HMA Community Strategies

Assessment of Unmet Mental Health Needs of People Living with HIV in Los Angeles County

October 2022

Having a serious health condition, like HIV, can be a source of major stress. A diagnosis of HIV can challenge one's sense of well-being or complicates existing mental health conditions. One of the most common mental health conditions that people living with HIV (PLWH) face is depression. Depression can range from mild to severe, and the symptoms of depression can affect day-to-day life. Both HIV-related medical conditions and HIV medications can contribute to depression.

The County of Los Angeles, Department of Public Health (DPH), Division of HIV and STD Programs (DHSP) commissioned HMA Community Strategies to assess the unmet mental health needs of people living with HIV, including those who use substances, and to identify gaps and areas of improvement to support re-engagement and retention in HIV care and treatment.

County of Los Angeles Public Health

LA County HIV Ending the HIV Epidemic

HRSA Health Resources & Services Administration

HMA Community Strategies

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Executive Summary

Background

This report summarizes the results of the *Assessment of Unmet Mental Health Needs of People Living with HIV in Los Angeles County (LAC)*. Research was conducted by Health Management Associates (HMA) Community Strategies and guided by a Research Advisory Board composed of three members of the LAC Ending the HIV Epidemic (EHE) Steering Committee.

HMA Community Strategies conducted the study utilizing a mixed-methods approach. The study aimed to understand behavioral health service utilization and the role that facility staff and institutional structures play in charting the trajectory of clients. We wanted to learn more about the role providers and behavioral health system stakeholders play in the mental health of people living with HIV (PLWH). The assessment includes the breadth of experiences and perspectives represented by each facet of the delivery system to inform stakeholders and funders of the best approach for future success.

The mixed-method approach included qualitative data (stakeholder interviews) and quantitative data (a 35-question online survey for clients and a 22-question survey of agencies that provide Mental Health and/or Substance Use Disorder services, hereafter "providers"). Client survey respondents (N=29) come from 27 ZIP Codes across LAC. The client survey respondents identify across LGBTQIA+ communities, the majority identifying as people of color (73%), 23% identified as transgender women, and 38% identified as living with HIV (of which 91% indicated they are virally suppressed).

Mental health and substance use conditions, collectively referred to as 'behavioral health conditions' are among the most common health challenges both in California and nationally.

They are key drivers in creating impairment, disability, morbidity, and are associated with higher health care costs and poorer clinical outcomes. Behavioral health conditions are associated with an 8.2 year decreased life expectancy[1] and those with severe mental illness have as high as a 25-year reduced life expectancy. Reductions in life expectancy are primarily related to co-morbid medical conditions, such as cardiovascular illness, diabetes, renal disease, and other chronic conditions, many of which are associated with higher risk behaviors and all of which contribute to increased health costs, while accidents and suicide are minor contributors to this effect.[2,3]

[1] Druss et al., *Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey*. (2011) Med Care. 49(6):599–604. Available at: Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey - PubMed (nih.gov)

[2] Goodell et al. for the Robert Wood Johnson Foundation, *Mental disorders, and medical comorbidity*, (2011) Available at http://www.ibhpartners.org/wp-content/uploads/2015/12/co-occurring-disorders-Druss.pdf

[3] Colton CW, Manderscheid RW. *Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states*. (2006) available at https://pubmed.ncbi.nlm.nih.gov/16539783/

THE LACK OF INTEGRATED DATA ACROSS THE VARIOUS BEHAVIORAL HEALTH SYSTEMS IS A SIGNIFICANT BARRIER TO UNDERSTANDING BEHAVIORAL HEALTH SERVICE UTILIZATION IN LAC. This bifurcated system (Specialty, Non-Specialty, and Drug Medi-Cal/Organized Delivery System) presents a challenge in understanding the trajectory of clients as they move from one level of acuity to another and/or one type of treatment to another (e.g., from mental health treatment to substance disorder treatment). HMA sought to obtain data from Department of Health Services (DHS), Department of Mental Health (DMH), and Substance Use Prevention and Control (SAPC), and to compare that data with Medi-Cal claims data. HMA was only able to obtain deidentified data from DMH.

TREMENDOUS BIOMEDICAL ADVANCEMENTS IN HIV PREVENTION AND TREATMENT HAVE LED TO ASPIRATIONAL EFFORTS TO END THE HIV EPIDEMIC. HOWEVER, THIS GOAL WILL NOT BE ACHIEVED WITHOUT ADDRESSING THE SIGNIFICANT MENTAL HEALTH AND SUBSTANCE USE ISSUES AMONG PLWH AND PEOPLE VULNERABLE TO ACQUIRING HIV. These problems exacerbate the many social and economic barriers to accessing adequate and sustained healthcare, and are among the most challenging barriers to ending the HIV epidemic. Rates of mental health problems are higher among both people vulnerable to acquiring HIV and PLWH, compared with the general population. Mental health conditions increase risk for HIV acquisition and for negative health outcomes among PLWH at each step in the HIV care continuum. Though we have the necessary screening tools to identify efficacious treatments of mental health problems among people living with and at risk for HIV, we need to prioritize mental health treatment with appropriate resources to address the current mental health screening and treatment gaps. Integration of mental health screening and care into all

Specialty Mental Health Services

Services provided to California beneficiaries via a county mental health plan (MHP).

To enroll in an MHP, enrollees typically meet criteria of an appropriate diagnosis, have a related functional impairment, and the proposed services must be medically necessary.

California's mental health plans have historically prioritized services especially for California adults with serious mental illness (SMI) and minors with serious emotional disturbance (SED). In LAC, the Department of Mental Health (DMH) provides Specialty Mental Health Services

Non-Specialty Mental Health Services

Services provided to individuals who have been diagnosed with a mild to moderate mental health disorder that do not meet the eligibility criteria for specialty behavioral health.

For Medi-Cal beneficiaries, these services are coordinated by Medi-Cal managed care plans and Federally Qualified Health Centers

Drug Medi-Cal – Organized Delivery System

To overhaul its SUD treatment system, in 2015 California's Department of Health Care Services applied for and received the nation's first Medicaid Section 1115 waiver to implement an SUD demonstration program. This undertaking, named the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot program, means that for the first time, Medi-Cal patients needing treatment are being assessed according to nationally recognized criteria and referred for treatment according to their individual needs.

In LAC, DMC-ODS paved the way for DPH's Substance Abuse Prevention Control (SAPC) to strengthen and increase access to SUD treatment services for adolescents and adults who are Medi-Cal eligible.

HIV testing and treatment settings would not only strengthen HIV prevention and care outcomes, but it would additionally improve global access to mental healthcare.[4]

Key Findings

Below we have identified the key findings that affect the provision of mental health (MH) and substance use disorder (SUD) services to PLWH. Throughout, we have focused on issues that surfaced as part of multiple data collection methods and among more than one stakeholder group. Data sources include key stakeholder interviews, provider and consumer surveys, an environmental scan, a literature review, and LADPH and LADMH data sets.

Data Limitations

- There is a lack of integrated data across the behavioral health systems and limited access to that data prevents thorough analysis of service utilization among PLWH.
- Within the data set, for a slight majority of patients with both HIV and a behavioral health (BH) diagnosis, the sexual orientation was unknown. This sexual orientation/gender identity and expression (SOGIE) data gap makes it more difficult to tailor public health messaging and interventions.

Eligibility and Service Utilization

- With the increase of health care coverage and declines in aggregate HIV incidence, the number of individuals eligible for Ryan White has declined; fewer PLWH are eligible under current guidelines.
- Data suggest that the current system (Ryan White and Specialty) is more successful in reaching Hispanic/Latinx populations despite the prevalence of HIV being more prominent in the Black community.

Service Delivery and Coordination

- Despite desire for more integrated models of care (Collaborative Care Model and a "one-stop-shop" model), linkages between MH and primary care remain an issue for many providers.
- Most providers have difficulty ensuring PLWH can receive timely referrals to MH services, as well as difficulties referring clients to both psychiatric and SUD services.
- Many providers reported difficulty matching PLWH to a licensed clinician on their staff with whom they identify, as well as difficulty coping with rules and regulations that limit how they can staff clinical care for PLWH.
- Many mental health service clients not currently receiving MH services via telehealth indicated they would be interested in accessing telehealth services.

[4] Remien, R. H., Stirratt, M. J., Nguyen, N., Robbins, R. N., Pala, A. N., & Mellins, C. A. (2019). Mental health and HIV/AIDS: the need for an integrated response. *AIDS (London, England)*, *33*(9), 1411–1420. https://doi.org/10.1097/QAD.0000000000002227

- Clients often experience difficulties navigating the current MH system; clients lack awareness of the services available and how to navigate those services, as well as long wait times and excessive paperwork to access these services.

Service Access and Navigation

- Many clients who have not received mental health services via telehealth indicated they would be interested in starting services via telehealth.
- Clients often experience difficulties navigating the current mental health system; clients lack awareness of the services available and how to navigate those services, as well as long wait times and excessive paperwork to access these services.

Financial and Funding Barriers

- Many MH providers do not receive Ryan White funding, nor do they have a DMH contract to provide mental health services.
- Providing wrap-around services is unsustainable for most providers.
- Providers are challenged by the current billing system; the opaque nature of reimbursement poses a significant barrier for service providers.

Workforce and Staff Capacity

- Staff retention is a significant issue at both the provider and systems levels; excessive turnover and inability to recruit and retain staff is a barrier to provision of MH services to PLWH.
- Nearly all providers have difficulty assessing relevant staff training resources and/or staff training opportunities.
- There is a need for more professional development of the MH workforce, as well as reconsideration of the content and emphasis of training efforts.

Recommendations

Enhancing behavioral health services and increasing service utilization requires a multi-dimensional, collaborative approach. Providing awareness, education, navigation, and linkage to health benefits, treatment providers, housing, food security, and transportation provide important direct help and generate a positive multiplier effect on the mental health concerns of PLWH and people vulnerable to acquiring HIV. This requires a collaborative approach among community-based organizations, mental health and substance use treatment providers, federally qualified health centers, county departments (DHS, DMH, DPH, and SAPC), and academic institutions. Our recommendations below are intended to address the key barriers mentioned above, and to enhance the systems for service delivery for PLWH.

System Integration and Data

- Establish a data infrastructure that enables the extraction and analysis of client-level data across county departments to identify who and which subgroups are not receiving services.
- Develop data sharing protocols and/or platforms that would allow patient health information to be more efficiently shared between DMH, DHS and DPH to avoid delays in data request.

- Add and align sexual orientation/gender identity and expression (SOGIE) data fields to ongoing data collection and data systems (for example, DPH IRB has established policies around SOGIE data collection to align with DHS/ORCHID).
- Collect comorbid health condition data as part of the data collection to track other major life stressors of PLWH in order to provide client-centered, whole person care.

Eligibility and Service Utilization

- Revise eligibility to allow Ryan White services to individuals who are Medi-Cal eligible.
- Reduce the administrative burden on providers and clients by minimizing or streamlining intake and reporting requirements.
- Encourage and incentivize providers to hire peers, community Health Workers (CHWS) or navigators to assist with insurance and paperwork.

Service Delivery and Coordination

- Modify screening tools to enhance alignment with Trauma Informed Care and Gender Affirming Care.
- Improve cross agency referrals by using the Los Angeles Network for Enhanced Services (LANES) to have more accurate patient data and facilitate referral communication. LANES is an independent, nonprofit organization developing a health information exchange for Los Angeles County residents to enable participating physicians, healthcare facilities, hospitals, health plans, and other healthcare providers to share patient clinical information efficiently and securely.
- Design and convene forums that bring together providers to discuss and plan improvements (e.g., how to strengthen implementation of "No Wrong Door").
- Develop a resource guide that provides detailed information on providers' services, capacity, and specialty services to enhance cross-agencies referrals.

Finance and Funding

- Develop and offer training to providers intended to clarify and standardize reimbursement policies, including guidance on CPT codes, rates, and proper documentation.
- Advocate for subsidizing BH services for individuals who are above the RW eligibility threshold but do not have other sources as payment of last resort.

Workforce and Staff Capacity

- Leverage the current efforts of the Zeroing In: Ending the HIV Epidemic consortium and other EHE capacity building organizations to provide better quality, relevant workforce training opportunities that prioritize the following:
    - Models of collaborative, holistic care
    - Co-occurring disorders; the intersection of HIV and SUD
    - SMI/high acuity mental health conditions
    - Advanced trauma-informed care and practices
    - Innovations in telehealth
    - Resources to improve workforce retention
- Coordinate training offerings among DHSP, DMH, SAPC, and the clinical provider organizations.
- Explore whether Licensed Marriage and Family Therapists (LMFTs) could be cross-credentialed to provide services now restricted to Licensed Clinical Social Workers (LCSWs).
- Collect data on the diversity and lived experience of staff working with PLWH.
- Expand Spanish-language providers.

Assessment

Methodology

HMA Community Strategies employed a mixed-methods research approach. This study draws on multiple sources of information including a literature review, landscape analysis, interviews with key stakeholders, providers, and systems personnel, provider and client surveys, as well as data provided by the LAC Department of Mental Health (DMH) and the LAC Department of Public Health (DPH).

HMA's research questions covered three distinct levels of inquiry, seeking to identify key needs and barriers in each of the following:

Level	Primary Focus	Key Research Questions	Data Source
Systems	Identification of cross-cutting issues affecting coordination and continuous improvement	How do we create a successful system of care? How can we best work across sectors to effectively address mental health needs?	Interviews, focus groups, surveys
Provider	Provider ability, capacity, and needs	Where are the gaps in linking people to care and providing follow up? What are the workforce and training needs of providers to treat the MH needs of PLWH?	Interviews, focus groups, surveys, DMH data
Client or Consumer	Current and historical barriers to care and needs of special populations	What are the main reasons clients are not accessing services or not linking to referrals? What are the differentiated needs for people of color, those with SUD, trauma history, etc.?	Interviews, focus groups, surveys, DMH data

Literature Review

HMA Community Strategies completed an analysis of professional and grey literature, including an analysis of local and state pilot projects like the California Reducing Disparities Project (CRDP). The aim of the review was to define best practices for: a) engaging people living with HIV who are not receiving care in mental health (MH) services; b) care for at-risk or underserved populations (i.e., people of color, transgender folks, cisgender women, people who inject drugs, etc.); and c) structuring public MH programs. The review (see Appendix to this report) includes a summary of individual and systems-level barriers to receiving MH and substance use disorder (SUD) treatment services for PLWH, innovative approaches and models of care for PLWH, and effective therapeutic interventions for PLWH. The analysis prioritizes approaches and interventions that consider diverse identities, cultural backgrounds, trauma history and social or structural barriers to care.

Key Stakeholder Interviews

HMA Community Strategies conducted interviews virtually through Zoom with administrative staff and providers, representing 15 different community-based organizations (CBOs) that provide MH services, SUD treatment or both to PLWH in LAC.

