Integrating HIV and Hepatitis Care into Behavioral Health Care SAMHSA’s Minority AIDS Initiative-Continuum of Care Pilot (MAI-CoC)

Lisa G. Kaplowitz, MD, MSHA, SAMHSA – Welcome & Intro
CAPT Ilze Ruditis, SAMHSA, CMHS- Overview
Seth Himelhoch, MD, University of Maryland
Moneta Sinclair, EdD, LPC, Positive Impact Health Centers
Emma Gianani-Maki, RN, University of Colorado, ARTS Center
Judith Ellis, SAMHSA, CSAP, Moderator
Stephen Carrington, SAMHSA, CSAT Q & A
Welcome from SAMHSA

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Senior Medical Advisor
Office of Policy, Planning and Innovation
Substance Abuse and Mental Health Services Administration
Disclosures

Presenter(s) have no financial interest to disclose.

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If you would like to receive continuing education credit for this activity, please visit:

http://ryanwhite.cds.pesgce.com
Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Describe integrated care models for HIV and Hepatitis screening, testing and care in behavioral health settings.
2. Identify internal and external partnerships required for integrated care, including prevention and treatment.
3. Discuss advantages and strategies working in integrated behavioral health and medical services.
AGENDA

• Brief Programmatic Orientation of SAMHSA’s MAI-CoC

• Presentations in varied geographic and programmatic settings:
  - Mental health clinic, university affiliate, Baltimore, MD
  - Mental health clinic, Atlanta, GA
  - Substance use disorder treatment clinic linked with a Community Prevention Partner, Denver, Colorado

• Questions and Answers, Discussion
Overview and Requirements

Ilze Ruditis, MSW, ACSW
CAPT, USPHS
Diplomate in Clinical Social Work
Sr. Program Manager
SAMHSA/CMHS/DSSI
WHY Initiate SAMHSA’s MAI-CoC?

• People living with HIV are disproportionately affected by viral hepatitis; HIV infection accelerates viral hepatitis progression, thus, related liver problems

• Integration and collocation of care can relieve burden for individuals with conditions that are frequently associated with cognitive impairment (HIV infection, substance use, and mental disorders), which may lead to gaps in medically necessary services

• Result – Improved care access, adherence to care, and behavioral health and clinical outcomes
HIV Care Continuum and MAI-CoC

MAI-CoC Pilot: Purpose

• The purpose of this jointly funded program is to integrate care (behavioral health (BH) treatment, prevention, and HIV medical care services) for racial/ethnic minority populations at high risk for BH disorders and high risk for or living with HIV (page 7).

• This program is primarily intended for SA treatment programs and community MH programs that can co-locate and fully integrate HIV prevention and treatment and HIV medical care services within their BH programs.
Definitions

• The FOA provides key definitions:

  • Co-location—providing the HIV services within the physical space of the BH program

  • Full Integration—clients receiving the entire spectrum of HIV medical care in coordination and conjunction with the BH services being received.
MAI-CoC Details - Populations of Focus

• Racial/ethnic minority populations at high risk for or having a mental and/or substance use disorder and who are most at risk for, or living with HIV, including African American and Latino women and men, gay and bisexual men, and transgender persons

• Other high priority populations, such as American Indian/Alaskan Natives, Asian Americans, and other Pacific Islanders may be included based on the grantee’s local HIV/AIDS epidemiological profile
MAI-CoC Program Details

• Up to 4 years (9/2014-9/2018) FOA ti-14-013

• 34 projects (up to $500,000) - (5% required for hepatitis screening, testing and vaccination)

• Funded under 3 Centers in SAMHSA- CMHS, CSAT and CSAP – in one FOA

• Almost all regions, with most in southeast and northeast
SAMHSA Government Project Officers for MAI-CoC

Center for Substance Abuse Prevention (CSAP)
- Patricia Sabry
- Barbara Rogers
- Karim Hamadi
- Morris Flood
- Judith Ellis

Center for Substance Abuse Treatment (CSAT)
- Kirk James
- Ed Craft
- Stephen Carrington

Center for Mental Health Services (CMHS) – Ilze Ruditis
Sites overview of their setting:

Agency and Program Structure

Experience and dynamics of integrating care

Relationships with Partner Agencies/Providers

Progress – Hepatitis, HIV, HIV services and mental and substance use disorders, prevention services
MAI-CoC - Variety of Settings

