FORUM ON HIV & SMI: FOSTERING A COOPERATIVE APPROACH TO ADDRESSING UNMET NEEDS, PARTS I & II
FEBRUARY 11TH & APRIL 8TH 2021
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NY Health & Human Services Planning Council | NYC DEPT OF HEALTH
Acknowledgements

This report does not represent the official position of the NYC Department of Health and Mental Hygiene or any of the participating state agencies: the New York State Department of Health, the New York State AIDS Institute, the New York State Office of Addiction Supports and the NYS Office of Mental Health. The findings presented in Part I of the forum and of this report represent the views of the NY HIV Health & Human Services Planning Council.

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Forum on HIV & SMI: Fostering a Cooperative Approach to Addressing Unmet Needs, Part I
February 11th, 2021

The Forum on HIV & SMI: Fostering a Cooperative Approach to Addressing Unmet Needs, consisted of two parts. Part I presented the findings of the Needs Assessment Committee of the NY Health & Human Services Planning Council (the Council). These findings were gathered over the previous three years, and included provider testimony, presentations from subject matter experts, an analysis of a data match between two datasets maintained by the Bureau of Mental Health in the NYC Department of Health to the NYC HIV Registry, and an analysis of Ryan White Part A participants. Part I solely represents the Council and does not represent the opinions, findings, or policy of our state partners (NYS Department of Health, NYS AIDS Institute, NYS Office of Mental Health, NYS Office of Addiction Supports) whose participation is vital to moving this work forward. Presentations from these state partners made up Part II of the forum.

Executive Summary

This forum, HIV & SMI: Fostering a Cooperative Approach to Addressing Unmet Needs, was convened to discuss how to improve care for a specific and disadvantaged population, people who have both HIV (PWH) infection and serious mental illness (SMI). For the purpose of this forum, serious mental illness referred to people with schizophrenia, bipolar disorder, and other mental illnesses with psychotic symptoms. It has been difficult to successfully bring medical services for HIV infection together with mental health services for people with serious mental illness, and we assembled with the hope of achieving a breakthrough in how to better integrate such care.

It should be noted that while mental illness is a common comorbidity of HIV infection, the purpose of this forum was to specifically shed light on people with SMI, a population that has a shortened life span, with death occurring 15 to 25 years earlier than the general population. This forum did not attempt to independently address some of the most common behavioral health problems seen in people with HIV, such as depressive disorders, anxiety disorders, stress disorders (including PTSD), and substance use disorders.

People with serious mental illness have many medical and psychiatric comorbidities, including some of the common behavioral health problems just noted. As such, they are a very complex population to treat. Of note, unlike many of the other medical comorbidities found in people with serious mental illness, HIV is transmissible, so achieving success with the diagnosis and treatment of HIV infection in this population must be part of our efforts to end the HIV epidemic.

Work over the past three years by the Needs Assessment Committee of the Planning Council preceded this forum. The Council gathered data on people with HIV and SMI. Studies show that people with mental health conditions and HIV have worse health outcomes than people with HIV overall. People with SMI have a significantly higher prevalence of HIV: 4-10 times higher than
those in the general population.\(^1\) People with HIV and SMI experience inequitable morbidity and mortality outcomes compared to people with HIV overall.

In New York City, among RWPA clients who received a service in Grant Year 2018 (March 1, 2018, to February 28, 2019) and had ever received a mental health assessment, 26% reported diagnoses of bipolar disorder or schizophrenia.\(^2\) These clients have significantly lower rates of viral suppression than PWH overall. Achieving viral load suppression reflects receipt of optimal treatment, improves health outcomes, and prevents transmission of HIV. In a 2020 retrospective data analysis matching people from the New York City HIV registry with two New York City Department of Health and Mental Hygiene datasets of people with SMI, 58% of people with HIV and SMI were virally suppressed compared to 83% of those who were not known to NYC Health Department as having a SMI and may be indicative of a disparity in care.\(^3\)

The forum brought together key stakeholders from across state government. Representatives from New York State’s Department of Health (DOH), Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS) and the AIDS Institute attended. Providing coordinated and integrated care for PWH and SMI requires coordination among the state’s agencies to address a number of barriers. After the presentation of the Needs Assessment Committee’s findings, stakeholders discussed key areas where processes are being adapted to support a more coordinated and integrated approach to HIV and SMI care.