The providers that participated included:

- AIDS Healthcare Foundation
- AltaMed
- APLA Health
- Being Alive
- Bienestar
- Black AIDS Institute
- East Valley Community Health Center
- Homeless Healthcare Los Angeles
- JWCH/Wesley Health Centers
- Los Angeles LGBT Center
- Northeast Valley Healthcare Corporation (NEVHC)
- Social Model Recovery Systems
- St. John's Well Child and Family Center
- Tarzana Treatment Centers, and
- Venice Family Clinic

Additionally, HMA Community Strategies interviewed representatives from the LAC DMH, LAC Commission on HIV, LAC Board of Supervisors, the Substance Abuse Prevention and Control Division (SAPC) and the Division of HIV and STD Programs (DHSP) of LAC DPH. These interviews provided a systems-level perspective of MH services for PLWH in LAC. Two interviews were conducted virtually through Zoom with individuals living with HIV to provide their first-hand experience navigating and receiving MH services in LAC.

Interview guides were developed separately for clients, providers, and staff from systems-level agencies to learn more about the strengths of the MH and SUD treatment ecosystem, barriers to receiving or providing care, and suggested tools and resources that could improve the quality of care. A content analysis was conducted of the interviews by coding responses manually in NVivo, looking for word and phrase repetitions, primary and secondary data comparisons, and missing information. NVivo is a software program that helps researchers discover more from qualitative and mixed methods data. Noteworthy quotations from transcripts were used to highlight major themes within the findings. The findings from the interviews are used to enhance findings from the provider and client survey, capturing a diverse range of providers, clients, and colleagues familiar with MH and SUD treatment services for PLWH in LAC.

Provider and Consumer Surveys

The consumer survey aimed to identify consumer-level barriers that restrict or prevent access to mental health or SUD treatment services for PLWH, as well as barriers to ongoing, quality MH and SUD services to PLWH. The survey consisted of a mix of multiple choice, open response, and matrix questions and included questions around their demographic background, experiences receiving mental health services, barriers to receiving care and needs related to their mental health. The survey included branching logic so that individuals who indicated they were not living with HIV would be ineligible to respond, thus gathering responses exclusively from PLWH.

The provider survey aimed to identify the provider-level barriers that restrict or prevent access to MH and SUD services for PLWH, as well as barriers to ongoing, quality MH and SUD services to PLWH. Like the consumer survey, the provider survey consisted of a mix of multiple choice, open response, and matrix questions. Providers were asked questions regarding the organization they represent, barriers and challenges to providing MH services to PLWH, and desired supports, training, or continued education to improve quality of care for PLWH.

The provider and consumer surveys were both distributed by the DHSP including distribution to the participants at the Coping with Hope Conference, as well as members of the Los Angeles County Commission on HIV, Connect to Protect Coalition Los Angeles (C2PLA), and to DHSP's listserv. Additionally, promotional flyers with a link and scannable QR code were distributed to encourage survey participation during a window from July 1 to July 31, 2022. The survey results were analyzed through Qualtrics and manually calculated, when necessary, in Excel. Analytics included descriptive statistics of responses. Questions with open-ended responses were analyzed to identify key themes across the responses. Thirty-five providers and twenty-nine consumers responded to the respective survey, though not every respondent answered each question, including the demographic questions. The consumer survey was translated into Spanish and six of the twenty-nine consumers completed the survey in Spanish.

Data

Department of Public Health

HMA Community Strategies obtained 2020 HIV Surveillance Annual Report and 2018 Sexually Transmitted Disease Tables from the DHSP website. This information was reformatted into excel tables. HMA then produced the graphs used in this assessment.

Department of Mental Health

HMA Community Strategies received a de-identified data from the DMH containing summarized tables of counts and percentages of patients living with HIV who have certain ICD-10 diagnoses and CPT codes tabulated by year (2019-2021), as well as descriptive information of the demographics of those patients living with HIV who have certain ICD-10 diagnoses and CPT codes.

DATA LIMITATION: It was HMA's goal to determine service utilization of mental health services by comparing data sets from DMH and DHS. The objective was to better understand service utilization of mental health services by PLWH. However, the county's inability to provide an integrated data set is a limitation of this assessment. Of key importance, there is a lack of integrated data systems across county providers – siloed data systems that cannot speak to each other which complicate the coordination of services across the county. HMA had difficulty obtaining data from various county departments and was ultimately unable to receive matched data that tied together datasets from both the DMH and the DHS. Moreover, there is a lack of identification of individuals who are living with HIV within the DMH dataset which also limited the ability to address key areas of inquiry envisioned by this assessment.

Environmental Scan

LAC has the largest population (~10,000,000) of any county in the nation, which is larger than 43 States, ranking ninth behind California, Texas, New York, Florida, Illinois, Pennsylvania, Ohio, and Georgia. Geographically, LAC poses unique challenges to providing services to all its residents, encompassing approximately 4,000 square miles with beaches, mountains, forests, and deserts. LAC is divided into eight Service Planning Areas (SPA) and each SPA varies in size, population density, socio-economic status, health status, and other demographic characteristics.

As of 2021, DHSP estimates that there were 53,330 people living with diagnosed HIV (PLWDH) in LAC. The majority of these persons are male (87%), a smaller fraction are female (11%) and a smaller number (but highly disproportionate compared to their share of the LAC population) are transgender men or women. The group with the plurality of PLWH are Latinx cisgender men who have sex with men (~40%), followed by White cisgender men who have sex with men (~24%), followed by Black/African-American cisgender men who have sex with men (~17%). The balance of males with HIV are injection drug users of multiple racial/ethnic groups as well as cisgender American Indian/Alaskan Native, Asian or Pacific Islander men who have sex with men.

In LAC, the majority (90%) of PLWDH who are in care are treating their infection with highly active antiretroviral therapy (ART) and effectively managing HIV as evidenced by their achievement of sustained viral suppression – a level of HIV in the bloodstream that is so low that it is undetectable. However, when accounting for all PLWH in LAC, (those in care and those out of care) only about 60% of PLWH are virally suppressed. While some PLWH can achieve viral suppression through the routine and consistent access to their health care delivery system, many other PLWH depend on access to a broader menu of medical and support services to achieve viral suppression. These services include but are not limited to medical care coordination services that improve health system navigation, housing supports, mental health, oral health, food and nutrition services, substance use treatment, and transportation services.

Overall, there are an estimated 59,400 PLWH in LAC. This represents nearly 1,400 new HIV infections each year and ~6,800 undiagnosed people living with HIV. At the end of 2021, ~0.6% of LAC residents were living with HIV. The group with the plurality of PLWH are Latinx cisgender men who have sex with men (~40%), followed by White cisgender men who have sex with men (26%), followed by Black/African-American cisgender men who have sex with men (23%). A smaller percentage of males with HIV are injection drug users of multiple racial/ethnic groups as well as cisgender American Indian/Alaskan Native, Asian or Pacific Islander men who have sex with men.

In 2011, in keeping with National efforts to better integrate HIV and STD public health efforts, the Department of Public Health combined the legacy HIV Epidemiology Program, the Office of AIDS Programs and Policy, and the Sexually Transmitted Disease Program to form the Division of HIV and STD Programs. DHSP continues to work closely and collaboratively with community-based organizations, other governmental offices, advocates, and people living with HIV/AIDS as it seeks to control the spread of HIV and sexually transmitted diseases, monitor HIV/AIDS and STD morbidity and mortality, increase access to care for those in need, and eliminate HIV-related health inequalities.

In January 2021, DHSP released of the ***Ending the HIV Epidemic Plan for LAC***. The EHE Plan focuses on four key pillars designed to help us reach the goal of reducing new HIV transmissions and acquisitions in the United States by 75 percent in five years (by 2025) and by 90 percent in ten years (by 2030.)

The four EHE Pillars are:

DHSP administers and oversees the Ryan White Care Act funding for LAC. The Ryan White HIV/AIDS Program provides Federal funds which are used to develop systems of care and pay for medical and support services for people living with HIV and their families (~$23,000,000 in Part A funding for LAC).

Medical and support services include:

- Ambulatory medical outpatient (AOM)
- Benefits specialty
- Medical care coordination (MCC)
- Mental health and neuropsychological testing
- Oral healthcare
- Medical subspecialty
- Residential care facility and services
- Housing services and assistance
- Language services
- Home-based case management
- Transitional case management
- Nutrition support and foodbank
- Legal services
- Substance abuse treatment and transitional housing
- Medical transportation
- Information and referrals

DHSP funds 65 Direct Service Organizations and Community-based Organizations throughout LAC. There are 11 agencies that receive mental health funding which include:

- AIDS Healthcare Foundation (AHF)
- AltaMed Health Services
- JWCH Institute
- Department of Mental Health Services
- LAC+USC Maternal Child & Adolescent Program
- LAC+USC Medical Center
- Northeast Valley Health Corporation
- Special Services for Groups

- St. John's Well Child and Family Center
- Tarzana Treatment Center
- Venice Family Clinic

The LAC Commission on HIV (CoH) serves as the local planning council for the planning, allocation, coordination, and delivery of HIV/AIDS services. The CoH is composed of 51 members appointed by the Board of Supervisors and represent a broad and diverse group of providers, consumers, and stakeholders. 33% of the membership are PLWH who are consumers of the federally funded Ryan White HIV/AIDS Program.

Separately from this assessment, in June 2021, DHSP held a virtual town hall entitled ***The Role of Mental Health Providers to End the HIV Epidemic and Achieve Health Equity***. Approximately 272 individuals attended (attendance varied throughout the presentation). There were several themes of note:

- MH services are often difficult to find and access – necessary information is either not available or challenging to access.
- A great deal of stigma and misinformation about MH services thwarts people from seeking services.
- Many of the clients presenting for services are both traumatized and stigmatized.
- Providers expressed hope for an integrated care system which streamlines linkage to care between providers.
- Ideally, Medical Care Coordination (MCC) could be restructured into a service that would be more responsive to clients' needs.

Several of these themes also surfaced in HMA's findings as noted below.

Key Themes from Stakeholder Interviews

N = 21

System Strengths and Areas of Improvement

Those interviewed offered several key areas where there have been improvements to the capacity of the system designed to serve PLWH including:

- Increased social marketing to de-stigmatize MH and HIV
- Greater acceptance of cultural competence and trauma informed care
- More availability of bilingual (English-Spanish) staff in some parts of LAC
- More staff with lived experience and/or backgrounds like the population of PLWH
- More providers offering integrated care in "one stop" settings that bring together physical health, behavioral health, and SDOH (transportation, food, housing, etc.)
- Improved screening practices and protocols
- Increased access to care via the flexibility allowable under telehealth to deliver services

Although more can be done in these areas, it is important to recognize progress and share the strengths of the system of care for PLWH. In the section below, we focus more directly on the barriers that exist at the system, provider, and client-levels, presenting key findings by topic or issue area.

System Level Barriers

The barriers identified at a systems level provide insight into the challenges of the workforce, care coordination, regulation, and funding of behavioral health services in LAC.

Workforce and Capacity Barriers

Ensuring client access to a qualified, licensed workforce capable of meeting the demand for MH and SUD services among PLWH was a key barrier frequently reported by those interviewed. Respondents elaborated that excessive employee turnover had preceded but was exacerbated by the COVID-19 pandemic. The larger issue hinged on the lack of a sufficient pipeline of qualified professionals, particularly those with experience working with PLWH. Many of those interviewed suggested a need for investing in hiring and retaining credentialed professionals committed and competent in this field.

Another theme centered on the need for more and enhanced professional development and training of the existing workforce serving PLWH. Many of those interviewed indicated a need for more relevant, engaging, and actionable training. In addition, inconsistent access to training was seen as a barrier. Interviewees cited wide variation in professional development policies across provider organizations who are responsible for ensuring ongoing professional development of employees.

Communication and Coordination Barriers

Significant barriers exist to communication and coordination of different County departments and providers. County departments are siloed, and services are poorly integrated. Based on input from interviewees, high acuity clients with chronic conditions are most likely to "fall through the cracks" due to difficulties in navigating across multiple County agencies and competing regulations.

In addition, data sharing is infrequent and/or inadequate to the task. For example, electronic medical record (EMR) systems frequently are unable to communicate with one another. SOGIE data is often not collected and captured within EMR systems. Privacy/security issues tend to outweigh the efficacy of coordinating care and reforming delivery systems. For example, federal policy designed to protect anonymity of those seeking SUD treatment overrides efforts to link MH and SUD care despite the large number of individuals with co-occurring disorders.

Policy and Regulatory Barriers

Excessive administrative compliance and reporting requirements were frequently reported as a system-wide barrier. The documentation required by the County MH system was most frequently cited as the most burdensome, leading some providers to forgo DMH contracts. In addition, interviewees viewed restrictions on eligibility for Ryan White services as a primary reason for under-utilization of services. In particular, there is a perception that some PLWH are "falling through the cracks" based on income and insurance requirements.

Financial and Funding Barriers

Interviewees identified low reimbursement rates as a factor impacting the system's ability to provide quality services. Moreover, there is a lack of clarity about reimbursement policies and a strong suspicion that methods for obtaining reimbursement vary widely across providers.

Another key barrier centers on the "carve out" provision for specialty MH services which are operated by LAC DMH. This creates a fractured system (see below) which is difficult to navigate.

- Specialty mental health services are provided to California beneficiaries via a county mental health plan (MHP). To enroll in an MHP, enrollees typically meet criteria of an appropriate diagnosis, have a related functional impairment, and the proposed services must be medically necessary. California's MHPs have historically prioritized services for California adults with serious mental illness (SMI) and minors with serious emotional disturbance (SED).
- Non-specialty services (mild to moderate) are provided to individuals who have been diagnosed with a mental health disorder that do not meet the eligibility criteria for specialty behavioral health. For Medi-Cal beneficiaries, these services are coordinated by Medi-Cal managed care plans like LA Care.
- For those who are uninsured, Ryan White MH services is the payor of last resort, however income levels determine eligibility.

Lastly, those interviewed identified several key areas where there is a need for additional funding including SUD services, inpatient MH services, psychiatric services, and medication management.

Provider Level Barriers

The barriers identified at a provider level offer insight into the challenges contractors face around workforce, regulation, and the linkage and care coordination of behavioral health services in LAC.

Workforce and Capacity Barriers

Providers agree on the difficulties posed by excessive staff turnover and need to focus on staff retention. Many providers would like to increase staff compensation, but the contractual nature of funding means providers find it difficult to adjust employee pay. Budget constraints, in turn, often lead to reliance on junior, inexperienced staff who require more oversight and supervision.

According to those interviewed, the staff positions identified as especially difficult to recruit/retain included: 1) Community Health Workers; 2) SUD Counselors (especially those who are bilingual); and 3) Benefits Coordinators. Several providers also cited positions that they wished they could fund including full-time therapists and navigators to assist clients with wraparound services and SDOH.

Providers were also clear about the need for more quality training and training that is directly relevant to workforce needs. Key areas mentioned repeatedly included training on Advanced Trauma care, Dialectical Behavioral Therapy (DBT), and Seeking Safety. Several providers noted that sexuality and substance use are often poorly covered in MH training. Providers also remarked that the process for getting training approved by DHSP may be a barrier as well.