Seth Himelhoch, MD, University of Maryland
Walter P Carter Clinic, Baltimore, MD

Moneta Sinclair, Ed D, LPC, Positive Impact
Health Centers, Atlanta, GA

Emma Gianani-Maki, MSS, RN, CAC III
University of Colorado, ARTS Center, Denver, Co
QUESTIONS?
STIRR-IT: INTEGRATED SCREENING FOR HIV AND HCV AND PROVISION OF RISK REDUCTION COUNSELING IN A COMMUNITY MENTAL HEALTH SETTING

Seth S. Himelhoch M.D., M.P.H.
Program Director, Project STIRR-IT
Professor
Department of Psychiatry
University of Maryland School of Medicine
WHAT DOES STIRR-IT MEAN?

Screening & Testing for HIV/HCV, Immunization for Hepatitis A & B, Risk Reduction Counseling linked to Integrated HIV Treatment

http://publichealthandeducation.blogspot.com/
WHAT IS STIRR?

• Evidence based practice

Assessing the STIRR Model of Best Practices for Blood-Borne Infections in Clients with Severe Mental Illness

Stanley D. Rosenberg1, Richard W. Goldberg2,3, Lisa B. Dixon2,3, George L. Wolford1, Eric P. Stade1, Seth Hinshaw1,2,3, Gerard Galluccio4, Wendy Potts5, Stephanie Tapscott6, and Christopher J. Weidman3

1Department of Psychiatry and Community and Family Medicine, Geisel School of Medicine, Lebanon, NH
2VA Capitol Health Care Network Mental Illness Research, Education, and Clinical Center, Baltimore, MD
3Department of Psychiatry, University of Maryland School of Medicine, Baltimore, MD
*State of Delaware, Division of Substance Abuse and Mental Health

Abstract

Objective—People dually diagnosed with severe mental illness and substance use disorders are at markedly elevated risk for HIV, hepatitis B, and hepatitis C, but generally do not receive basic recommended services. Several barriers impede receipt of services, including lack of programs offered by mental health providers, and client refusal of available services. Clients from ethnic minority groups are even less likely to accept recommended services. The intervention tested was designed to facilitate integrated infectious disease programming in mental health settings, and to increase acceptance of such services among clients.

Methods—A randomized controlled trial (n=256) compared enhanced treatment usual care (Control) to a brief intervention to deliver best-practices services for blood-borne diseases in an urban, largely minority sample of dually diagnosed clients. The intervention included Screening, Testing for HIV and Hepatitis B, Immunization for Hepatitis A and B, Risk reduction counseling and medical treatment, Partners and support (STIRR) at the site of mental health care.

Results—Clients randomized to STIRR had high levels (over 80%) of participation and acceptance of core services. They were more likely to be tested for HIV and HCV, immunized for Hepatitis A and B, increase the Hepatitis knowledge and be drug-free at a treatment center. However, they showed no reduction in risk behavior, were more likely to be referred to care (81 vs. 75%) and showed no increase in HIV knowledge. Intervention costs were $341 per client.

Conclusions—STIRR appears to be efficacious in providing a basic, best-practice package of interventions for dually diagnosed clients.
NIH Public Access
Author Manuscript

Published in final edited form as:

Assessing the STIRR Model of Best Practices for Blood-Borne Infections in Clients with Severe Mental Illness


STIRR is efficacious at providing basic, best-practice package for dually diagnosed clients

offered by mental health providers, and client refusal of available services. Clients from ethnic minority groups are even less likely to accept recommended services. The intervention tested was designed to facilitate integrated infectious disease programming in mental health settings, and to increase acceptance of such services among clients.

Methods—A randomized clinical trial (n=236) compared enhanced treatment as usual (Control) to a brief intervention to deliver best practice services for blood-borne diseases in an urban, largely minority sample of dually diagnosed clients. This intervention included Screening, Testing for HIV and hepatitis, Immunization for hepatitis A and B, Risk reduction counseling and medical treatment. Facilitated support (STIRR) at the site of mental health care.

Recruitment—Clients randomized to the treatment group were more likely to participate and acceptance of core services. They were more likely to be tested for HIV and HCV, immunized for hepatitis A and B, increase hepatitis knowledge and to reduce their substance abuse. However, they showed no reduction in risk behavior, were no more likely to be referred to care (81 vs. 75%) and showed no increase in HIV knowledge. Intervention costs were $545 per client.