Some especially promising areas include the will to establish of clearer picture of the data we have on people with HIV and SMI, and an analysis of available data by forging data agreements that gather metrics on testing, treatment, engagement, retention, viral suppression and health outcomes (HIV and co-morbidities); an impetus to coordinate and expand the roles of peers, or people with lived experience in facilitating supportive interventions and care, as well as integration for paths to certification; the integration and lowering of thresholds for licensures, particularly for smaller, community-based organizations and clinics; and a focus on dismantling stigma and decreasing criminalization through the expansion of appropriate mental health support and interventions for people in crisis.

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\(^3\) Khosa, Perminder (2020, Jul.). Persons with Serious Mental Illness Referred to Select Bureau of Mental Health Services and Matched to Persons with HIV. Presentation to the Needs Assessment Committee of the HIV Health and Human Services Planning Council of New York.
Stigma

Stigma affects every aspect of care for PWH, especially among populations whose quality of care and experience with stigma is impacted by intersecting identities and inequities.

• In accordance with NYS’s ETE blueprint, surveys were conducted by healthcare organizations providing HIV services in NY to measure levels of HIV-related and key population-related stigma among staff. Findings from 12 participating sites show:
  o Out of six key populations, staff reported highest enacted stigma toward people living with a mental health diagnosis (PLMHD), 2-3 times that of trans individuals
  o Almost 1 in 5 staff reported a lack of comfort working with PLMHD (18%)
  o 36% of staff had not received training on stigma related to HIV or key populations and 17% were not aware of facility policies against discrimination
• Stigma-reduction strategies must:
  o Address intersectionality and be included in all levels of programming
  o Improve visibility of mental health among providers and PWH to counteract misinformation and contradict negative attitudes and beliefs
  o Bolster contact and peer support networks for PWH to facilitate improved access to behavioral health services
• PLMHD prefer approaches that address institutional and structural discrimination over public education
• Addressing structural stigma, especially through legal and policy interventions to protect stigmatized groups, promotes physical and mental wellbeing

Relevant Discussion
• People with SMI experience particularly severe stigma and often do not receive medical care that is comparable to the general population
• Providing access to appropriate and comprehensive care reduces stigma
• Criminalization of mental health is a significant issue
• How do we change the way we respond to individuals with severe mental illness who need assistance when in crisis?
  o Models that are a mental health intervention instead of a public safety intervention

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4 Ahmed, C. et al. Measuring and Addressing Stigma in Healthcare Settings: Key Findings from Staff Survey Results and Steps Taken
5 Recommended reading: Lisa Bowleg’s May 21, 2020 webinar on intersectionality
6 For further reading on approaches to reducing stigma
Data

Coordinate data toward the development of a care continuum cascade for PWH with SMI to identify gaps in service and to target resources.

The Council seeks collaboration to:

- Designate PWH with SMI as a priority population for inclusion on the NYS public facing data dashboard\(^7\) to track the following measures:
  - Rates of HIV testing among people with SMI in OMH operated and/or licensed facilities
  - An HIV care continuum among PWH with SMI on rates of engagement in care, retention in care & viral suppression
  - Care sites where people with SMI are accessing HIV care to strengthen linkage, coordination, and additional support
  - Identified reportable HIV indicators for Health Homes

- Assess and build up the capacity of care centers, including psychiatric hospitals, for people with SMI to administer, support & measure:
  - HIV testing
  - HIV treatment access
  - PrEP/PEP access & support
- Implement systems-wide utilization of SHIN-NY, RHIOs and/or PSYCKES data to identify, engage and support clients lost to care
- Assess cost and client benefit for developing a state and city-wide integrated electronic medical record system (inclusive of funders and physical and mental health) to facilitate the coordination of care among people with HIV who receive funded services.
- Conduct recurring Medicaid matches (possibly utilizing the available Medicaid warehouse in the DOHMH Bureau of Mental Health) to:
  - Harness additional funding to support matching clients who have indicative behavioral health encounters against the HIV registry to identify PWH with SMI to ensure enhanced coordination of care
- Conduct recurring matches of Health and Recovery Plans (HARP) recipients and applicants to both the NYC and NYS HIV Registry to identify clients that would benefit from:
  - Supportive navigation
  - ART access
  - Housing support