Policy and Regulatory Barriers

Providers identified multiple areas of current policy and regulatory factors that impact service delivery. Many suggested that changes may be needed to Ryan White eligibility criteria. As this population of potential clients shrinks (i.e., uninsured and low income PLWH), they would like to be able to expand eligibility for Ryan White type services.

Many providers suggested that changes may be needed to Ryan White eligibility

In another vein, providers noted that the amount of paperwork and documentation required at client intake functions as a disincentive for both potential clients and clinicians. In addition, ongoing

documentation requirements do not seem to work well with providers using a FQHC structure. As a result, some providers have opted to forgo MH services, while others are contemplated discontinuing these services. Some providers were also reluctant to treat SUD due to contractual billing limitations and siloed models of care.

Like their system-level counterparts, providers noted the poor quality and inconsistent systems for EMR and data sharing in LAC. They also echoed sentiments about the lack of transparency within the current system for insurance reimbursement. For many providers, the current system is opaque, with no clear workarounds or guidelines for how to flexibly respond.

Service Linkage and Coordination Barriers

Among providers, there is widespread desire for greater linkages and cross-agency referrals. Many of those interviewed said that they experienced difficulties in identifying peer partners/agencies to whom they can confidently refer clients for quality care. The need for strengthened linkages was especially pronounced for SUD and specialty MH services. Another gap identified by providers was psychiatric services, especially bilingual (English-Spanish) psychiatrists.

Providers want to be able to provide a "warm hand-off" when referring clients externally. To do this, they would like access to more information about the cultural competence and trauma-informed capacity of peer agencies.

Another key barrier centered on linkages to primary care. Providers reported ongoing issues with lack of MH awareness among primary care physicians, manifest as not referring to or recognizing need for MH referral and/or reluctance to prescribe medication for MH. More generally, providers were interested in moving toward collaborative care models that integrate services (HIV/MH/PCP/SUD) unless already involved in a FQHC or a similar model of integrated care.

Client Level Barriers

The barriers identified by consumers provide insight to the challenges of contextual and attitudinal experiences, workforce, and access of behavioral health services in LAC.

Environmental and Contextual Barriers

Clients experience real life challenges and have undiagnosed trauma that poses significant barriers to accessing and receiving care. According to those interviewed, these individuals in active addiction and SUD are often unable or unwilling to access consistent care and treatment. In addition, many are struggling with lack of reliable transportation, food, and housing insecurity, unstable or infrequent connectivity via phone and internet, etc. Participants also may need more flexible hours of operation and service (because many have multiple jobs that do not offer flexibility). Those with undocumented status have additional barriers in terms of accessing wraparound services and benefits other than physical/mental health.

Attitudinal Barriers

Stigma surrounding MH is a clear barrier for many clients. MH stigma is manifest as internalized shame and/or reluctance to accept MH services. According to those interviewed, it is especially pronounced among Latino, Asian, Undocumented, and Trans populations. In addition, many potential clients have a deep-seated mistrust of the health care system based on prior experiences with county agencies, as well as negative perceptions of court-ordered treatment.

Access and Service Delivery Barriers

Clients often experience difficulties navigating the system of care and require substantial assistance. Intake paperwork tends to be overwhelming and off-putting. Eligibility requirements can be confusing. Timely access to services can be a challenge. Clients often desire care from a person who closely resembles themselves. They would like staff to understand their background, experience, and/or same gender identification. For clients who are often in crisis, these kinds of barriers diminish participant willingness and enthusiasm for treatment and care.

Client Experiences

There is a lack of compassion by medical staff. They need to treat people as a person and not a number. It's also challenging to find substance use disorder treatment services. People feel totally lost.

- Latino gay male living with HIV since 2003

Sometimes the world feels like it's not suited for me. There seems to be no empathy for straight HIV+ women. Providers are not asking if you need counseling services. They need motivational interviewing skills – to really understand me.

- White straight woman living with HIV since 2013

Key Themes from Surveys

Provider Survey

N = 35

Characteristics of Provider Organizations

Of the 35 organizations represented in the responses collected, 54% reported focusing on providing mental health services for PLWH, 35% reported focusing on both mental health and SUD services for PLWH and 11% report focusing solely on SUD treatment for PLWH.

Most respondents (71%) noted that their organization has 12 or less staff members providing services specifically for PLWH, and 52% of respondents represent federally qualified health centers or community-based organizations. Over half (61%) of respondents represent organizations that provide services in the service planning areas (SPAs) 4, 6, and 8, which present the Metro LA region, South Los Angeles, and the South Bay,

Roughly a third (27%) of respondents noted that their agency does not receive Ryan White funding and 12% noted that they did not know whether their agency receives Ryan White funding or not. Under half (40%) of respondents indicated that they are not contracted with DMH to provide mental health services and 25% of respondents did not know if they were contracted with DMH.

respectively. About half (49%) of respondents indicated that translation services are available in Spanish for MH services at their organization.

MH/SUD Screening and Intake for PLWH

Most commonly respondents agreed or strongly agreed that their organization is experiencing challenges related to screening and intake in the following areas (Table 1):

- **Providing services to PLWH at their organization not covered by Ryan White Funding (65%);**
- **Obtaining MH referrals from Primary Care and other physical health care practices (60%);**
- **Obtaining referrals from other community-based organizations (CBOs) (52%); and**
- **Obtaining referrals from Administrative Services Only (ASOs) Insurance Benefits (47%).**

A common theme among both the survey respondents and the key stakeholder interviews is the barrier of client eligibility for Ryan White services – thus making it difficult to refer. When asked how to improve the screening and intake process for PLWH at their organization, respondents suggested reducing the administrative burden and paperwork required to complete the referral process. Respondents suggested hiring more staff members and expanding their capacity to better meet the demand of PLWH seeking MH services. Respondents also suggested offering mobile services or conducting street outreach to screen and complete intakes in the community and meeting clients where they are. One respondent noted that there is a need for more inpatient and residential facilities to refer clients to, as well as greater awareness and information among providers so they are prepared to properly refer clients.

Table 1. Provider Strengths and Challenges Related to Screening and Intake

Please indicate the extent to which you agree with the following statements about screening and intake. Our agency/organization experiences challenges in...	"Disagree" or "Strongly Disagree"	"Agree" or "Strongly Agree"
Providing services to the population of PLWH not covered by Ryan White.	25%	65%
Obtaining mental health referrals from Primary Care and other physical health care practices.	30%	60%
Obtaining referrals from other community-based organizations (CBOs).	24%	52%
Conducting intake with clients living with HIV with active addiction/SUD.	40%	50%
Obtaining referrals from Administrative Services Only (ASOs) Insurance Benefits.	26%	47%
Completing the required intake and screening paperwork and forms to initiate services for PLWH.	43%	38%
Using existing tools to identify and diagnose the MH/SUD needs of PLWH.	48%	33%
Ensuring that screening and identification procedures are consistently applied with PLWH.	43%	52%

Quality of MH/SUD Services Delivery for PLWH

When asked what challenges they are experiencing related to the quality of services for PLWH, respondents were somewhat split across all categories listed. **Most commonly, respondents agreed or strongly agreed that their organization experiences challenges with providing integrated and/or collaborative models of care with other providers for PLWH (47%) and developing treatment plans that meet the individuals needs of PLWH (47%).**

When asked how to improve the quality of MH and SUD service delivery for PLWH at their organization, respondents suggested offering flexible hours of operation (i.e., offering services at night and during the weekend) as well as offer mobile services that meet people where they are in the community. Respondents also suggested having dedicated staff that serve PLWH and hiring staff with lived experience such as PLWH, people who use drugs (PWUD) or who are in recovery, sex workers, and people who have experienced homelessness. Respondents reported that more staff training in different treatment modalities (e.g., Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing, DBT) and different models of care (such as trauma informed care and whole person care) would improve the quality of care for PLWH. One respondent suggested hiring peer staff and having a peer support program to improve retention in care and the overall quality of care.

Table 2. Provider Strengths and Challenges Related to Quality of Care and Service Delivery

Please indicate the extent to which you agree about the following statements about quality service delivery. Our agency/organization experiences challenges in...	"Disagree" or "Strongly Disagree"	"Agree" or "Strongly Agree"
Providing integrated and/or collaborative models of care with other providers for PLWH.	37%	47%
Retaining clients living with HIV in care/treatment long enough to see significant progress.	33%	39%
Providing personalized, whole-person care to PLWH.	53%	42%
Ensuring that clients living with HIV receive trauma-informed care.	40%	30%
Developing treatment plans that meet the individuals needs of PLWH.	53%	47%
Providing care that is culturally competent to clients' race/ethnicity, sexual orientation, and/or gender identity.	65%	30%

MH/SUD Service Linkages and Referrals for PLWH

When asked what challenges they experience related to MH and SUD service linkages and referrals for PLWH, respondents indicated they agreed or strongly agreed that there were challenges in all categories listed in Table 3 below. **The most common challenges indicated by respondents were difficulty ensuring PLWH can receive timely referrals to MH services (80%), being able to successfully refer PLWH to psychiatric services (80%) and trouble identifying high quality providers to whom we can refer PLWH for SUD services (80%).**

When asked how to improve MH and SUD service linkages and referrals from their organization, respondents suggested more opportunities for providers to network, collaborate, and build relationships with one another to facilitate warm hand offs and improve communication. Additionally, respondents noted that hiring more MH staff and case managers at their agency would allow them to avoid referring out to begin with. One respondent noted that providers should use the Los Angeles Network for Enhanced Services (LANES) to have more accurate patient data and facilitate referral communication.

Table 3. Provider Strengths and Challenges Related to Linkage to Care and External Referrals

Please indicate the extent to which you agree with the following statements about service linkages and referrals. Our agency/organization experiences challenges in...	"Disagree" or "Strongly Disagree"	"Agree" or "Strongly Agree"
Identifying high quality providers to whom we can refer PLWH for MH services.	25%	70%
Ensuring PLWH receive timely referrals to MH services.	20%	80%
Referring PLWH to specialty MH services.	20%	75%
Referring PLWH to psychiatric services.	20%	80%
Ensuring PLWH receive timely referrals to SUD services.	15%	75%
Identifying culturally competent providers to whom we can refer PLWH for MH services.	25%	65%
Following up to ensure that referred PLWH receive care after a referral has been made.	20%	70%
Identifying high quality providers to whom we can refer PLWH for SUD services.	10%	80%
Identifying culturally competent providers to whom we can refer PLWH for SUD services.	15%	70%

Staffing and Workforce Aspects of MH/SUD Service Delivery for PLWH

When asked what challenges they are experiencing related to MH and SUD staff and workforce for PLWH, respondents indicated they agreed or strongly agreed that there were challenges in all categories listed. **The most common challenges indicated by respondents were difficulty matching clients living with HIV to a licensed clinician with whom they identify (90%), difficulty coping with rules and regulations that limit how they can staff clinical care for PLWH (84%) and difficulty assessing relevant staff training resources and/or staff training opportunities (75%).**

When asked how to improve staff and workforce capacity for MH services and SUD services for PLWH at their organization, respondents suggested providing more opportunities for professional growth and increase salary to better retain staff. One respondent noted that increased funding for staff to be trained on the intersection of HIV and MH and/or SUD. Another respondent noted that hiring more staff

with lived experience or hiring peer support staff can both help meet the need by increasing capacity, as well as provide greater competency and higher quality care for PLWH.

Table 4. Provider Strengths and Challenges Related to Workforce

Please indicate the extent to which you agree with the following statements about staffing and workforce. Our agency/organization experiences challenges in...	"Disagree" or "Strongly Disagree"	"Agree" or "Strongly Agree"
Hiring qualified clinical staff to meet the MH needs of PLWH.	11%	74%
Retaining quality qualified clinical staff to meet the MH needs of PLWH.	11%	74%
Coping with rules and regulations that limit how we can staff clinical care for PLWH.	5%	84%
Matching PLWH clients to a licensed clinician with whom they identify.	0%	90%
Providing adequate supervision and oversight of more junior staff and interns involved in MH/SUD services for PLWH.	16%	58%
Assessing relevant staff training resources and/or staff training opportunities.	5%	75%
Retaining quality clinical staff to meet the SUD needs of PLWH.	10%	70%
Involving staff and interns involved in MH/SUD services for PLWH.	5%	50%
Hiring qualified clinical staff to meet the SUD needs of PLWH.	10%	65%

Reporting and Compliance Aspects of MH/SUD Service Delivery for PLWH

When asked what challenges they experience related to reporting and compliance for MH and SUD services for PLWH, respondents agreed or strongly agreed that there were challenges in all categories listed. **The most common challenges indicated by respondents were obtaining and/or sharing data with or from other service providers (74%), providing staff with guidance on how to navigate billing and reimbursement systems for PLWH (68%), and obtaining reimbursement for MH services with PLWH due to siloed models of care (67%).**

When asked how to improve reporting and compliance processes, one respondent suggested creating a platform that would allow patient health information to be more efficiently shared between DMH, DHS and DPH to avoid delays in data requests. Another respondent suggested streamlining the reporting process by reducing the number of requirements and reducing the required documentation.

Table 5. Provider Strengths and Challenges Related to Reporting and Compliance

Please indicate the extent to which you agree with the following statements about reporting and compliance. Our agency/organization experiences challenges in...	"Disagree" or "Strongly Disagree"	"Agree" or "Strongly Agree"
Providing MH services to PLWH due to contractual billing limitations.	17%	61%
Obtaining reimbursement for MH services with PLWH due to siloed models of care.	6%	67%
Obtaining and/or sharing data with or from other service providers.	5%	74%
Obtaining and/or sharing data with or from the Department of Mental Health (DMH)	17%	50%
Providing staff with guidance on how to navigate billing and reimbursement systems for PLWH.	5%	68%
Obtaining and/or sharing data with or from the Department of Health Services (DHS).	11%	61%
Meeting deadlines for compliance reporting tied to MH service delivery for PLWH clients.	11%	50%
Obtaining and/or sharing data with or from Substance Abuse Prevention and Control (SAPC).	5%	63%
Obtaining reimbursement for SUD services with PLWH due to siloed models of care.	11%	50%
Providing SUD services to PLWH due to contractual billing limitations.	11%	50%
Obtaining and/or sharing data with or from the Department of Public Health (DPH)	17%	61%
Meeting deadlines for compliances reporting tied to SUD services for PLWH clients.	17%	50%

Barriers to Care

The three most identified barriers to providing MH and SUD services for PLWH is a **lack of referral partners for services not offered by our organization (22%), inadequate staff/workforce to meet the need for services (21%) and a lack of facilities or space to provide services (17%)**.