Conclusions—STIRR appears to be efficacious in providing a basic, best practice package of interventions for dually diagnosed clients.
WHAT IS STIRR?

• Evidence based practice
• Provides HIV & HCV Screening and Testing, Immunization and Risk Reduction Counseling

CDC RECOMMENDATIONS

• HIV screening for all persons aged 13-64 in all health care settings in the United States
• HCV testing for all people in 1945-1965 age group and/or engage in IDU
• Vaccination with HBV and HAV for those who engage in unsafe sex or risky drug use

http://www.cdc.gov/knowmorehepatitis/
WHAT IS STIRR?

• Evidence based practice
• Provides Screening, Immunization and Risk Reduction Counseling
• Targets people with Serious Mental Illness (SMI)

WHY THOSE WITH SMI?

• They may be at Higher Risk:

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>PREVALENCE AMONG THOSE WITH SMI</th>
<th>PREVALENCE IN THE GENERAL POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>1-23%</td>
<td>0.03%</td>
</tr>
<tr>
<td>HCV</td>
<td>8.5-30%</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

Himelhoch et al., Psychiatric Services, 2007; Psychosomatics, 2009
THIS IS CRITICAL...

CDC.gov
WHAT IS STIRR?

• Evidence based practice
• Provides Screening, Immunization and Risk Reduction Counseling
• Targets people with Serious Mental Illness (SMI)
• Occurs in Behavior Health Centers

WHY BEHAVIORAL HEALTH CENTERS?

• Less than ½ people at risk for HIV and HCV with SMI receive testing
• Reliance on mental health system to provide medical care
• Maximize efficiency to ensure people get into early treatment
• Allow for co-location of treatment
WHY BALTIMORE?

http://www.insidethehuddle.tv/articles/traveler-baltimore-md-home-ravens
MARYLAND

[Map showing HIV diagnosis rates by jurisdiction in Maryland, with Baltimore highlighted.]

http://phpa.dhmh.maryland.gov
RISK FOR HIV AND HCV

• Study of 153 people with SMI receiving mental health services in Baltimore, Maryland
  • ~25% reported history of IDU
    • 92% reported sharing needles
  • 83% reported history of unprotected sex
    • ~30 reported unprotected sex in last 6 months
  • ~20% reported MSM history

Himelhoch et al., J Community Psychol 2011
CLINIC DEMOGRAPHICS

• Over 80% self-identify as African-American.
• Average age is 53 years (range: 18-69 years)
• Half are women
• Over 70% diagnosed with SMI
• Vast majority with history of substance use
STIRR IT-TEAM

• NURSE
  • Delivers STIRR-IT intervention

• PEER NAVIGATOR
  • Assists nurse and provides additional support

• NURSE PRACTITIONER
  • Provides on-site access for treatment and referral

• CONSULTANTS
  • ID and Psychiatry
STIRR-IT DELIVERY MODEL

• Integrated staff
• Accessible office near waiting room
• Blood drawing facilities on-site
• Vaccines stored and delivered on-site
• Connected to Electronic Medical Record
  • Accessible notes and results of testing
    - Active care partnerships exist throughout the University medical center complex
STIRR IT Summary
Screen, Test, Vaccinate, Reduce Risk and Ref for Later Integrated Treatment

- Education about Hepatitis and HIV
- Testing for Hepatitis and HIV
- Vaccination for Hepatitis A & B (Twinrix)
- Discussing risk factors for getting Hepatitis and HIV
- Discussing ways to lower risk of contracting Hepatitis and HIV
- If positive, access to services needed
- Evaluation of the project (research interviews)

<table>
<thead>
<tr>
<th>Research Visit 1</th>
<th>Intro Consent Baseline ($25 Gift Card)</th>
<th>Clinical Visit 1</th>
<th>Overview of Project Education of HEP &amp; HIV Blood draw</th>
<th>Visit Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Clinical Visit 2</td>
<td>Blood Results Review of Risk Factors Twinrix #1 or HEP A #1</td>
<td>Today</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical Visit 3</td>
<td>Review of Risk Factors Twinrix #2</td>
<td>1 week later</td>
</tr>
<tr>
<td>Research Visit 2</td>
<td>Re-Assessment ($25 Gift Card)</td>
<td>Clinical Visit 4</td>
<td>Review of Risk Factors Twinrix #3 or HEP A #2</td>
<td>1 month later</td>
</tr>
<tr>
<td>Research Visit 3</td>
<td>Discharge ($25 Gift Card)</td>
<td></td>
<td></td>
<td>6 months later</td>
</tr>
</tbody>
</table>