Relevant Discussion

- What is the housing status for people with HIV and SMI? Broken down by borough?
- For hospital-based (psych and general) diagnoses of HIV among people with SMI, did the HIV diagnosis occur during a client’s first crisis or after multiple crises?
- Were clients younger or older upon initial HIV diagnosis? Psychotic breaks among people with schizophrenia frequently occur around ages 20-25.
- People with SMI are more likely to be diagnosed for HIV once they are in the medical system
- Is the HIV Registry matched with Medicaid to better understand service utilization?
- Medicaid data is not in the HIV Registry
- Data sharing agreements with state for specific projects do exist, but none focusing on SMI

• People with SMI tend to migrate out of OMH system to get their HIV care – in very early days of HIV epidemic – many people left OMH system and were able to receive funded HIV hospice and end of life care.
• More information about access to HIV care in the OMH system would paint a clearer picture of this population

Testing/Prevention

Data from a small match conducted between the NYC HIV Registry with two Bureau of Mental Health datasets, SPOA (Single Point of Access) and AOT (Assisted Outpatient Treatment), illustrate the need to diagnose HIV earlier, as later stages of HIV disease progression are associated with poorer health outcomes.

• Expand the implementation of an HIV status neutral approach to prevention and treatment as part of a larger intervention to address stigma around SMI
• PrEP and PEP protocol implementation, including education, training and navigation should be built out at all OMH licensed/operated inpatient and outpatient mental health sites and programs, to ensure access to timely referrals
• Build strategic partnerships to enhance capacity and establish routine HIV testing at sites where people with SMI regularly access care
• Implement CDC guidance for HIV testing in OMH inpatient units & clinic settings
• Adapt the STIRR model to routinize opt-out HIV testing, during annual medical assessments for all clients that access outpatient mental health programs
• Require enhanced capacity of mental health providers and institutions, including in-patient sites, to support HIV medication access and adherence among clients
• Improve capacity among Behavioral Health providers to conduct referrals to HIV prevention and care services.
• Facilitate seamless coordination of care between behavioral and physical health.

Engagement & Navigation

Clients with serious disorders and/or psychosis are more vulnerable to becoming lost to care or experiencing gaps in treatment. Coordinating and integrating care can support better health outcomes for all clients.

• Fund support for increased communication and collaboration between HIV and Behavioral Health funders and programs in NYC to maximize EHE/ETE efforts
• Develop dependable referral and coordination of care relationships with primary care providers
• Expand availability of low threshold services to facilitate client readiness for treatment: walk-in, late & weekend hours, etc.
• Strengthen linkages & availability of readily available psychiatric care
• Simplify referrals for inpatient and outpatient psychiatric services
• Address barriers to engagement in HARP & Home & Community Based Services (HCBS) programs for PWH with SMI

8 https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(20)30273-3/fulltext
Findings from the Forum on HIV & SMI: Fostering a Cooperative Approach to Addressing Unmet Needs
A Report by the Needs Assessment Committee of the NY HIV Health & Human Services Planning Council

- Expand access to Modified Directly Observed Therapy (MDOT) for HIV, HCV, and psychiatric medications
- Improve capacity of Community Based Organizations (CBOs) to identify and manage people with HIV who may have SMI:
- Develop best practices to inform agency specific crisis action plans
- Streamline & accelerate access to additional support services, i.e., HARP, AOT, inpatient stays and other appropriate interventions, support and referrals
- Build effective referral pathways, guidance, and capacity to ensure people with HIV and SMI can access needed care from the full range of OMH operated and/or funded programs
- Reduce staff turnover to strengthen client trust and engagement

Relevant Discussion
- People with SMI have a right to housing - but are unaware. Have met homeless people with SMI who have no idea they can qualify for housing - this info should be more accessible, as should points of service/access to social workers.
- NYNY1 provides housing for people with SMI. My experience with clients with SMI who are not on meds and may be unstable - will often become lost to care. May do well on ART but won’t take psych meds.
- Clients are afraid of disclosing to case managers that they have had a substance use relapse – afraid they will lose their housing.
- Technology deserts and limited income – people do not have the technology to access some of the services that have come online, particularly since the pandemic began.
- Need to review rules and penalties imposed around housing considering the exacerbation of substance use during the pandemic
- Housing unit staff are not trained in harm reduction – not necessarily prepared to meet clients where they are, particularly if the client is actively using substances. When providers are not based in a harm reduction approach, clients may feel they will be penalized for disclosing their substance use.

