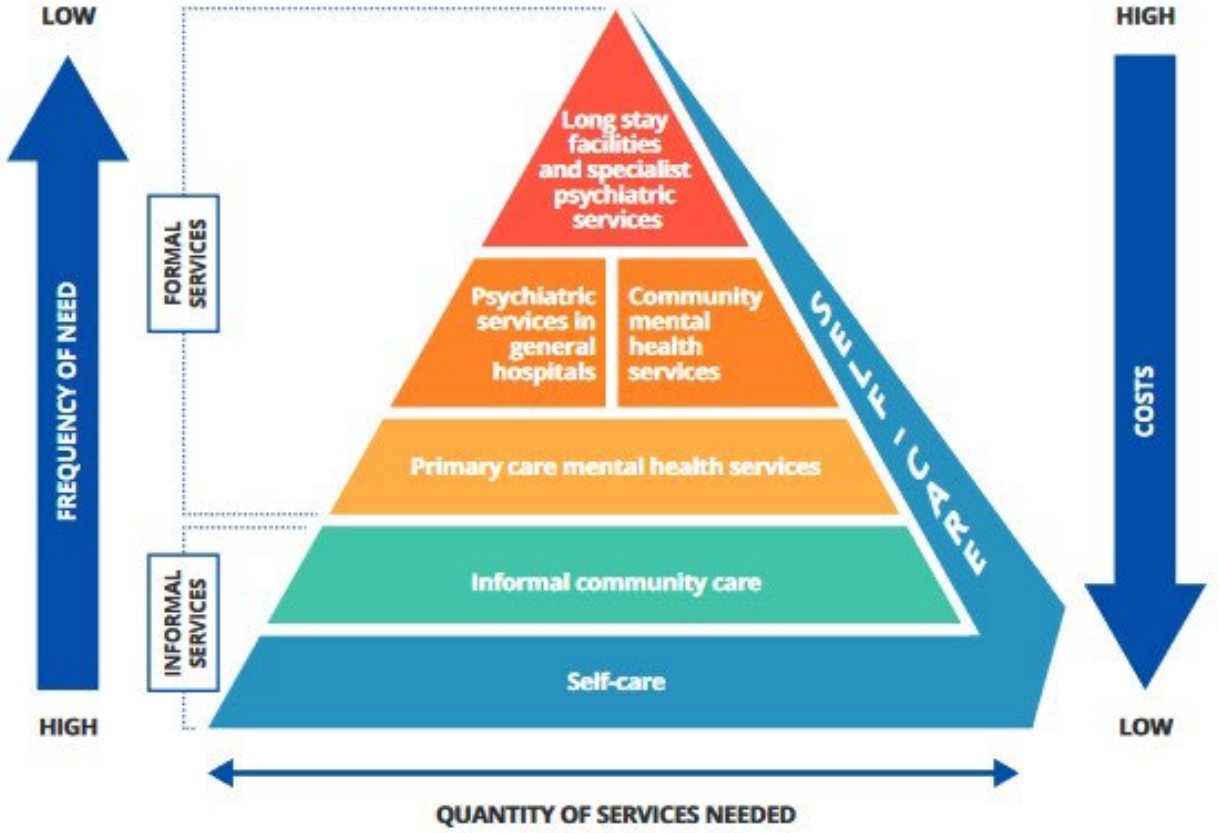
Is the BH evaluation conducted by one or more BH specialists (e.g., LCSW, psychologist, mental health nurse practitioner or clinical nurse specialist, psychiatrist).	RTM: Role:
If more than one BH provider is involved, is communication between BH providers occurring consistently and documented?	RTM: Role:
How much patient/client voice is incorporated into the treatment plan?	RTM: Role:
Are diagnosis and treatment plan documents shared with the patient/client?	RTM: Role:
Are next steps and the treatment plan shared among BH and/or HIV or primary care team members?	RTM: Role:
Who is the designated team member for coordinating the next steps (setting follow- up appointments, completing off-site therapist appointments, seeing off-site psychiatrist, arranging for transportation as needed, providing ongoing emotional support, etc.)? Does everyone on the team know whose responsibility this is?	RTM: Role:

6 Warm Off-Site Referrals

Does the client agree with the plan for off-site BH service(s)?	RTM: Role:
Does the HIV or primary care clinic take responsibility for making the off-site appointment and sharing insurance information with the client and the referral site? Whose responsibility is it to make the appointment and assure the client is prepared with what they need?	RTM: Role:
What information on BH services location, practices, and contact information and on ways to access crisis support if needed before first appointment (i.e., needs to reschedule or BH symptoms escalating out of control) is provided to the client?	RTM: Role:
What arrangements are made for support services to assist in completing scheduled appointment(s) – i.e., transportation to and from appointment; the HIV or primary care clinic patient navigator (if available) offers to escort?	RTM: Role:
If BH medications are prescribed, have the options for mail order vs. in-person pick-up of the medications been provided to the client and the BH therapist (clients may prefer to have mail ordered BH medication if needed along with their HIV-related medications)?	RTM: Role:
How will the HIV or primary care clinic team member(s), BH therapist/ team and the client stay informed of updates (e.g., BH, HIV, and other medical information release form signed by client and each organization; virtual case conferences or ECHO sessions set-up for monthly updates)?	RTM: Role:

Key Success Ingredients

- Welcoming atmosphere
- Routine behavioral health screening
- Everyone knows their roles/responsibilities
- Clear, timely documentation
- Structures in place for routinized communication among team members and with client
- Structures in place for warm hand-offs between HIV or primary care clinic teams members and to external providers



World Health Organization, 2007. The optimal mix of services. Mental health policy, planning, and service development information sheet.