Table 6. Barriers to Care for Respondents

Barrier	Percentage of Respondents (%)
Lack of referral partners for services not offered by our organization.	22%
Inadequate staff/workforce to meet the need for services.	21%

Lack of facilities or space to provide services.	17%
Insurance coverage/eligibility concerns.	13%
Inadequate training and professional development for staff.	10%
Compliance and reporting requirements.	6%
Lack of reimbursement/inadequate reimbursement for services.	3%
Lack of cultural competency when communicating with clients who are using or injecting drugs.	3%
Lack of cultural competency when communicating with clients who are LGBTQ+.	2%

Provider Supports, Training and Continued Education

When asked what supports and resources they would like, respondents agreed or strongly agreed that they were interested in all the supports listed. **Respondents tended to express interest in resources on availability of wraparound services for PLWH (90%), access to data on all services utilized of PLWH (85%), and forums and networking that bring together other providers to discuss plan improvements (85%).** Additionally, respondents noted that they would like more resources for housing and housing supports for their clients, as well as training to provide culturally competent care and services.

Table 7. Desired Resources and Supports Among Respondents

Please indicate the extent to which you agree with the following statements about your desires for support. Our agency/organization would benefit from the provision of...	"Disagree" or "Strongly Disagree"	"Agree" or "Strongly Agree"
Resources on availability of wraparound services for PLWH.	0%	90%
Forums and networking that bring together other providers to discuss plan improvements.	5%	85%
Access to data on service utilization of PLWH.	5%	85%
Resources on workforce retention.	10%	75%
Information about best and/or evidence-based practices.	15%	75%
Models of integrated and/or collaborative care.	5%	75%

Regarding training and continuing education, respondents indicated that they or their organization could benefit from training in all the categories listed. The most selected areas respondents agreed they could benefit in learning more about were **co-occurring disorders (90%), high acuity mental health conditions (85%) and advanced trauma-informed care and practices (85%).** Regarding specific training

topics, respondents indicated that they would like to participate in training related to de-escalation techniques, psychodynamic treatments, trauma informed care practices and harm reduction models of care.

Table 8. Desired Training Topics Among Respondents

Please indicate the extent to which you agree with the following statements about your desires for training and continuing education. Our agency/organization would benefit from training and professional development focused on...	"Disagree" or "Strongly Disagree"	"Agree" or "Strongly Agree"
Innovations in telehealth.	15%	65%
Serving the LGBTQ+ population	5%	74%
Serving the transgender population, specifically.	5%	80%
Different treatment modalities.	5%	80%
Advanced Trauma-Informed care and practices.	5%	85%
Navigation of financial and reimbursement systems.	5%	60%
High acuity SUD.	5%	80%
Serving people living with HIV.	15%	65%
High acuity MH conditions.	5%	85%
Co-occurring disorders.	5%	90%
Serving the formerly incarcerated or justice-involved population.	0%	80%

Client Survey

N = 29

Respondent Demographics

Responses were collected from 29 consumers of MH or SUD services in LAC, with most respondents between the ages of 35 and 64 (72%). **Most (73%) respondents identify as people of color** -- 40% of respondents identified as Hispanic or Latinx, 24% of respondents as Black or African American and 9% as Asian American -- and 18% of respondents identified as White. Just over half of respondents (55%) identified as heterosexual or straight, 31% identified as gay, 7% identified as pansexual and 4% identified as asexual. Many respondents identified as cisgender (65%) and **21% of respondents identified as transgender women**. More than a third (38%) of respondents indicated that they are living with HIV or AIDS, 91% of which reported that they are virally suppressed or undetectable.

Mental Health Acuity

More than half (55%) of respondents indicated their MH was fair or poor, and 45% of respondents indicated their MH was good, very good or excellent. During the past year, 14% of respondents said they

had experienced depression, 13% of respondents reported they had difficulty sleeping or experienced insomnia, and 13% of respondents indicated they had anxiety. Additionally, 6% of respondents noted they had experienced post-traumatic stress and 6% of respondents noted they had engaged in regular and harmful use of drugs and/or alcohol. A majority (73%) of respondents said that the COVID-19 pandemic has had a negative impact on their MH and wellbeing and 34% of respondents noted that their HIV status had has a negative impact on their MH and wellbeing.

Service Utilization

Roughly a third (36%) of respondents indicated that when they have negative thoughts or feelings, they ask for help from friends or family, and 42% of respondents reported asking for help from a health care provider. Moreover, respondents noted that they cope with negative thoughts or feelings by sharing with friends, self-medicating with drugs or alcohol, distracting themselves with work or hobbies and exercising. Unfortunately, 13% of respondents indicated they did not ask for help from anyone when they had negative thoughts or feelings.

Nearly all (91%) of respondents reported having ever gotten help from a MH professional. Most (55%) received individual or group therapy and 25% have been prescribed medication for their MH condition or SUD. Most often, respondents were connected to therapy or medication by a health care professional (50%) or a friend or family member (20%). When asked what mental health conditions respondents needed support with, **most respondents identified needing support with depression (100%), anxiety (100%), post-traumatic stress disorder (PTSD) (60%), or an eating disorder (44%).**

Table 9. Client Needs and Service Utilization by Mental Health Conditions

Mental Health Symptom	I NEED help for this, but I have NOT tried to get help	I NEED help for this and HAVE tried to get help, but HAVE NOT gotten help	I NEED help for this, and I HAVE gotten help	I DO NOT need help for this
Depression	22%	22%	56%	0%
Anxiety	22%	22%	56%	0%
Post-traumatic stress disorder (PTSD)	33%	11%	22%	33%
Eating disorder	22%	11%	11%	56%
Bipolar disorder	11%	0%	11%	78%
Obsessive compulsive disorder (OCD)	22%	0%	11%	67%
Compulsive hoarding disorder	22%	0%	11%	67%
Stimulant use disorder (cocaine, meth, etc.)	22%	0%	11%	67%
Alcohol use disorder (alcoholism)	22%	11%	0%	67%
Opioid use disorder (heroin, etc.)	11%	0%	0%	89%
Psychotic disorders, including schizophrenia	11%	0%	0%	89%

When asked what other areas respondents needed support with besides MH, most respondents identified needing **financial support (40%), educational support (33%), and legal support (30%).** Fortunately, of the areas of support listed, most respondents did not indicate needing support.

Table 10. Client Needs and Service Utilization by Area of Support

Area of Support	I DID NOT NEED this type of help	I NEEDED this type of help, but they DID NOT connect me with help for this issue	I NEEDED this type of help, and they DID connect me with help for this issue
Immigration support	90%	10%	0%
General medical care	80%	0%	20%
Housing support	80%	10%	10%
Transportation	80%	10%	10%
HIV medical care	80%	0%	20%
Gender-affirming medical care	80%	0%	20%
Food support	70%	20%	10%
Substance use treatment	70%	20%	10%
Legal support	70%	30%	0%
Educational support	67%	33%	0%
Financial support	60%	40%	0%

Barriers to Care

Half of respondents noted it was somewhat or very easy to get connected to MH care, and respondents noted the ease was attributed to the efficiency of care, how easy it was to schedule an appointment, having visits over Zoom and the clear communication they received from providers. The other half of respondents reported it was somewhat or very difficult attributed this to a long waitlist, managing a SUD, difficulty understanding payment, coverage and eligibility for services and challenges with finding a therapist that was a good fit.

Non-Users of MH Services

Among those *not* receiving MH services, the most common reasons cited were a perception that it was too expensive (36%) or that it takes too much time to start services (i.e., waitlists, paperwork, etc.) (27%). Moreover, some of those not receiving MH services indicated worry about being misunderstood or judged based on their MH needs (22%), their HIV status (11%) or their race/ethnicity (11%). In addition, there were relatively high percentages of respondents in the "neutral" category (particularly for MH needs and on the basis of their HIV status) which may be interpreted as less some degree of "wariness" about receiving MH services.

Table 11. Barriers to Care Among Non-Users of Mental Health Services

Statement	Disagree	Neutral	Agree
I would feel ashamed of myself for getting help from a professional with my mental health.	100%	0%	0%
I am worried about what my friends or family might think of me getting help from a professional for my mental health.	89%	11%	0%
I am worried that a mental health professional might not understand or judge me for my mental health needs.	44%	33%	22%
I would like to get help from a professional for my mental health.	0%	22%	78%
I am worried that a mental health professional might not understand or judge me for my gender identification.	89%	11%	0%
I am worried that a mental health professional might not understand or judge me for my sexual orientation.	78%	22%	0%
I am worried that a mental health professional might not understand or judge me for my race/ethnicity.	67%	22%	11%
I am worried that a mental health professional might not understand or judge me for my HIV status.	56%	33%	11%

Users of MH Services

Of the respondents who reported receiving mental health services, over half (60%) indicated that they were "neutral" with regard to whether or not their counselor looked like them and just less than half of respondents were "neutral" with regard to whether or not their counselor could relate to them (44%).

Table 12. Client Feelings Regarding Mental Health Services Received

Statement	Disagree	Neutral	Agree
My counselor could relate to me.	0%	44%	53%
My counselor looked like me.	10%	60%	30%
I worked on and talked about what I wanted to get help with.	10%	20%	70%
I felt heard, understood, and respected.	10%	30%	60%
I felt that my gender identity was respected.	0%	10%	90%
I felt that my gender identity was understood.	0%	20%	80%
I felt that my race/ethnicity was respected.	0%	10%	90%
I felt that my race/ethnicity was understood.	0%	22%	78%
I felt that my HIV status was respected.	0%	20%	80%
I felt that my HIV status was understood.	0%	40%	60%
I felt that my sexual orientation was respected.	0%	22%	78%
I felt that my sexual orientation was understood.	0%	40%	60%

Overall, the survey data shows that none of the respondents reported feeling disrespected or misunderstood based on gender identification, sexual orientation, race/ethnicity, or HIV status. However, the **neutral responses were relatively high for both sexual orientation and HIV status**. These results suggest **that there is room for improvement in demonstrating greater understanding of clients** on these dimensions.

Telehealth

Half of respondents reported receiving MH services through Zoom or telehealth and half reported receiving care in person. Of those who received telehealth services, 80% reported a good, very good or excellent experience, noting that they were able to avoid driving to their appointments. One respondent who reported receiving telehealth services noted there was a lack of personal connection which impacted the quality of their experience. **Of the respondents that have not received MH services via telehealth, 55% indicated they would be interested in starting services via telehealth.**

Key Themes from Data

Department of Public Health

As of December 31, 2021 there were **53,310 people living with diagnosed HIV in LAC**. The majority of PLWDH in LAC were assigned male at birth (89%) and identify as Latinx (46%). The greatest percentage of PLWDH in the county are 50-59 years of age (29%). The following tables reflect only those who are living with HIV and have been diagnosed. It is estimated that

Table 13. HIV Cases by Demographic, as of 2021.

	Count	Percentage (%)
TOTAL	53,310	100%
SEX		
Male	47,342	89%
Female	5,968	11%
AGE		
13-19	96	< 1
20-29	3,674	7%
30-39	10,488	20%
40-49	11,086	21%
50-59	15,560	29%
≥60	12,406	23%
RACE/ETHNICITY		
White	13,809	26%
Black	10,783	20%
Latinx	24,347	46%
Asian	2,012	4%
Native Hawaiian/Pacific Islander	82	< 1

American Indian/Alaskan Native	313	1%
Multi-race	1,895	4%

Among PLWDH assigned male at birth, MSM was the most common exposure category- 88% of male PLWDH were MSM—followed MSM/IDU. Among people assigned female at birth, heterosexual contact was to the most common exposure category- followed by injection drug use (IDU).

Table 14. HIV Cases by Exposure Category, as of 2021.

	Male		Female	
	Total PLWDH Count	**%**	**Total PLWDH Count**	**%**
Male-to-male sexual contact (MSM)	41,860	88%	-	-
Injection drug use (IDU)	1,445	3%	1,283	21%
MSM/IDU	2,932	6%	-	-
Hemophilia/transfusion	60	< 1	42	1%
Heterosexual contact	877	2%	4,488	75%
Perinatal exposure	105	< 1	141	2%
Other risk	63	< 1	14	< 1

HIV infection is organized into three stages: acute HIV infection (stage 1), chronic HIV infection (stage 2), and acquired immunodeficiency syndrome (AIDS) (stage 3). Individuals with stage 3 HIV infection are more prone to comorbidities, specifically mental illness as compared to individuals in stage 1 or 2. In 2020, 1,401 PLWDH were diagnosed during HIV stages 1 and 2 and 647 during stage HIV stage 3 (AIDS), meaning they had fewer than 200 CD4 cells/mm3 at the time of their diagnosis. In 2020 most of the HIV stage 1 and 2 diagnoses were among PLWDH age 20-29 (36%), and HIV stage 3 (AIDS) diagnosis was highest for PLWDH between 30-39 years of age. There were 584 deaths among PLWDH, of which approximately 77% were at least 50 years of age.

Table 15. HIV Stage 1-3 Count by Demographic (LADPH HIV Surveillance Annual Report (2020))

	HIV Stage 1 or 2 Count	HIV Stage 3 Count	Total PLWDH Count (%)	
TOTAL	1,401	647	53,310	100%
SEX				
Male	1258	557	47,342	89%
Female	143	90	5,968	11%
AGE				
13-19	38	5	96	< 1
20-29	504	100	3,674	7%
30-39	413	208	10,488	20%
40-49	244	141	11,086	21%
50-59	147	126	15,560	29%

≥60	55	67	12,406	23%
RACE/ETHNICITY				
White	264	110	13,809	26%
Black	298	120	10,783	20%
Latinx	730	367	24,347	46%
Asian	61	22	2,012	4%
Native Hawaiian/Pacific Islander	< 5	< 5	82	< 1
American Indian/Alaskan Native	7	< 5	313	1%
Multi-race	29	26	1,895	4%

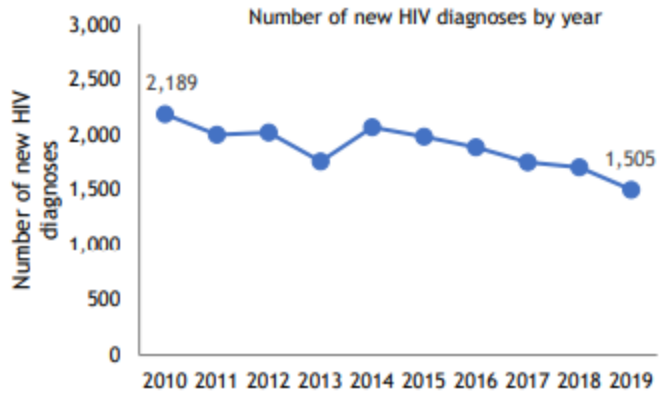
More than a third of PLWDH live in the Metro Service Planning Area (34%), which houses the Hollywood-Wilshire and Central health districts- two of the top three most impacted health districts in the county. In 2020, 170 PLWDH were diagnosed with HIV stage 1 or 2 in the Hollywood-Wilshire health district and 126 in the Central health district; 60 were diagnosed with HIV stage 3 (AIDS) in the Hollywood-Wilshire and 75 in Central. The Hollywood-Wilshire health district only retained 40% of PLWH in care in 2021.