Service Integration

Research shows that integrated mental health care can increase HIV treatment access and improve overall health outcomes.

- Implement programs that improve viral load suppression for PWH with SMI and can be expanded with proof of concept. Examples include:
  - Psychiatrists that train medical providers on how to prescribe psychotropic medicine, currently used to help alleviate cost and create access in rural areas.
  - Establishment of a NYC and NYS ombudsman for serious mental illness, who can facilitate and address clients’ crisis issues immediately
  - Focus on resources for psycho-social rehab and assistance to navigate interpersonal relationships - how to live your best life with serious mental illness

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• Fund increased access to behavioral health providers who are linguistically competent and support culturally safely
• Incentivize the inclusion of community health workers, ideally peers with lived experience
• Coordinate and incentivize a dual/triple peer certification program among NYS AIDS Institute, NYS OASAS and NYS OMH
• Promote pathways to full time positions for peer community health workers
• Create a tax or payment structure for peer community health workers that ensures maintenance of benefits, financial stability, and appropriate remuneration
• Coordinate and integrate physical and mental health treatment plans and ensure access by all providers, including support services
• Pilot development of internal care coordination dashboards that highlight clients’ care status through medication prescriptions, ART access/adherence, and viral load measures
• Further integrate and coordinate care between behavioral health, including substance use, and HIV care, through single site access for all services

Relevant Discussion
• High functioning peers can help facilitate a safety net in programming.
• Hard for people with SMI to engage through the current technological means
• Peers have been seen to provide the most effective impact
• Really necessary to have all relevant state and city agencies here to ensure coordinated care for people with SMI
• OMH licenses facilities, especially ambulatory ones – providers have had to maintain in-person capacity because we know that clients may not have the capacity to receive services over telehealth. OMH wants to know when that isn’t happening – providers should make deliberate and deliberative assessment of who needs to be seen in person. Especially for folks who need services like injectables, or labs drawn – and OMH needs to hear when providers are not maintaining that capacity.

Intervention

Clients in need of psychiatric hospital stays rarely receive support for HIV care or ART access/adherence. Capacity building and funding to support the maintenance/re-introduction of ART during psychiatric inpatient care and throughout systems of emergency care could strengthen engagement.

• Primary care HIV providers should receive communication from psychiatric hospitals when clients are admitted as a routine process
• Continuity of HIV care should be part of every discharge plan
• Prioritize and improve supportive housing access for PWH with SMI by streamlining access through a client centered process

Relevant Discussion

• In 2016, won a terrific victory toward ending the HIV epidemic – every person who is income eligible (and eligible for public services) has a right to housing – nothing comparable in mental health – often leaves people trapped in the shelter system. A dual diagnosis can get someone housed through HASA, but people with mental health conditions are left in desperate straits.
• ACT teams showed up 12 hours after the incident – everyone says that another entity is responsible for stabilizing this person who lives in a congregate facility with me.
• People cannot travel with all of their medication
• When thinking about someone in a psych facility – they cannot reach people on the outside

Re-engagement in Care

• Designate people with HIV and SMI with unsuppressed viral loads as a priority population for outreach services that re-connect clients to care based on missed/high viral loads and missed prescription refills.
• Coordinate existing behavioral health programs throughout NYS and NYC, i.e., NYC HRA, Comprehensive Psychiatric Emergency Programs (CPEP), Day Treatment, ACT Teams (multiple institutions operate ACT teams funded by DOHMH and OMH to facilitate client support)

Relevant Discussion

• People frequently use libraries to stay connected because they do not have cell phone minutes
• Prior to COVID, people with SMI would attend our support groups – but this isn’t a way to connect people to care during the pandemic. Secured smart phones for clients – showed them how to use the phones – but frequently, clients lose their phones. Had to find innovative ways to keep clients safe and still deliver services
Planning Next Steps

To move these findings forward, assistance and support is needed from all stakeholders in attendance: the NYS Office of Mental Health, Office of Addiction Support, AIDS Institute and Department of Health. These agencies are critical partners in the development of strategies that appropriately identify and support PWH with SMI.