SCHEDULE MAY CHANGE DUE TO MISSED APPOINTMENTS

Have questions or concerns?
Please contact Rachel or Joseph at the STIRR IT clinic
STIRR-IT—RESULTS TO DATE

http://www.insidethehuddle.tv/articles/traveler-baltimore-md-home-ravens
DEMOGRAPHICS

<table>
<thead>
<tr>
<th>CHARACTERISTICS</th>
<th>PARTICIPANTS (N=121)</th>
<th>OVERALL CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td>50 YEARS</td>
<td>53 YEARS</td>
</tr>
<tr>
<td>AFRICAN-AMERICAN</td>
<td>96%</td>
<td>80%</td>
</tr>
<tr>
<td>FEMALE</td>
<td>39%</td>
<td>50%</td>
</tr>
<tr>
<td>HIGH SCHOOL</td>
<td>55%</td>
<td>50%</td>
</tr>
<tr>
<td>SMI DIAGNOSIS</td>
<td>100%</td>
<td>70%</td>
</tr>
</tbody>
</table>
OUTCOMES

• Successfully implemented model

• Process Measures:
  • 121 began receipt of STIRR services
  • 84 completed STIRR services to date
  • 54/110 (50%) received immunization
    • (21= already had immunity)

• Outcome Measures:
  • 30 HCV positive (25%)
  • 7 HIV positive (6%)
  • 100% referred to care
QUESTIONS?
Managing Co-Occurring Disorders in a SAMHSA CoC – The Fuse Project
Atlanta, GA
Moneta Sinclair, EdD, LPC, MAC
Clinical Director, Addiction Services
Program Director, FUSE
Merging of Two Phenomenal Agencies
March 1, 2015

**Positive Impact, Inc.**
Founded 1993 in Atlanta to provide MH services for people affected by HIV

By 2015, each year the agency provided:
- HIV prevention services and HIV/STI testing to over 4,000
- IMPACT, licensed substance abuse treatment program, to 75
- Behavioral Health services in 4 HIV primary care settings
- Comprehensive behavioral health services (individual, couples, group & psychiatry) to 600
- Training 250 behavioral health professionals

**AID Gwinnett/Ric Crawford Clinic**
Founded in 1990 to provide HIV care to PLWHA in North Metro-Atlanta

By 2015, each year the agency provided:
- HIV prevention services and HIV/STI testing to over 1500
- HIV Specialty Care to 800 in two locations
- Case management and patient advocacy to all patients
- Wrap around services including transportation and housing support
SAMHSA Continuum of Care Pilot:

FUSE
Facilitating Unified Service Efforts

Integrating Behavioral Health, Prevention, and Primary Care
Populations of Focus

African American and Latino men and women, gay and bisexual men, transgendered individuals, and people with addictions and/or substance misuse.

Veterans and their families will also be served.
Areas of Focus

• Co-locating HIV primary care and behavioral health
• Substance abuse prevention/HIV prevention: CLEAR
• Mental health and substance abuse counseling
• Substance abuse treatment navigation services
• Substance abuse treatment: IOP, CCP, and New Beginnings
• HIV/Hepatitis testing, Hepatitis vaccination
• Wrap-around recovery support and retention
Primary Modes of Service Entry to FUSE

No Wrong Door is our mantra

- Prevention: HIV/Hep/STI testing
- Mental Health: Individual & Couples Psychotherapy and Psychiatry
- Addictions: IOP, CCP, Risk Reduction (through community outreach and local jails)
- Primary HIV care
- Linkage via Partnership with AID Atlanta SBIRT
FUSE Year Two Progress

• Prevention:
  • HIV testing: 100
  • Hepatitis C testing: 94
  • Hepatitis A&B vaccination: 36
  • CLEAR intervention: 10 completed series

• Mental health: 48

• Substance use disorder/Co-occurring disorders (COD):
  • Treatment navigation: 189
  • Outpatient drug/alcohol treatment: 56