Table 16. PLWDH and Care Continuum by Service Planning Area

	PLWDH Count	Engaged in Care	Retained In Care
Antelope Valley	1,221	72%	49%
San Fernando	7,989	73%	51%
San Gabriel	4,153	73%	50%
Metro	18,226	64%	44%
West	2,535	66%	45%
South	6,820	70%	49%
East	3,911	71%	50%
South Bay	7,988	70%	52%
All LAC	52,843	70% (average)	49% (average)

Over the last 10 years, there has been a notable decrease in the number of newly diagnosed HIV cases (see Figure 1). Researchers believe that declines in HIV new diagnoses are due in part to increased efforts to get PLWH to know their status and become virally suppressed and the increase in the use of pre-exposure prophylaxis (PrEP) among people who do not have HIV but are at substantial risk.

Figure 1. Number of new diagnoses per year.



Department of Mental Health Services

HMA received a limited set of behavioral health encounter and diagnosis data from DMH for MH services provided to program participants with HIV who had BH diagnoses from 2019-2022. For all years**, a small majority of encounters did not include report of a BH diagnosis**, suggesting that while these individuals did have one or more BH diagnoses on their record, the clinicians were not including any BH diagnoses on the claims for services provided during these years. We have included the full set of bar charts from the data in the appendix.

There are a few key themes from the limited data set (see appendix):

- **Depressive episodes and anxiety** disorder are the top BH diagnoses among PLWDH in 2019, 2020 and 2021. Between 2019 and 2021, on average, 22% of PLWDH were diagnosed with a depressive episode and 15% were diagnosed with an anxiety disorder.
- The cumulative incidence of SUD indicates a **prevalence of co-occurring disorders** among individuals receiving MH services.
- More than half of the patients for which data was received were Hispanic/Latino/a/x. However, based on the prevalence and incidence of HIV among Black/African American individuals in LAC, **it is likely that Black/African Americans are less likely to access and use MH services**.
- There is a need to better capture SOGIE as a data field.

Key Findings

Below we have identified the key findings that affect the provision of mental health (MH) and substance use disorder (SUD) services to PLWH. Throughout, we have focused on issues that surfaced as part of multiple data collection methods and are among more than one stakeholder group. Data sources include key stakeholder interviews, provider and consumer surveys, an environmental scan, a literature review, and LADPH and LADMH data sets.

Data Limitations

- There is a lack of integrated data across the behavioral health systems and limited access to that data prevents thorough analysis of service utilization among PLWH.

- Within the data set, for a slight majority of patients with both HIV and a behavioral health (BH) diagnosis, the sexual orientation was unknown. This sexual orientation/gender identity and expression (SOGIE) data gap makes it more difficult to tailor public health messaging and interventions.

Eligibility and Service Utilization

- With the increase of health care coverage and declines in aggregate HIV incidence, the number of individuals eligible for Ryan White has declined; fewer PLWH are eligible under current guidelines.
- Data suggest that the current system (Ryan White and Specialty) is more successful in reaching Hispanic/Latinx populations despite the prevalence of HIV being more prominent in the Black community.

Service Delivery and Coordination

- Despite desire for more integrated models of care (Collaborative Care Model and a "one-stop-shop" model), linkages between MH and primary care remain an issue for many providers.
- Most providers have difficulty ensuring PLWH can receive timely referrals to MH services, as well as difficulties referring clients to both psychiatric and SUD services.
- Many providers reported difficulty matching PLWH to a licensed clinician on their staff with whom they identify, as well as difficulty coping with rules and regulations that limit how they can staff clinical care for PLWH.
- Many mental health service clients not currently accessing received MH services via telehealth indicated they would be interested in starting services via telehealth.
- Clients often experience difficulties navigating the current MH system; clients lack awareness of the services available and how to navigate those services, as well as long wait times and excessive paperwork to access these services.

Service Access and Navigation

- Many clients who have not received mental health services via telehealth indicated they would be interested in starting services via telehealth.
- Clients often experience difficulties navigating the current mental health system; clients lack awareness of the services available and how to navigate those services, as well as long wait times and excessive paperwork to access these services.

Financial and Funding Barriers

- Many MH providers do not receive Ryan White funding, nor do they have a DMH contract to provide mental health services.
- Providing wrap-around services is unsustainable for most providers.
- Providers are challenged by the current billing system; the opaque nature of reimbursement poses a significant barrier for service providers.

Workforce and Staff Capacity

- Staff retention is a significant issue at both the provider and systems levels; excessive turnover and inability to recruit and retain staff is a barrier to provision of MH services to PLWH.
- Nearly all providers have difficulty assessing relevant staff training resources and/or staff training opportunities.
- There is a need for more professional development of the MH workforce, as well as reconsideration of the content and emphasis of training efforts.

Recommendations

Enhancing BH services and increasing service utilization requires a multi-dimensional, collaborative approach. Providing awareness, education, navigation, and linkage to health benefits, treatment providers, housing, food security, and transportation provide important direct help and generate a positive multiplier effect on the mental health concerns of PLWH and people vulnerable to acquiring HIV. This requires a collaborative approach among community-based organizations, MH and substance use treatment providers, federally qualified health centers, and county departments (DHS, DMH, DPH, and SAPC). Our recommendations below are intended to address the key barriers above, and to enhance the systems of service delivery for PLWH.

System Integration and Data

- Establish a data infrastructure that enables the extraction and analysis of client-level data across county departments to identify who and which subgroups are not receiving services.
- Develop data sharing protocols and/or platforms that allow patient health information to be more efficiently shared between DMH, DHS and DPH to avoid delays in data requests.
- Add and align sexual orientation/gender identity and expression (SOGIE) data fields to ongoing data collection and data systems (for example, DPH IRB has established policies around SOGIE data collection to align with DHS/ORCHID).
- Collect comorbid health condition data as part of the data collection to track other major life stressors of PLWH in order to provide client-centered, whole person care.

Eligibility and Service Utilization

- Revise eligibility to allow Ryan White services to individuals who are Medi-Cal eligible.
- Reduce the administrative burden on providers and clients by minimizing or streamlining intake and reporting requirements.
- Encourage and incentivize providers to hire peers, community Health Workers (CHWS) or navigators to assist with insurance and paperwork.

Service Delivery and Coordination

- Modify screening tools to enhance alignment with Trauma Informed Care and Gender Affirming Care.
- Improve cross agency referrals by using the Los Angeles Network for Enhanced Services (LANES) to have more accurate patient data and facilitate referral communication. LANES is an independent, nonprofit organization developing a health information exchange for Los Angeles

County residents to enable participating physicians, healthcare facilities, hospitals, health plans, and other healthcare providers to share patient clinical information efficiently and securely.
- Design and convene forums that bring together providers to discuss and plan improvements (e.g., how to strengthen implementation of "No Wrong Door")
- Develop a resource guide that provides detailed information on providers' services, capacity, and specialty services to enhance cross-agencies referrals.

Finance and Funding

- Develop and offer training to providers intended to clarify and standardize reimbursement policies, including guidance on CPT codes, rates, and proper documentation.
- Advocate for subsidizing BH services for individuals who are above the RW eligibility threshold but do not have other sources as payment of last resort.

Workforce and Staff Capacity

- Leverage the current efforts of the Zeroing In: Ending the HIV Epidemic consortium and other EHE capacity building organizations to provide better quality, relevant workforce training opportunities that prioritize the following:
    - Models of collaborative, holistic care
    - Co-occurring disorders; the intersection of HIV and SUD
    - SMI/high acuity mental health conditions
    - Advanced trauma-informed care and practices
    - Innovations in telehealth
    - Resources to improve workforce retention
- Coordinate training offerings among DHSP, DMH, SAPC, and the clinical provider organizations.
- Explore whether Licensed Marriage and Family Therapists (LMFTs) could be cross-credentialed to provide services now restricted to Licensed Clinical Social Workers (LCSWs).
- Collect data on the diversity and lived experience of staff working with PLWH.
- Expand Spanish-language providers .

About HMA Community Strategies

This report was produced and written by HMA Community Strategies (HMACS), a division of Health Management Associates. HMACS was formed to address the social needs that affect public health care. Contributions to this report were made by Charles Robbins, MBA (project director), Michael Butler, MA, Brandin Bowden, MS, Stephen Palmer, PhD, Drew Hawkinson, and Ryan Maganini.

Founded in 1985, Health Management Associates, Inc. (HMA) is a leading national health care and human services consulting company specializing in publicly funded programs and that has provided consulting services in all 50 states. With more than 500 subject matter experts, HMA provides a broad range of consulting services to advance health equity and racial justice. We have a strong presence in Southern California through our Los Angeles office which has experts who know the local social service, public health, and health care systems. For more information, visit www.healthmanagement.com.

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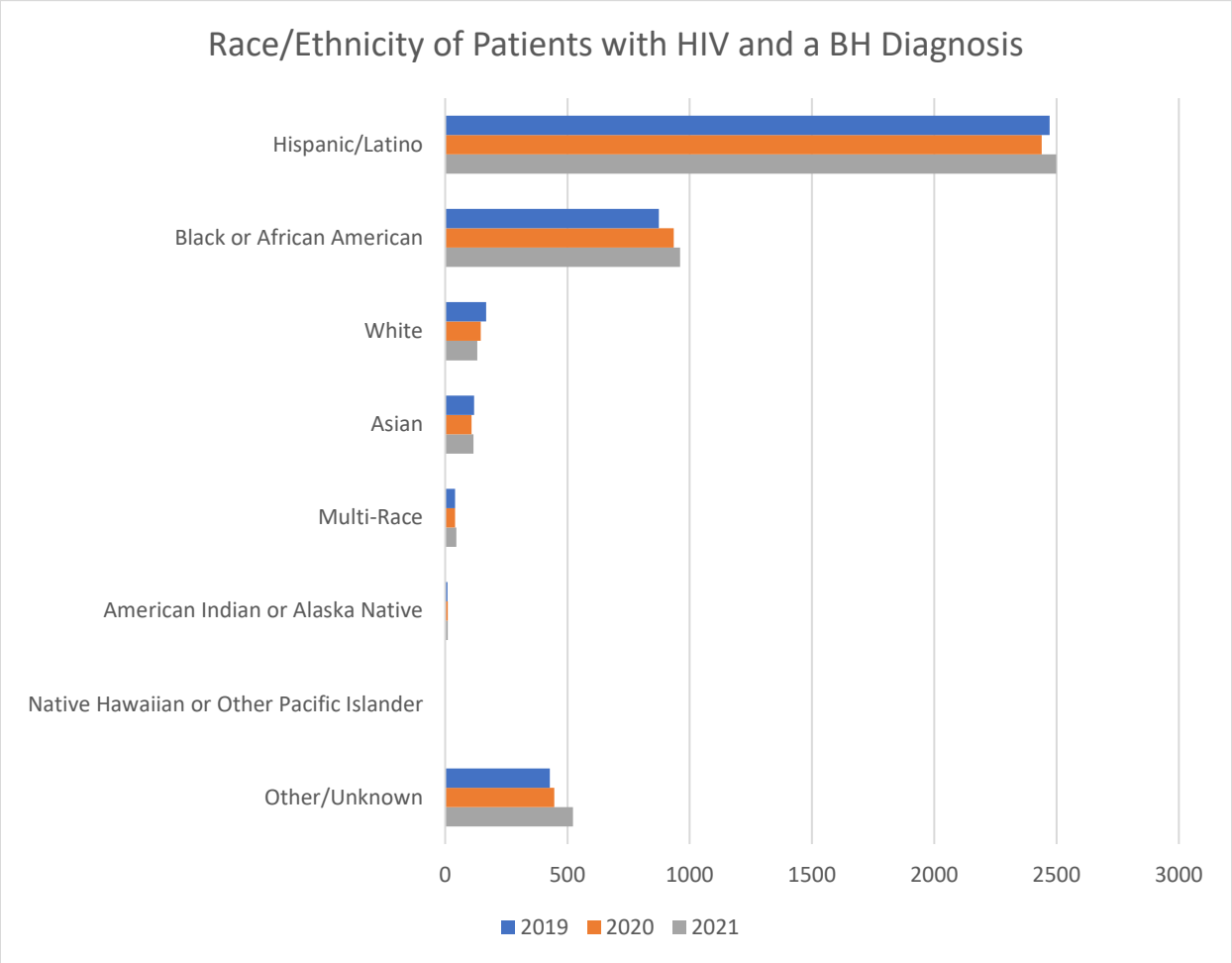
Appendix

Department of Mental Health Services Data

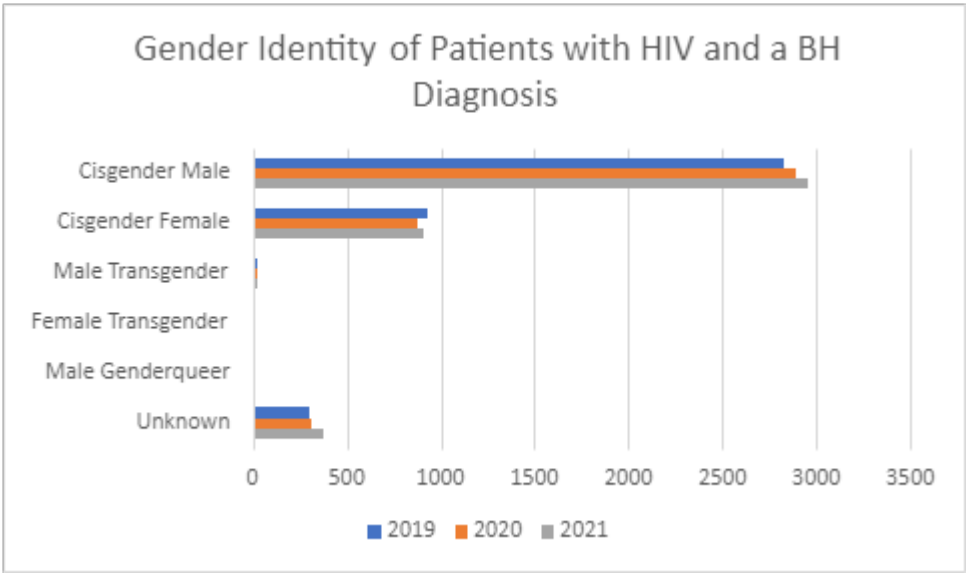
HMA received BH encounter and diagnosis data from DMH for health services provided to program participants between 2019 and 2021 with HIV who had ever had a BH diagnosis. Regarding the demographic data, it is not clear if these fields were self-reported by clients or based on provider reporting, which could lead to either misclassification or account for the "other" or "unknown" responses.