Relevant Discussion

- How do we change the way we respond to individuals who need assistance when in crisis?
- Models that are a mental health intervention instead of a public safety intervention
- Need more resources around housing, but do have resources in other areas, such as food and support
- Trauma informed care - this philosophy should saturate our services – helps individuals feel safe and supported
- Persistent mental health challenges without adequate support for lacking social determinants of health
- Engage and employ peers to facilitate programs – high functioning peers can act as a safety net.
- Preparing agencies and programs to deliver services/navigate/manage people with SMI
- Accessible site maps for navigating clients to SMI care
- Criminalization of mental health is a substantial issue*
- COVID – multiplied needs and challenges around access- How do we increase access? Can we streamline access and transform how we help people move through crisis?
- Looking at models – expansion of trauma informed care grounded in trauma informed supervision.
- Include and enhance presence of persons with lived experience
- Peer certification advocacy for people with HIV, STI care and for PrEP – have not yet developed programs to try to train peers with SMI. In thinking of transformation of policing – this is an employment opportunity and way to develop societal holistic care. Peers have been shown to be highly effective – have not used that lived expertise for people with SMI -
- How do you engage people with SMI with high system utilization and challenges engaging in ambulatory care? For past 2 years – performance opportunity program with Medicaid Managed Care – including HIV SNPs. With persons who have been flagged – implementing a critical time intervention, care managers can intensively engage with individuals to access whatever services they need – can we provide some HIV navigation around this? Prevention/treatment? Hopeful we will see some of these high utilizers get connected to ambulatory care… (CAN WE GET MORE INFO)
- For PEP/PrEP Carve in of the pharmacy program into Medicaid FFS – should look through proposed formulary to ensure all ARVs are included in preferred drug program – to ensure physicians can avoid a complicated pre-authorization process
- Community based non- state operated, non-hospital clinic system the PSYCKES bureau is launching a continuous quality improvement program – specific focus on social determinants… PSYCKES must play a critical role in a preventive and supportive system. Voluntary clinic participation.
• Started many people on ARVs when they were admitted into psych service. Integrating the system – could only find that clients were on ART by checking the PSYCKES system – the DOHMH should make it the standard of care that anyone entering an ER who is on Medicaid has their PSYCKE profile pulled – we encourage this among our partners to ensure ART is continued
• Must look at Medicaid warehouse data – how often are HIV diagnosis included in claims – of those folks – are these being captured in BH settings? That’s an easy question to answer with looking at the data -when are people on or off ARTs
• Critical information on clients must be accessible across systems
• How often are MH settings including an HIV diagnosis in their settings – do we know?
• Need to take a deeper dive to understand the full picture.
• Housing is primary to ensure adherence and stability for clients. Housing must be a priority – safety first then address conditions – from personal experience, know that housing first facilitates all other stability needed to live your best life
• None of the critical medical information is connected across facilities – people with SMI are often transient – need more coordination to access supportive care and not get lost
• Medicaid is undergoing changes that are in line with the forum. Office of Health Insurance Programs (OHIP) have done a few webinars
• Current waiver pending with the federal govt – next waiver priorities are value-based payment and social determinants of health. Waiting on current budget to see integrated licensure and recognition of having more programs go forward in an integrated fashion. Integration of OMH and OASAS – merits of having programs go forward in an integrated fashion
• Grant funded peer certification – HIV, HCV, and Harm Reduction tracks - tried to model OASYS. barriers: everything proposed to the feds must have a budget neutrality component.
• In Medicaid – advised to work with DSRIP (which ended last year, state re-applying, previously declined by Trump admin). Previously, peers did a lot of navigation. – NY Presbyterian had peers in the ER. Had a lot of demo experience – at end OHIP wanted to know what best practices can be made permanent – see a lot of possibility – re-engage concept of peer delivery – either through best practices in last DSRIP, or now that more integrated avenues are taking place- could we have essential peer certification coded into the agencies – existing structure is not interdisciplinary but initial steps are being taken to move in that direction.
• Licensure – seen challenges with integration on the article 28 side, and the loading in of low threshold primary care services – challenge Dept is wrestling with- trying to make such licensure more accessible for smaller providers – attempt to lower threshold of requirements is still challenging for the smaller providers, especially when looking at article 32s.
• Peers are instrumental – creating a new track 4 mental health – and opening up tracks for peer certification. Some trainings that are required across different peer services – trying to figure out how to certify peers across multiple fronts – i.e., take cultural core for SERPA, for peer certification – can streamline this to facilitate certification. Having preliminary convos on how to help peers get certified in multiple areas, like agencies and hospitals. If you have to take a core course for multiple certifications – idea is to take the course and allow it to count against multiple certificates.
• Multiple entities would need to be part of a data matching program to get a better picture of how PWH with SMI are faring – will follow up with Joseph Kerwin – include surveillance and state access to the Medicaid data warehouse. Bring some more people to the table - including people at Al. [Key to include Tri-County area]
• Unknown if systematic testing for HIV is happening in OMH licensed and operated programs
• Many types of OMH programs – no standard HIV policy that cuts across all programs – clinic program, expectation that on admission, a thorough health assessment will be conducted – within that we provide different guidance. Every program has a different standard of care. In clinic programs, there is an expectation that there will be a comprehensive standard of care.