• Peer support: 114

• Primary care: 43
The Complexity of Co-Occurring Disorders

• The link between mental health and substance abuse
  • One may contribute to the other
• HIV can exacerbate either or both disorders
  • Increased psychological distress
  • Some illicit drugs known to increase replication of virus
• Integrating treatment – disorders need to be addressed concurrently for improved health outcomes
The Case of William

• 30 year old, AA, Gay-identified male
• Presents for HIV testing, confirmed HIV positive
• Immediately screened for high-risk behavior, MH, substance use disorder (SUD), primary care needs
William in Prevention

• Association of sexual activity and drug use
• Offered enrollment in CLEAR (Choosing Life: Empowerment! Action! Results!)
  • Goal: Promoting healthy living and more productive choices
  • Skill development for living with HIV
• Referred to clinical services for HIV primary care and the treatment navigator for SUDs
William in Behavioral Health

- Registration
- Assessed for ASAM level of care needed
- Deemed appropriate for intensive outpatient treatment services - IMPACT
- Assigned SUDs counselor & certified peer specialist (CPS) to develop WRAP (Wellness Recovery Action Plan)
- Offered and received Hepatitis C testing and began A&B vaccination series; RHHT completed
William in Behavioral Health (cont’d)

• Behavioral health assessment/diagnostic interview Assessed with 10 year history of depression and chronic substance abuse – Was one of disorders first? Does it matter?

• Psychiatry

• SMART treatment plan developed to address 5 life areas – MH, SUDs, medical, legal, and CM
<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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</thead>
<tbody>
<tr>
<td>Process Group 1:00-2:30</td>
<td>Creative Process 1:00-2:00</td>
<td>Poetry Workshop 1:00-2:30</td>
<td></td>
<td>Anger Management 1:00-2:00</td>
</tr>
<tr>
<td></td>
<td>Break</td>
<td></td>
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</tr>
<tr>
<td>Seeking Safety/Yoga 2:45-3:45</td>
<td>HIV Education 2:10-3:10</td>
<td>Poetry Workshop Process 2:45-3:30</td>
<td></td>
<td>15 minute break</td>
</tr>
<tr>
<td></td>
<td>15 minute break &amp; snacks</td>
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<tr>
<td>Emotional Maturity 4:00-4:45</td>
<td>Relapse Prevention 3:15-4:30</td>
<td>Healthy Relationships 3:45 - 4:45</td>
<td>Emotional Maturity 4:00-4:45</td>
<td>12 step 2:15-3:00</td>
</tr>
<tr>
<td>Clean up 4:45-5:00</td>
<td>Clean up 4:45-5:00</td>
<td>Clean up 4:45-5:00</td>
<td>Clean up 4:45-5:00</td>
<td>Weekend Planning 3:15-3:45</td>
</tr>
<tr>
<td>Continuing Care 5:00-7:00pm</td>
<td></td>
<td>Continuing Care 5:00-7:00pm</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
William in Primary Care

• Nurse case manager assesses medical history and continually tracks appointment and medication adherence

• Blood/lab tests conducted to obtain baseline measures for HIV and medication determination

• Lab results indicate CD4 of 320, viral load of 10K

• Placed on Atripla based on his genotypes and phenotypes
William’s Outcome

• Placed in transitional housing and consistently attended IMPACT program and medical appointments
• Experienced a relapse; processed with MH/SUDs counselor and treatment plan updated addressing contributing factors. Addressed underlying MH issues that fueled SUDs
• Became employed
• Completed CLEAR and the Hepatitis vaccination series
• Completed the IMPACT program with sustained recovery within 18 months and continues MH/SUDs counseling
• HIV is undetectable with a CD4 of 700+
• He is healthy, productive, and HAPPY
• We all share in his accomplishment
QUESTIONS?
Integrating HIV and Hepatitis Care into Behavioral Healthcare

Emma Gianani-Maki, MSS, RN, CAC III
Medical Case Manager
University of Colorado at Denver, School of Medicine
Mission

To save lives and improve the quality of life for persons struggling with substance abuse and dependence, through the application of empirically supported treatments.
Project REACH

- Peer Educator Services
- Culturally Specific Education and Support Groups
- Risk Reduction Groups
- Peer Groups
- Abstinence Monitoring
- Incentives for Participation
- Infectious Disease Testing
- Hepatitis A & B Vaccination
- Tobacco Cessation
Project REACH (continued)