The World Health Organization (WHO) developed the **Optimal Mix of Services: Pyramid Framework** as guidance about the continuum of behavioral health severity and needed support. The pyramid shows that specialist services represent the highest-cost care but are the least frequently needed. By contrast, self-care or informal community care has a high frequency of need and can be provided at a relatively low cost. For primary care, this pyramid is particularly helpful in understanding that, following screening for a behavioral health condition, clients with symptoms that do not meet screening thresholds for additional evaluation by a specialist still can benefit from being supported in self-care or connected to informal services. In many cases, providing self-care and community-based support can help to prevent worsening of symptoms and even can assist in building resilience and wellness.

Implementing Substance Use Disorder (SUD) Services in HIV Care Settings

This toolkit of linked resources was created for use by multidisciplinary healthcare team members to improve substance use disorder (SUD)-related health outcomes for people with HIV with SUD(s) in all stages of recovery. The resources have been organized into five components to assist in full implementation of interventions ranging from the use of evidence-based SUD assessments, diagnosing, harm reducing education and resources, behavioral health services, and medication-assisted treatments. Clinic-wide non-stigmatizing and supportive messaging among the entire clinic team is essential as is maintaining financial sustainability to provide for the time and efforts of team members providing these services along with other HIV-related care services. As with the HIV care continuum, each component of the SUD care continuum (prevention, screening, diagnosing, engagement, behavioral health therapy including medication-assisted treatment [MAT] when appropriate) is equally important. Check out the resources in each of the following components and feel free to use them or tailor them to best meet the needs of your patient population.

With whom should we connect?
Identify and set up relationships with any outside partners for SUD care, support, and needed services. Try to establish a seamless system of care for your clients. Share your SUD services and successes with your partners.

Is everyone on board?
Introducing a new service requires buy-in and participation from the whole team.

What do we have to offer?
Which services will you offer in-house versus partnering with an outside agency.

Who's on first?
Determine the roles for each of your team members, and what kind of training and support they will need to succeed.

How are we going to support this?
Plan and implement funding, billing, and reimbursement systems.

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https://aidsetc.org/toolkit/sud

Resources to assist with each component:

- **Is everyone on board?**
  - Mental Health/Substance Use Care Clinic/Health Center Readiness Assessment Tool
  - Words Matter: The Power of Language to Strengthen Services for HIV and Substance Use Disorder Discussion Guide
  - Interrupting Stigma: A Conceptual Map Depicting Stigma Pathways & Intervening Strategies at the Intersection of HIV and Opioid Use Disorder Toolkit
  - Are all subpopulations included in plan? (i.e., adolescents & young adults, LGBTQ+ clients, women, pregnant individuals, clients older than 50 years, all clients with SUD diagnosis even if not HIV and or HCV virally suppressed)
- **Who's on first?**
  - Clinical team member roles in the process (screening, diagnoses and treatment, harm reduction and education, follow-up)
  - The New Comprehensive Healthcare Integration Framework, National Council for Mental Wellbeing
- **How are we going to support this?**
  - Reimbursement for Medications for Addiction Treatment Toolkit
  - State Strategies in Action: Building Relationships with Your State Medicaid Agency to Support Peer Services
- **What do we have to offer?**
  - Screening
  - Motivational Interviewing
  - SBIRT
  - Harm Reduction Counseling: A Safety Manual for Injection Drug Users, Harm Reduction at SAMHSA
  - Cognitive Behavioral Therapy
  - Contingency Management
  - Tobacco Use Cessation
  - Medication-Assisted Treatment (MAT) for opiate use disorder or alcohol use disorder
  - American Society of Addiction Medicine Criteria Assessment Interview Guide
- **With whom should we connect?**
  - Emergency Department (alcohol withdraw)
  - Inpatient Care (detox) or Residential Treatment Center or MAT
  - Harm Reduction Center (SSPs, SAPs)
  - Outpatient Treatment Center
  - Mental health professional(s) for mental health therapy
  - Crisis Intervention, Suicide hotline

https://aidsetc.org/toolkit/sud

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Next Steps

- Identify what and how behavioral health care services in your clinic(s) are currently being providing (routine screening, diagnosis process for those screening positive, linkage and retention in BH care once diagnosed).
- Where are improvements needed? Are their gaps in your BH care continuum? Are all subpopulation BH needs being addressed (i.e., gay/bi/pansexual men, cisgender women, transgender individuals, adolescents/young adults, heterosexual cisgender men, etc.)?
- How can gaps be addressed?
- Use the AETC Program tools to discuss ways of improving
- Reach out to your regional AETC for capacity building assistance as needed

Thank You!

Questions? Comments?

John Nelson (nelsonj3@sn.rutgers.edu)

AETC Program National Centers and HIV Curriculum

- **National Coordinating Resource Center –** serves as the central web –based repository for AETC Program training and capacity building resources; its website includes a free virtual library with training and technical assistance materials, a program directory, and a calendar of trainings and other events. Learn more: https://aidsetc.org/
- **National Clinical Consultation Center –** provides free, peer-to-peer, expert advice for health professionals on HIV prevention, care, and treatment and related topics. Learn more: https://nccc/ucsf.edu
- **National HIV Curriculum –** provides ongoing, up –to-date HIV training and information for health professionals through a free, web –based curriculum; also provides free CME credits, CNE contact hours, CE contact hours, and maintenance of certification credits. Learn more: www.hiv.uw.edu