• Are people in OMH operated and licensed facilities being tested for HIV/is access to HIV meds facilitated?

• Where can we insert an HIV protocol into OMH services?

• Still see significant gaps

• Dr. Manseau was instrumental in facilitating the survey

• Directors of state licensed OMH program understand a portion of their clientele do have HIV or may need PrEP –

• In OASAS - can apply to OMH over time. OASAS require testing for HIV and HCV – can be incorporated into OMH – should be flagged for inclusion -as we plan for the merger – creates some complications around CONSENT. Many people are being treated involuntarily – question ability to have capacity to give consent. Both systems have limited treatment capacity – OASYS is working on that – includes resource limitations and workforce issues – even if a program cannot directly treat - Linkage or referral could be included in guidance from a state agency

• Many people are being treated involuntarily – question of capacity to give consent – but these can be managed with guidance. Linking to treatment is the tricky part – both systems have limited treatment capacity. OASAS is working on this. Resource limitations and workforce issues – but can provide linkages

• There was an HIV policy in OMH, required HIV assessment/testing but a lack of capacity to implement. HIV assessment should be done in outpatient programs – but law did not apply to outpatient only inpatient programs

• People with SMI – have no more or less capacity to consent to medical treatment than anyone else – shocking how little capacity average people have – very low threshold to consent to something that is not invasive.

• In different regulations for different programs – generally more vague than realized – given guidance and recommendations… OMH is happy to engage in a conversation about how to enhance the capacity of the system to address HIV and co-occurring disorders i.e. substance use – and can set guidance and standards of care – testing and point of access is important – but there are barriers - many clinics lack clinicians on a full time basis, many don’t have nurses – it is necessary to think about these things.

• Given that people with SMI die 15-25 years earlier than general population the lack of integrating medical care into the treatment for people with SMI is a call to action. Death is an important issue in HIV and SMI. Lack of adequate medical care contributes to the premature death rate.
Forum on HIV & SMI: Fostering a Cooperative Approach to Addressing Unmet Needs, Part II
April 8th, 2021

For Part II of the forum, the NYS AIDS Institute, the NYS Office of Addiction Services & Supports and the NYS Office of Mental Health presented on work that can be leveraged to improve care for PWH with SMI. Below are summaries of each presentation and the relevant discussion that followed.

NYS AIDS Institute (AI): Understanding PWH and SMI in NYS
Johanne Morne, Director
Joseph Kerwin, Deputy Director of Medical Policy and Health Care Financing

- Article 28 Licensure for Primary Care
- HIV/SMI Data
- Support for addressing Social Determinants of Health
- AIDS Institute plans for promoting peer certification requirements across state agency programs (OMH, OASAS, DOH)
- Next steps

A key barrier to integrating care revolves around regulatory hurdles.