- EBP Substance Abuse and Cognitive Therapy Groups
- Individual Sessions
- Medication Assisted Treatment
- Primary Care with Nurse Practitioner
- Medical Case Management with RN
- Transportation Assistance
- Psychiatric Care
- Gender Response
- Trauma-Informed Care
PARTNER WITH:

Sisters of Color United for Education

- Colorado’s oldest Promotora de Salud Program
- 25 years providing prevention/testing/education
- Provides Peer curriculum, Mi Vida Su Vida, adapted from SISTA, integrated to REACH
- Houses LISTOS (Latinos Integrating Sexual Teaching Others Safe Sex)
- Integrated Peer, on-site with REACH
- Prevention/education groups and trainings for schools and the community, and events
Progress

- 128 enrolled in Project REACH
- Program is serving 28 patients who are HIV+ each month, and 5 newly positive under the project since inception
- 126 HIV tested / and five newly identified HIV+
- 126 hepatitis tested / and 30 newly identified HCV+
- Over 300 people have received rapid testing for infectious diseases since the inception of Project REACH – Estimate 10-15% HCV+ rate in the agency

*: due to inclusion of community outreach testing
Integrated Care

Mental Health
Substance Use Disorder Treatment
Medication Assisted Treatment
Primary Care
Why Integrated Care?

“….produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.”

Where is your agency on the Continuum of Integration?

- Coordinated Care
- Co-Located
- Integrated
Care Models

Coordinated Care

• Collaboration (two or more systems)
• Independent locations
• Targeted Communication
• Linkage to care
Co-Located Care

- Same or shared systems
- Close proximity or same space
- Regular communication
- Symbiotic roles
Integrated Care

- Same or shared systems
- Communication
- Collaboration
- Functions as a team
- Multi-disciplinary
Internal and External Partnerships

Local Public Health Agency and Infectious Disease Non-Profits

Primary and Dental Care

- Case Management
- ID Specialists
- Psychiatric
- Outreach

- Medical Case Management
- Primary Care
- SUD Treatment
- Holistic Services

Prevention Specialists

Holistic Services
Identify internal and external partnerships required for integrated care, including, prevention treatment

<table>
<thead>
<tr>
<th><strong>Internal Partnerships</strong> (Define, and are MOU’s necessary?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Case Management/Medical Case Management</td>
</tr>
<tr>
<td>▪ Infectious disease specialists</td>
</tr>
<tr>
<td>▪ Primary care</td>
</tr>
<tr>
<td>▪ Psychiatric</td>
</tr>
<tr>
<td>▪ SUD treatment</td>
</tr>
<tr>
<td>▪ Outreach</td>
</tr>
<tr>
<td>▪ Holistic Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>External Partnerships</strong> (Define, and are MOU’s necessary?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Organizations that provide outreach, engagement and prevention services</td>
</tr>
<tr>
<td>▪ Local Public Health Agency</td>
</tr>
<tr>
<td>▪ Primary Care Facilities</td>
</tr>
<tr>
<td>▪ Dental Care Agencies</td>
</tr>
<tr>
<td>▪ Harm Reduction Organizations</td>
</tr>
<tr>
<td>▪ Infectious Disease Non-Profits (i.e. Liver Health Connection)</td>
</tr>
<tr>
<td>▪ Holistic Services</td>
</tr>
<tr>
<td>▪ Infectious disease specialists</td>
</tr>
</tbody>
</table>
What is your vision?

"My question is: Are we making an impact?"

How do we make an impact?
Challenges

- **Funding** mechanisms
- Organizational **capacities**
- Physical **locations**
- **Differing** perceptions
- Technological **systems**
- Professional **barriers**
- Perception of **cost** and benefits
Integration Benefits

- Improved patient outcomes
- Reduction of stigmas
- Financial savings
- Greater treatment participation
Resources

SAMHSA-HRSA Center for Integrated Health Solutions

Resources (continued)

Agency for Healthcare Research and Quality
• http://integrationacademy.ahrq.gov/

Medication Assistance
• http://pharmacycard.org/
Project REACH

Emma Gianani-Maki, MSS, RN, CAC III
Medical Case Manager

Emma.Makigianani@ucdenver.edu
QUESTIONS?

Discussion!
For further information, please contact:

• Ilze Ruditis, MSW, ACSW
• CAPT, USPHS
• ilze.ruditis@samhsa.hhs.gov