Client Characteristics

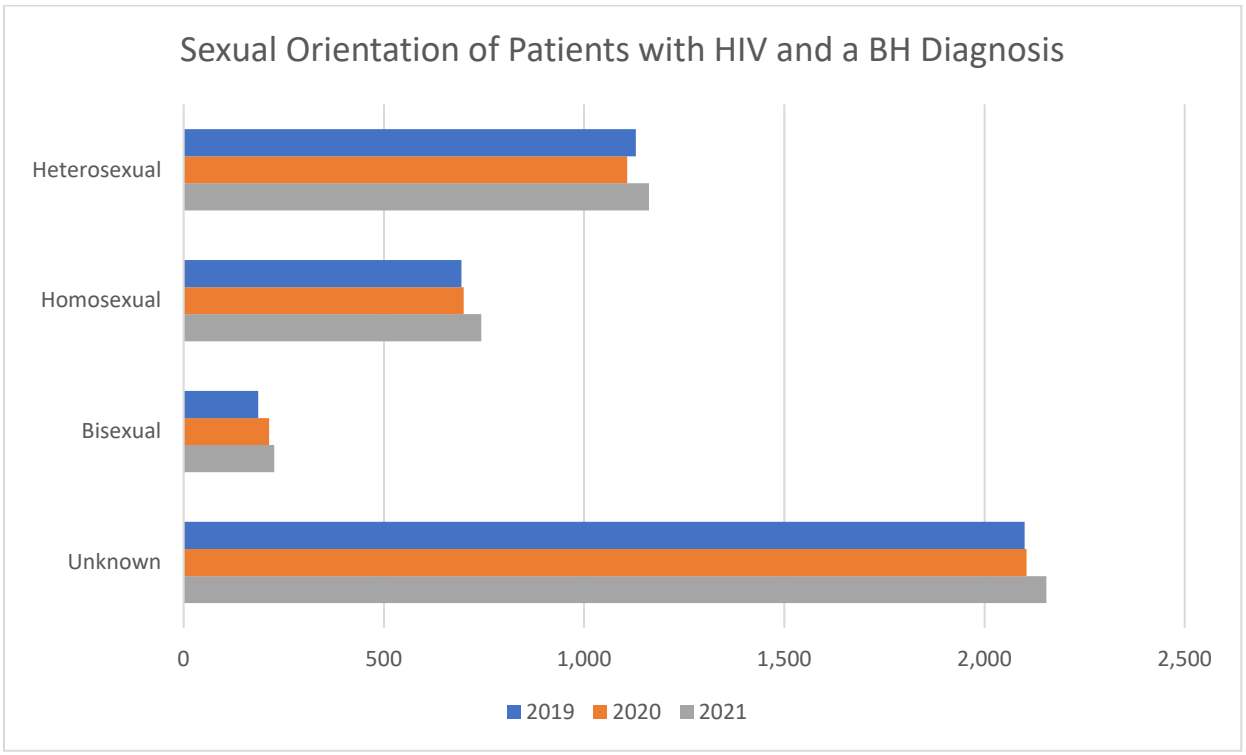
More than half of the patients for which data was received were Hispanic/Latino/a/x. However, based on the prevalence and incidence of HIV among Black/African American individuals in LAC, **it is likely that Black/African Americans are less likely to access and use MH services**.



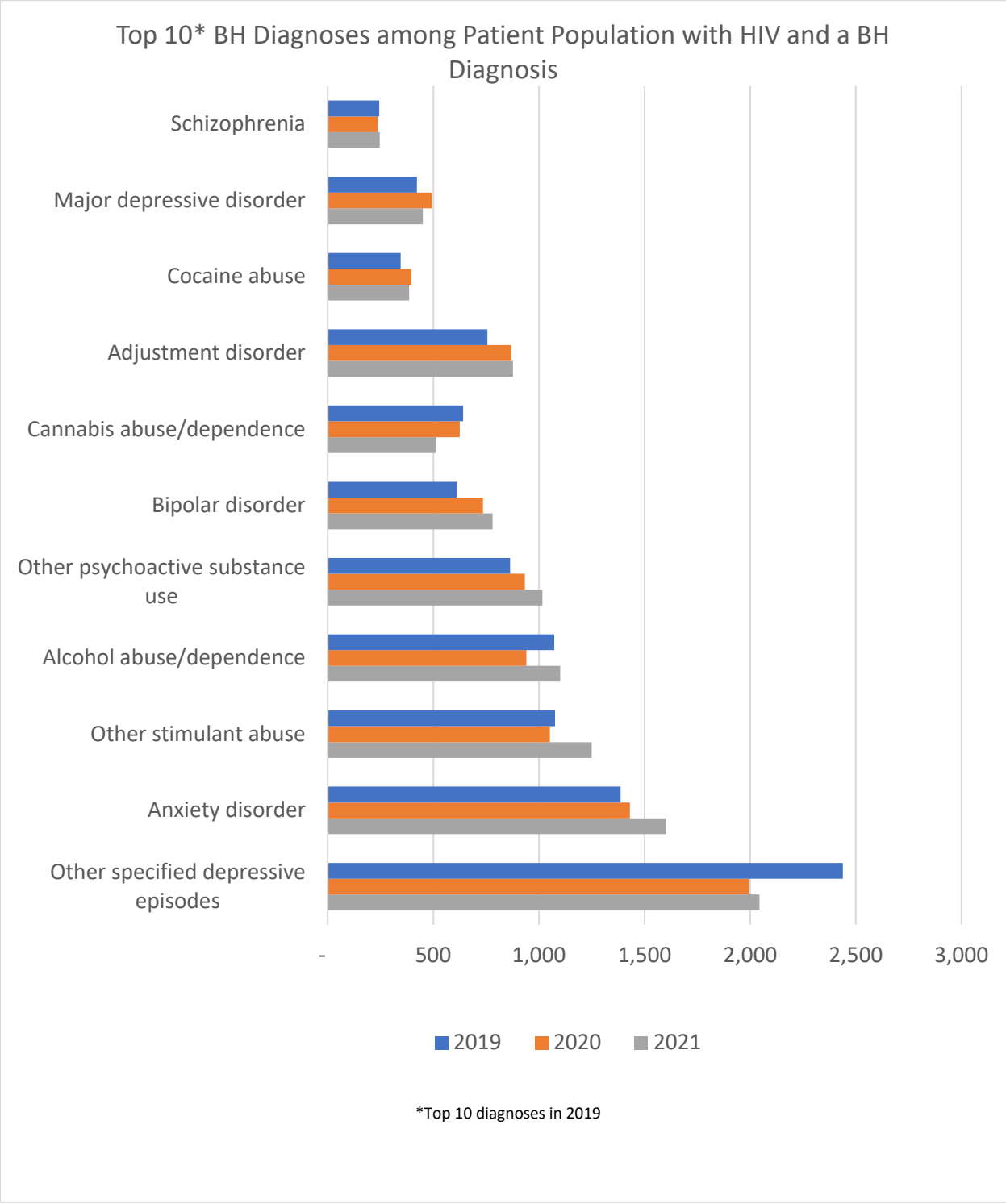
Three-quarters of patients with HIV and a BH diagnosis identified as male.



For a slight majority of patients with HIV and a BH diagnosis, sexual orientation is reported as unknown. The cause for this underreporting in not clear but may be due to failure of providers to ask or clients declining to provide the information. Either way, this suggests a need to educate providers on best practices for SOGIE data collection. **This data gap may make it more difficult to tailor public health messaging and interventions**.

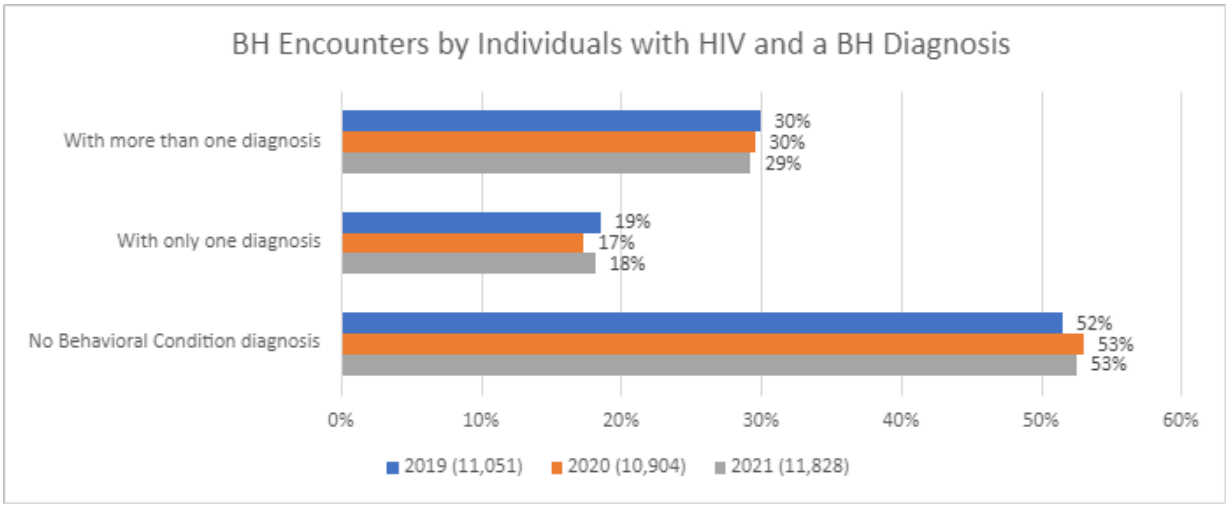


Depression and anxiety are the top BH diagnoses in each year studied. The cumulative incidence of substance use disorders indicates a prevalence of co-occurring disorders among individuals receiving MH services.

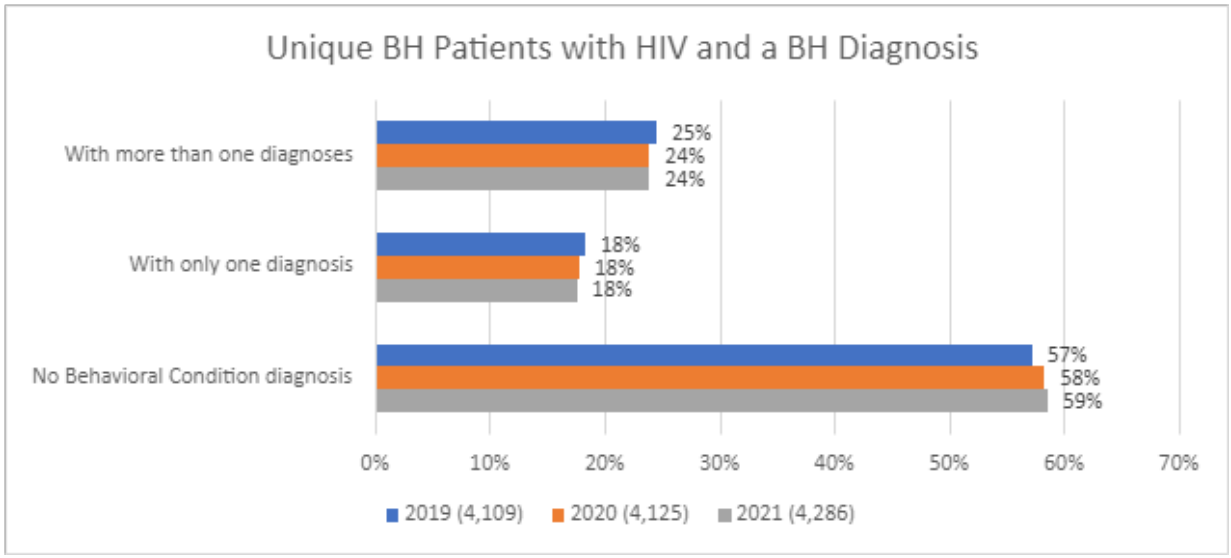


Service Utilization

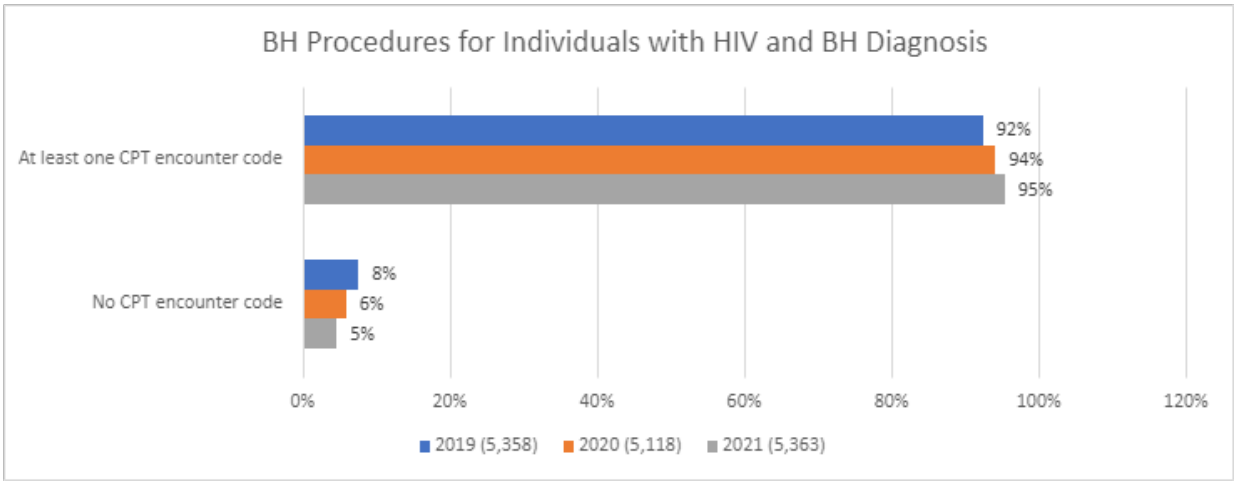
Between 2019 and 2021 **a small majority of encounters did not include any BH diagnosis**, suggesting that while these individuals did have one or more BH diagnoses on their record, the clinicians were not reporting any BH diagnoses on the claims for services provided during these years. The COVID-19 pandemic may have impacted the service utilization rates for 2020 and 2021, with fewer individuals accessing services during those years.



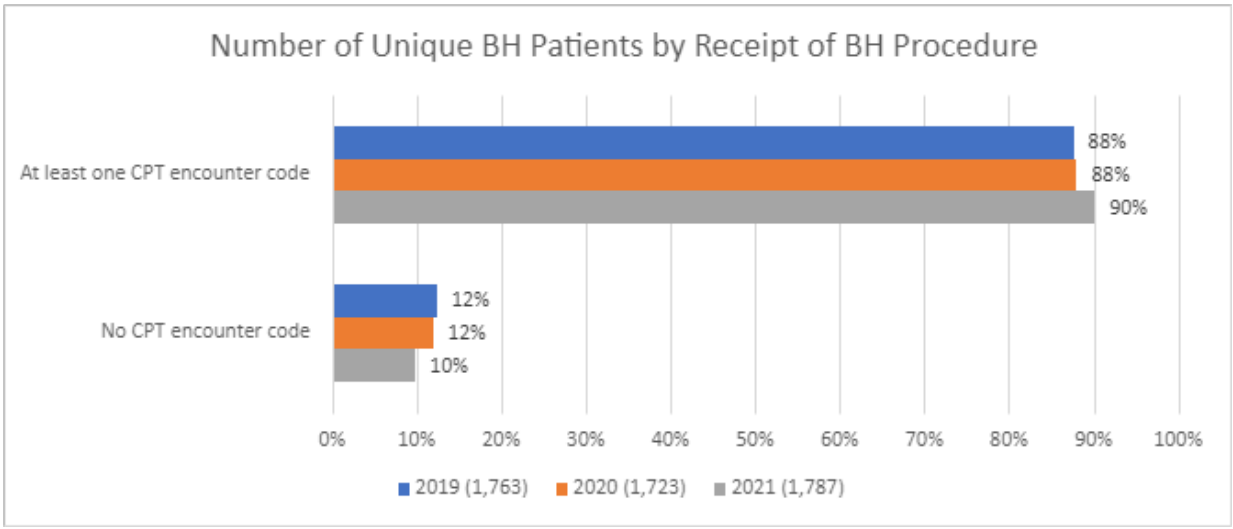
Similarly, a small majority of unique patients with HIV with a BH diagnosis history did not have any BH diagnosis recorded in 2019, 2020, or 2021.