Health Care Facilities Licensure: Siloed approach to facility licensure. DOH, OMH and OASAS all have policies for licensing facilities.

Certificate of Need (CON process): New York's Certificate of Need (CON) process governs establishment, construction, renovation, and major medical equipment acquisitions of health care facilities, such as hospitals, nursing homes, home care agencies, and diagnostic and treatment centers. Under NYS Public Health Law health care facilities must be approved through this review process.

This allows the state to dictate standards of care, quality standards and the ways providers are reimbursed for providing care.

Article 28 refers to hospitals - broad term – includes nursing homes, birth centers, etc.

CON Process is arduous – very intense, heavy administrative burden that requires significant fiscal and personnel resources that is managed by the NYSDOH Office of Primary Care and Hospital Systems Management. Completed applications are submitted to the Public Health and Health Planning Council (PHHPC)\(^\text{13}\). PHHPC submits recommendations to the NYSDOH

\(^\text{13}\)https://www.health.ny.gov/facilities/public_health_and_health_planning_council/background.htm The PHHPC consists of the Commissioner of Health and 24 members. Membership on the Council is required to reflect the diversity of the State's population, including the State's various
Commissioner. The AI staff serve as subject matter experts for the CON process where care of PWH is included. The AI is only engaged in this process by invitation – but is required to track all PWH who are impacted by these systems. i.e., if an organization is creating a new clinic, or closing a clinic, or as facilities change, AI is charged with tracking every patient impacted by those changes.

**Classifications of Primary Care Clinics**\(^\text{14,15}\): General Diagnostic and Treatment Center (D&TC) (Level 3): Diagnostic and treatment centers are a medical facility as defined in 10 NYCRR section 751.1 or an extension clinic as defined in 10 NYCRR 401.1(g).

Limited Care Clinics (Level 2): Limited Care Clinics provide physical health services and may be in combination with behavioral health and/or dental services. Maximum of 6 rooms in total, and the combination of room types cannot exceed 3 physical examination rooms, 3 dental examination rooms, and/or 3 consultation rooms.

Accessory Care Clinic (Level 1): Accessory Care Clinics are meant to supplement an existing behavioral health clinic (Article 31), substance abuse clinic (Article 32), or otherwise be incidental to the main occupancy use of the facility. Accessory Care Clinics are limited to a maximum of 3 rooms in total, and total rooms may be in any combination of physical examination rooms and/or dental examination rooms.

Through the first DSRIP process the question of crossing over various licensures with facilities that provide multi-purpose types of care looked at mixing primary care, behavioral health, substance use services and dentistry. In 2019, the DOH tried to streamline the process to provide different kinds of licensure. The accessory care clinic is relevant to co-existing behavioral health and/or substance. The process is not simple and is also governed by federal regulations.

**HIV/SMI Data:** Relevant data sources for this population include the AIDS Institute Reporting Systems (AIRS), NYS HIV Surveillance Registry, NYS Medicaid Data Warehouse (MDW) – all of which are very well protected by laws and statutes that ensure patient privacy. MDW is well regulated and protected. The AI is an end user of the MDW. The data use agreement\(^\text{16}\), held between the AI and the Office of Health Insurance Programs, which defines how AI can use this data, allow the AI to track and monitor HIV services and care among the Medicaid population. Currently, through the office of Health Care Financing and Analytics (HCFA), AI runs an algorithm against the Medicaid data to capture members likely to be positive for HIV. These individuals are then matched against the NYS HIV Surveillance Registry. This process occurs twice a year due to geographic areas and population densities. The members must include representatives of the public health system, health care providers that comprise the state's health care delivery system, and individuals with expertise in the clinical and administrative aspects of health care delivery, in issues affecting health care consumers, health planning, health care financing and reimbursement, in health care regulation and compliance, and in public health practice.