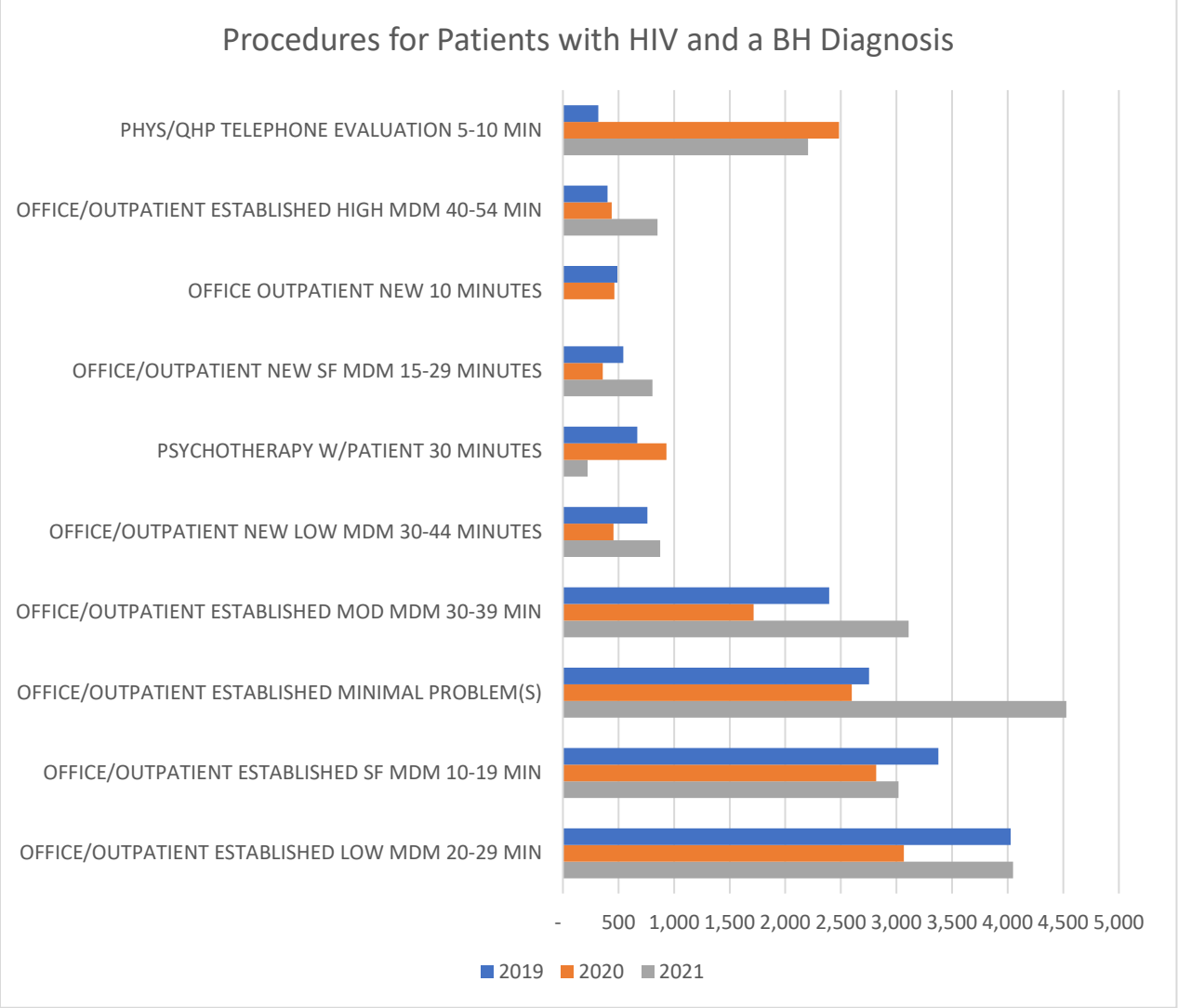
The vast majority of encounters for patients with HIV and at least one BH diagnosis code in each of the years examined had at least one CPT encounter code potentially related to BH, suggesting that when clinicians identified BH diagnoses, they were providing services for them.



Similarly, most patients with a BH diagnosis in each of the years analyzed received at least one service potentially related to BH.



Most of the procedures provided to patients with HIV and a BH diagnosis that could potentially be related to BH were common physician Evaluation or Maintenance (E/M) codes that could potentially be for conditions unrelated to BH. However, given the prevalence of anxiety and depression and the common treatment of these conditions with prescription medications, having a high proportion of procedures for medication management, which would typically be coded with an E/M code, is not surprising. The chart below provides procedures that utilize Medical Decision Making (MDM). It is notable that longer duration procedures had the least number of encounters. The most common interactions with providers are office and outpatient appointments that are under 30 minutes in duration.


Procedures for Patients with HIV and a BH Diagnosis
PHYS/QHP TELEPHONE EVALUATION 5-10 MIN
OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40-54 MIN
OFFICE OUTPATIENT NEW 10 MINUTES
OFFICE/OUTPATIENT NEW SF MDM 15-29 MINUTES
PSYCHOTHERAPY W/PATIENT 30 MINUTES
OFFICE/OUTPATIENT NEW LOW MDM 30-44 MINUTES
OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30-39 MIN
OFFICE/OUTPATIENT ESTABLISHED MINIMAL PROBLEM(S)
OFFICE/OUTPATIENT ESTABLISHED SF MDM 10-19 MIN
OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20-29 MIN
- 500 1,000 1,500 2,000 2,500 3,000 3,500 4,000 4,500 5,000
2019 2020 2021

Literature Review: Mental Health Care for People Living with HIV

Introduction

People living with HIV (PLWH) are more likely to experience negative mental health conditions compared to the general population.[5] A 2001 study with over 2,800 PLWH in the US found that 36% had major depression and 15.8% had generalized anxiety disorder. Comparatively, just 8.4% of adults overall in the US reporting major depression in 2020 and 2.7% reporting generalized anxiety in 2020.[6,7,8] Not only is this higher prevalence of mental health issues in PLWH due to stress, stigma, and shame associated with positive HIV status, it is also because a large portion of PLWH are part of racial, sexual, and/or minority groups and are subject to minority-related stress, which has been long associated with negative mental health.[9] Additionally, PLWH are more likely to live with other behavioral health conditions, including substance use disorders (SUD), serious mental illness (SMI), and post-traumatic stress conditions, which are often a result of underlying social and structural factors such as poverty, housing instability, stigma and shame, and trauma.[10,11] These underlying factors compounded with mental and behavioral health conditions negatively impact the health outcomes of PLWH and pose substantial barriers to retention in HIV care and treatment adherence.[12] They also make it more challenging to engage and retain individuals in mental health care and can lessen the impact of mental health care because individuals have more pressing and competing needs. People living with mental and behavioral health conditions are also at higher risk of acquiring HIV, given the behavioral risk factors of HIV transmission.[13] Therefore, taking a status neutral approach, public health efforts to intervene on the intersection of HIV and mental health can support both prevention and care efforts.[14]

Individual-Level Barriers

Roughly half (54%) of individuals living with any mental illness in 2020 in the United States did not seek or receive treatment.[15] Additional individual-level barriers deter PLWH from seeking and receiving treatment for mental and behavioral health services, including fear of discrimination from mental health providers as well as internalized stigma and shame.[16] Perceived stigma from mental health providers was a commonly identified barrier among Latinx individuals , a group disproportionately impacted by HIV In LAC.[17] Cultural values of machismo and strong familial ties, as well as fear of deportation, were also reported as causing mistrust of mental health professionals. Individuals felt that seeking treatment from mental health professionals would expose "weakness," cause distrust or stigma among family, or expose an undocumented status. Similar cultural barriers were shared with other population groups in

[5] https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hiv-and-mental-health
[6] Bing EG, Burnam MA, Longshore D, Fleishman JA, Sherbourne CD, London AS, et al. Psychiatric disorders and drug use among human immunodeficiency virus-infected adults in the United States. Arch Gen Psychiatry 2001; 58:721–728.
[7] https://www.nimh.nih.gov/health/statistics/major-depression
[8] https://www.nimh.nih.gov/health/statistics/generalized-anxiety-disorder
[9] https://psycnet.apa.org/record/2012-32754-018?fbclid=IwAR1VEV_u7htVFNGV_a_huxb6Kh7luQUB33TS0Ezzqo34wMrRpgkvHVeAKTk
[10] https://journals.lww.com/aidsonline/fulltext/2019/07150/mental_health_and_hiv_aids__the_need_for_an.1.aspx
[11] https://williamsinstitute.law.ucla.edu/wp-content/uploads/GNC-Youth-CA-Dec-2017.pdf
[12] https://journals.lww.com/aidsonline/fulltext/2019/07150/mental_health_and_hiv_aids__the_need_for_an.1.aspx
[13] https://journals.lww.com/aidsonline/fulltext/2019/07150/mental_health_and_hiv_aids__the_need_for_an.1.aspx
[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6016418/
[15] https://www.nimh.nih.gov/health/statistics/mental-illness
[16] https://journals.lww.com/aidsonline/fulltext/2019/07150/mental_health_and_hiv_aids__the_need_for_an.1.aspx
[17] https://cultureishealth.org/wp-content/uploads/2021/01/Latino-Population-Report.pdf

California, like Black people and LGBTQ+ people, in reports written as part of the recent California Reducing Disparities Project (CRDP). These reports revealed that individuals from these groups often experience stigma from mental health professionals as well through microaggressions like misgendering and racial stereotyping that can often lead individuals to feel misunderstood by mental health professionals and can even result in the misdiagnosis of mental health conditions and lead to poorer mental health care outcomes.[18,19,20] Underlying these barriers is a lack of cultural, racial, and ethnic diversity among mental health professionals. This lack of a culturally and linguistically competent mental health workforce also deters individuals from seeking mental health care in the first place.

Systems-Level Barriers

In addition to these individual-level barriers and challenges that diverse groups of PLWH experience, there are differences in the structures and priorities of the mental and physical health care systems that make it even more challenging for PLWH to be linked with appropriate mental health care. Navigating the mental health care system is challenging for groups that are not engaged in mental health care; in particular, Latinx and Black people who may already be reticent to engage in mental health care because of perceived stigma. Population reports produced through the CRDP reveal that individuals do not have effective ways to get connected to counselors that might serve their needs and have concerns about the cost of paying for mental health care, including insurance coverage. This is partially due to physical healthcare professionals, including those serving PLWH, not consistently screening for and discussing mental health care with their patients.[21,22,23] Though this is evolving, this stems from the fact that HIV care providers have not traditionally incorporated measures targeting mental health into their approach to quality management.[24,25] Therefore, mental health professionals and physical health professionals have a tendency to operate in silos and have not historically collaborated in patient care planning, making it more challenging to communicate health information and data between one another and coordinate to provide holistic care. A recent white paper developed for Covered California echoes these challenges, with mental health care providers and consumers noting that current bifurcations of specialty and non-specialty mental health—also known as "carve out" mental health—as well as primary care and behavioral health care, present challenges to integration.[26]

Approaches to Care

Promotores/Peer Navigators

Latinx communities have a history of peer navigators, or promotores, to support health professionals and help patients navigate health care systems. Research from the CRDP as well as in other large urban locations in the US has shown that interventions leveraging promotores are effective in establishing trust between patients and clinicians, improving patient linkage to care and retention, and even

[18] https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.201700382
[19] https://cultureishealth.org/wp-content/uploads/2021/01/First_Do_No_Harm-LGBTQ_Report.pdf
[20] https://cultureishealth.org/wp-content/uploads/2021/02/African-American-Population-Report-1.pdf
[21] https://cultureishealth.org/wp-content/uploads/2021/01/Latino-Population-Report.pdf
[22] https://cultureishealth.org/wp-content/uploads/2021/02/African-American-Population-Report-1.pdf
[23] https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4999.pdf
[24] https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4999.pdf
[25] https://www.walshmedicalmedia.com/open-access/integrating-mental-health-care-for-people-living-with-hiv-2375-4273-1000139.pdf
[26] White paper was accessed privately by Health Management Associates

reducing community stigma of mental health care.[27,28,29,30,31] As described in these studies and reports, local mental health service organizations, primary care clinics, and federally-qualified health centers (FQHCs) hire individuals who come from the communities they serve and who understand these communities' cultural values and beliefs.

In certain practices, promotores have been trained in the basics of mental health screenings, care navigation, and motivational interviews. Promotores are then embedded into primary care practices to perform mental health screenings, like the PHQ9, and coordinate with clinical staff to support patients in seeking mental health care and facilitate patients' linkage to care. An example workflow for promotores integration in primary care practices is included in Appendix A. Promotores also had varying additional roles across different interventions. In one intervention, promotores also led group support sessions in primary care settings.[32] In another intervention in community health clinics, promotores were able to address some of the underlying social determinants of individuals' mental health conditions by linking them with food supports, housing benefits, etc.[33] At Bienestar, a community-based organizations in LAC serving Latinx PLWH, promotores also serve as grassroots outreach workers to conduct outreach and education to the target population at nightclubs, streets and intersections, health fairs, opioid treatment programs, needle exchange sites, and shopping centers.[34] A 2009 study examining factors related to disparities among Latinx PLWH also noted that promotores can play a critical role in supporting health literacy for mental health services as well as for HIV care by rooting care interventions in cultural values of family care and community care.[35] While the integration of promotores into primary and clinical care teams was beneficial in most evaluations, it was noted that practices must take caution to ensure that promotores are not seen as mental health counselors themselves and that their roles and relationships with other care team members is properly defined so as not to supplant case managers or care coordinators. Additionally, while promotores and peer navigators can help strengthen connections between communities and providers, it is paramount that mental health providers enhance their own skills and practices to provide culturally affirming care—using gender-affirming and non-judgmental language, recognizing and addressing implicit bias, providing multi-lingual service, etc.

Holistic, Patient-Centered Care

Another key strategy for practitioners serving PLWH, as well as specific communities disproportionately impacted by HIV, is integrating case management and holistic care methods into mental health care. Given the complex underlying social conditions and behavioral health conditions PLWH may experience—such as housing instability, financial insecurity, trauma, external and internal stigma and shame, and substance use—mental health care for PLWH must incorporate macro-level social work practice to address these contextual factors underlying depression, anxiety, and other mental health

[27] https://cultureishealth.org/wp-content/uploads/2021/01/Latino-Population-Report.pdf
[28] https://link.springer.com/content/pdf/10.1007/s10900-010-9313-y.pdf
[29] https://psycnet.apa.org/record/2016-10052-001
[30] https://link.springer.com/article/10.1007/s10488-016-0737-2
[31] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3752383/pdf/nihms496530.pdf
[32] https://psycnet.apa.org/record/2016-10052-001
[33] https://link.springer.com/content/pdf/10.1007/s10900-010-9313-y.pdf
[34] https://cultureishealth.org/wp-content/uploads/2021/01/Latino-Population-Report.pdf
[35] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3752383/pdf/nihms496530.pdf

conditions.[36,37] In doing so, mental health practitioners can help clients externalize mental health challenges they face and create more comprehensive and effective care plans. Another promising practice in furthering holistic, patient-centered care is transdiagnostic approaches to care. Transdiagnostic approaches to care recognize that different mental health conditions, like depression and anxiety, are often co-occurring and can share related symptomology, therefore, clinical approaches to care can be streamlined to address multiple mental health conditions together.[38] One study evaluating a 10-session cognitive behavioral therapy (CBT) intervention for gay and bisexual individuals to alleviate minority stress found combined improvements in substance use disorder, depression, anxiety, and sexual risk behavior using this transdiagnostic approach.[39] A tailored approach using Cognitive Behavioral Therapy for adherence and depression (CBT-AD) has also been seen as effective for improving depression and increasing ART adherence among PLWH.[40] This approach modifies traditional CBT modules by incorporating psychoeducation about ART adherence and identification of barriers to adherence into seven sessions: activity scheduling, adaptive thinking, problem solving, relaxation, and relapse prevention.[41] Tailored CBT and cognitive-behavioral stress management (CBSM) have also been found to be successful at increasing positive mental health outcomes in Latinx PLWH.[42]

Key Strategies to Consider:

- Utilizing promotores/peer navigators to assist in screening, outreach, and linkage of individuals to care and address cultural barriers between individuals, communities, and practitioners.
- Integrating case management with mental health care to address social determinants and contextual factors associated with mental health conditions.
- Utilizing transdiagnostic care approaches to address syndemic behavioral health conditions (depression, anxiety, substance use, sexual risk behavior).
- Tailoring CBT to incorporate and address ART adherence.
- Training care teams on and centering motivational interviewing skills, trauma-informed care, and culturally affirming practices in approaches to care.

Models of Care

Collaborative Care Model

Given the overlap of and interaction between mental health and physical health conditions PLWH often face, it is imperative that systems of mental healthcare and physical healthcare serving PLWH are streamlined and aligned. Recent HRSA HIV/AIDS Bureau (HAB) guidance on mental health interventions to eliminate disparities in viral suppression rates among Ryan White funded clinics points to the Collaborative Care Model (CCM) as a promising approach.[43] The CCM is an evidence-based approach to care where primary care providers, care managers, and psychiatric consultants all work together to

[36] https://targethiv.org/sites/default/files/file-upload/resources/Expanding%20Access%20to%20BH%20Care%20for%20PLWH.pdf
[37] https://journals.lww.com/aidsonline/fulltext/2019/07150/mental_health_and_hiv_aids__the_need_for_an.1.aspx
[38] Sauer-Zavala S, Gutner CA, Farchione TJ, Boettcher HT, Bullis JR, Barlow DH. Current definitions of 'Transdiagnostic' in treatment development: a search for consensus. Behav Ther 2017; 48:128–138
[39] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4573250/pdf/nihms698590.pdf
[40] https://targethiv.org/sites/default/files/Newcomb2015.pdf
[41] https://targethiv.org/sites/default/files/media/documents/2021-03/CQII%20Eliminating%20Disparities%20Due%20to%20Mental%20Health%20Issues.pdf
[42] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3752383/pdf/nihms496530.pdf
[43] https://targethiv.org/sites/default/files/media/documents/2021-03/CQII%20Eliminating%20Disparities%20Due%20to%20Mental%20Health%20Issues.pdf

create care plans with shared responsibility, integrate the delivery patient-centered treatment, and track and measure integrate physical and mental health outcomes. In practice, organizations that implement the CCM routinize and streamline mental and behavioral screenings in HIV care settings, incorporate on-site psychiatric consultants into care planning and case reviews, and compile patient data and records on physical health and mental health in one shared system.[44] In doing so, the goal of the CCM is to better address co-occurring and synergistic mental and physical health needs of patients. A recent editorial review even suggested implementing CCM models in HIV testing sites, so that individuals could be screened for and linked with mental health services in tandem with linkage to HIV care services.[45] Care coordinators and patient navigators often serve as the bridge between physical health and mental health professional in this collaborative effort. One evaluation of an HIV safety-net clinic's implementation of the CCM found that this integration and collaboration in care increased patient trust, reduced stigma of mental health, and over time, with reinforcement across patients' care teams, lead to greater self-management of depression.[46] The CRDP Latinx population-specific report also points to the CCM as a favorable approach to reducing potential barriers certain populations have in navigating complex physical and mental health care systems and reducing duplicative assessments.[47] One study of CCM implementation in a Canadian health system found this approach was effective even in acute care settings because psychiatric consultants and case coordinators were able to better engage and link out-of-care individuals with appropriate mental and physical health care following acute physical health or psychiatric episodes.[48]

"One-Stop-Shop" Model

Closely aligned with the CCM approach is the "one-stop-shop" model. By co-locating physical health, behavioral health, and social support services, collaborative care teams can streamline linkages and increase care retention. In one example, Broward County, a Ryan White Part A EMA, modified the standards of care in their contracts with six HIV care providers to require behavioral health assessment at every client visit and for mental health services to be available on-site so that clients could be given a warm handoff by physical health teams.[49] Using a CCM approach, the County also integrated physical and mental health outcomes goals by requiring clinics to report on the retention and viral suppression rates specifically for clients linked to mental health treatment. Across the six clinics, this resulted in a 21.1% increase in the number of clients receiving mental health care, a 26.3% increase in HIV care retention, and a 1.5% increase in viral suppression overall. In another example, Cooper Health System in Camden, New Jersey employed the CCM to build a one-stop-shop for PLWH that included HIV primary care, SUD and OUD treatment services, medication management and pharmacy services, mental health counseling, chronic disease self-management training classes, and wraparound services. Additionally, they adopted an opt-out policy for HIV and hepatitis C virus (HCV) screening across their entire health system and included EMR practice alerts for HIV and HCV testing to promote provider adherence.

[44] https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4999.pdf
[45] https://journals.lww.com/aidsonline/fulltext/2019/07150/mental_health_and_hiv_aids__the_need_for_an.1.aspx
[46] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6446432/pdf/10.1177_2050312119842249.pdf
[47] https://cultureishealth.org/wp-content/uploads/2021/01/Latino-Population-Report.pdf
[48] Journeying with HIV patients across the health care spectrum — an examination of a seamless model of HIV Psychiatry of a large urban general hospital
[49] https://targethiv.org/intervention/trauma-informed-approach-integrating-hiv-primary-care-and-behavioral-health-services?utm_source=bpURL

Patients who screened positive for HIV or HCV were immediately linked to their one-stop-shop for care. In addition to Medicare, Medicaid, and commercial insurance reimbursement, this model was funded by Ryan White Part A and C funds and used 340 pharmacy services. Over a three-year period, patient enrollment in behavioral health treatment increased fourteen fold, HIV care retention rate increased from 33.0% to 79.6%, and overall viral suppression increased from 61.5% to 72.2%.[50] HRSA HAB has promoted the use of telehealth and tele-psychiatry in clinics where the ability for in-person onsite staffing is challenging.[51] Recent federal funding efforts through Substance Abuse and Mental Health Services Administration (SAMHSA) and HRSA have also pushed providers to provide collocated or collaborative HIV and HCV testing, treatment, and care within behavioral health settings to increase HIV and HCV screening, streamline linkage to treatment, and strengthen the relationship between behavioral and physical health care delivery across the system.[52]

Key Strategies to Consider:

- Developing interdisciplinary care teams that include HIV primary care clinicians, care coordinators, and psychiatric consultants who collaborate on patient cases.
- Integrating physical and mental health treatment planning to create patient goals with shared accountability across providers.
- Using shared data systems to compile patients' physical and mental health records and measure outcomes.
- Updating standards of care in vendor contracts to require routinized behavioral health screening at HIV care appointments.
- Co-locating physical health, behavioral health, and social support services to support efficient linkages to treatment.
- Building spaces for telehealth and tele-psychiatry in HIV care clinics when in-person behavioral health services is not possible.

Therapeutic Interventions for Trauma

Much of the literature around therapeutic approaches to trauma involves a discussion of treating PTSD and working with individuals with a PTSD diagnosis. In fact, one study estimates that somewhere between 35% to 65% of PLWH report having PTSD, significantly higher than the portion of the general population with PTSD in the Unites States, which is estimated to be around 2% to 4%.[53] That said, the recommended therapeutic treatments for PTSD from the American Psychological Association (APA) include Brief Eclectic Psychotherapy, EMDR Therapy, Narrative Exposure Therapy, and medications alone or in conjunction with psychotherapy.[54] In addition, certain therapies were found in the literature to be significantly efficacious among PLWH, specifically. These therapeutic modalities included Resilient Affective Processing (RAP), Prolonged Exposure (PE) therapy and group therapy modalities. RAP is a treatment modality characterized by participants completing writing exercises that allow them to record

[50] https://targethiv.org/intervention/integration-comprehensive-hiv-medical-care-addiction-services?utm_source=bpURL
[51] https://targethiv.org/sites/default/files/media/documents/2021-03/CQII%20Eliminating%20Disparities%20Due%20to%20Mental%20Health%20Issues.pdf
[52] https://www.samhsa.gov/sites/default/files/grants/pdf/fy-22-mai-si-nofo.pdf
[53]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5568823/#:~:text=Higher%20rates%20of%20PTSD%20may,was%20being%20diagnosed%20with%20HIV.
[54] https://www.apa.org/ptsd-guideline/treatments

their thoughts associated with HIV trauma as a vehicle to process their feelings.[55] One pilot study that looked at the effectiveness of RAP in reducing stress related to HIV found that participants who participated in RAP reported lower levels of HIV-related stress and lower levels of methamphetamine use.[56] Prolonged Exposure Therapy (PET), according to the Institute of Medicine, is the only treatment modality that is evidence-based, with significant empirical data that demonstrates efficacy.[57] The therapy model is characterized by the provider guiding the patient through imagined and real-life exposures to places or situations that trigger stress as a way of processing their feelings. One study found PET to be effective in reducing HIV-related stress symptoms as well as substance use among PLWH.[58] In addition to RAP and PET, various group therapy models were found to be effective in reducing HIV related stress among PLWH as well. One group therapy model that was found the be effective was characterized by a combination of cognitive behavioral therapy strategies for trauma and stress appraisal approaches.[59] Sessions were characterized by individuals appraising stress triggers, setting goals around stress management, and then roleplaying between group members to practice and build skills.[60] Additionally, much like many other group therapy models, this particular model included plenty of time dedicated to sharing, mutual support and feedback around HIV infection and coping.[61] Although these studies suggest efficacy among PLWH, it is not clear if this efficacy remains among specific subgroups of PLWH, including racial and ethnic minorities and transgender individuals.

Key Strategies to Consider:

- HIV status is one of many considerations when recommending a therapeutic modal for addressing trauma.
- Readiness and individual choice are important components to empower PLWH to engage with therapeutic modalities to address trauma.
- Linguistic and cultural competency are integral to effective therapeutic interventions to address trauma among PLWH.
- Resilient Affective Processing, Prolonged Exposure therapy, and group therapy modalities have been shown to be effective in lowering HIV-related stress among PLWH.

Efficacy of Telehealth Among Latinx/Spanish Speaking Individuals

Telehealth modalities can be organized into different categories, as summarized by Marcoux and Vogenberg, including synchronous virtual engagement over the phone or through video chat, asynchronous messaging through a patient portal or virtual communication platform, remote patient monitoring (RPM), and the passive collection of data using devices or online applications.[62] As it applies to behavioral health therapeutic care, psychiatry and psychotherapy have been demonstrated to be as

[55] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5482007/
[56] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5482007/
[57] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4391814/#:~:text=People%20living%20with%20HIV%20(PLWH,and%20substance%20use%20in%20PLWH.
[58] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4391814/#:~:text=People%20living%20with%20HIV%20(PLWH,and%20substance%20use%20in%20PLWH.
[59] https://targethiv.org/sites/default/files/Sikkema2007.pdf
[60] https://targethiv.org/sites/default/files/Sikkema2007.pdf
[61] https://targethiv.org/sites/default/files/Sikkema2007.pdf
[62] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5010268/

effective when delivered synchronously through a webcam or other technology as compared to in-person services.[63] Among monolingual Spanish speaking individuals and Latinx immigrants in the United States, this synchronous delivery of telepsychiatry and tele-psychotherapy have been found to be efficacious across different studies.[64,65,66] One study examined the effectiveness of psychiatry visits delivered in-person as compared to videoconferencing to treat depression among Hispanic individuals, where all participants were found to report a reduction in depression symptoms regardless of how the services were delivered.[67] Despite the observed effectiveness, certain challenges are presented when deploying telepsychiatry or tele-psychotherapy for this population. One challenge is the "digital divide," or "digital inequality" which refers to the gap in access to broadband internet services and technology, which is particularly relevant for low income and housing unstable individuals.[68] Moreover, among those with access and availability to technology and internet services, there may be discomfort and a lack of familiarity with use, presenting a learning curve among some individuals.[69] These challenges with technology, combined with language and cultural barriers of the provider and stigma of behavioral health treatment itself, can create hesitancy to begin treatment. These barriers can be addressed with discrete and specific interventions, despite the systemic nature of the issue. One study suggests providers invest in a more robust IT support for clients, making technical assistance more readily available and culturally competent.[70] The same study also suggests investing in advertising of telehealth technology to patients to grow awareness as well as provide educational resources to address the learning curve.[71] Despite the barriers, telehealth modalities still demonstrate efficacy among this population provided that the individuals offering the virtual services speak Spanish and can provide culturally competent therapeutic care.

Key Strategies to Consider:

- Resources should be provided to make technology and internet services more accessible and easier to use for monolingual Spanish speaking individuals and Latinx immigrants.
- The same hesitancy to access in-person behavioral health care like stigma and cultural differences holds true for telepsychiatry and tele-psychotherapy.
- Offering telepsychiatry and tele-psychotherapy for monolingual Spanish speaking individuals and Latinx immigrants present an opportunity to significantly address need, demand, and gaps in treatment.

[63] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5723163/
[64] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5488804/
[65]https://pubmed.ncbi.nlm.nih.gov/27631958/
[66] https://pubmed.ncbi.nlm.nih.gov/23026854/
[67] https://pubmed.ncbi.nlm.nih.gov/23026854/
[68] http://www.webuse.org/webuse.org/pdf/Hargittai-DigitalDivideWhatToDo2007.pdf
[69] https://pubmed.ncbi.nlm.nih.gov/22424078/
[70] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8300069/
[71] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8300069/