\(^\text{15}\) Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) Parts 711, 712, 713, 715 and 716 set forth the architectural, engineering, equipment and construction and other physical environment standards for all health facilities subject to Department of Health oversight pursuant to Public Health Law (PHL) Article 28. Licensed primary care clinics, particularly those in underserved communities, that seek to provide primary care services or other services in the same facility, such as behavioral health, and/or dental services, are often challenged to meet the physical environment standards. The following guidelines establish different classification categories that are designed to provide direction, allowed within our regulations, related to minimum physical environment standards for specific classifications of Article 28 primary care clinic operators (Level 1 and 2) because of their limited size and scope. The purpose of these guidelines is to promote access to primary care services.

to the heavy lift incurred. The yield does not change significantly enough to justify a higher frequency.

**NYS AI Questions:**

- Define which health outcomes for PWH with SMI: Beyond viral load suppression and what other clinical outcomes, i.e., stage of infection at diagnoses, concurrent diagnoses of HIV/AIDS, common sites for diagnoses, mortality data.
- How can the AIDS Institute facilitate timely support for addressing the social determinants of health among PWH with SMI? Social determinants of health are a current focus of the AI.
- Can the AI develop metrics regarding the care and health outcomes of PWH with SMI to be included on the ETE dashboard?
- What are the AI plans to consolidate/coordinate peer certification requirements across OMH, OASAS and AI so that peers can draw upon a variety of experiences and training to address the needs of PWH with SMI?
- Peers have long been centered in the work of the AI – looking for a generalist model of peer delivered services but that does not always align with the way Medicaid nationally looks at community health workers. The AI continues to look at how to support peers in the work.
- Continue to support leadership development toward peer employment opportunities for PWH with SMI.
- Can the AI present on findings toward the possibility of the state providing paths to full employment for people with lived experience with HIV and SMI that balance income and benefits, especially housing?

**Discussion:**

1. *Is part of the challenge in having a unique identifier for clients – is that something the state would consider?*

   *All Payer Database*\(^{17}\) is a player in how we match data. **Discussions on a unique identifier have not come up but should involve Wendy Levy and John Fuller. There is a question of what a mega-match across all AI datasets would look like, and be facilitated, but touching the MDW in a way that is not in line with the data use agreement requires NYS DOH counsel and for OHIP to sign off.**

2. *Does aligning AI peer education with the national Medicaid requirement require a Medicaid waiver?*

   *Waiting to see what happens with the new DSRIP application – to see if that’s the best way to address it, or if it needs a state amendment. Three of the harm reduction services available through Medicaid are peer delivered services – despite the administrative burden and low reimbursement rates.*
   
   *The confidentiality of data is protected by laws and regulations which also act as hurdles to the kind of care integration that would be a gold standard in another sense.*

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\(^{17}\) [https://www.health.ny.gov/technology/all_payer_database/](https://www.health.ny.gov/technology/all_payer_database/) The APD will house data from public and private insurance payers, including insurance carriers, health plans, third-party administrators, and pharmacy benefit managers, as well as Medicaid and Medicare. Eventually, the APD will add other health related data that includes functional assessments, surveys, public health registries, social determinants of health, and clinical data from electronic health records.
NYS Office of Addiction Services & Supports (OASAS)
Carmelita Cruz, Esq., Senior Attorney
Belinda Greenfield, Bureau Director of Adult Treatment Services
Vinnie Chesimard, Lead on Early Intervention Services
Kelly Ramsey, MD Associate Chief of Addiction Services

OASAS Regulatory Framework for HIV
Certification of OASAS programs is pursuant to Article 32 of the Mental Hygiene Law, which covers all OASAS programs: outpatient, residential, detox, and inpatient. OASAS (and OMH) also has a public advisory body, the Behavioral Health Services Advisory Council\(^{18}\), which reviews and comments on applications for certification and makes recommendations to the Commissioner. This body shares some physician with the Public Health and Health Planning Council (PHHPC).

OASAS worked with Healthix\(^{19}\) and the Staten Island Performing Provider System (PPS)\(^{20}\) to develop a consent form in line with 42-CFR Part 2\(^{21}\). Substance use treatment records are subject to HIPPA and 42-CFR Part 2, which have very stringent confidentiality guidelines. The federal government has looked at aligning 42-CFR Part 2 more closely with HIPPA. We do have a consent form that is available – possibly TRS 64 (Authorization for Access to Patient Information through a Health Information Exchange Organization).

*Does this allow more sharing of information?*

Part 807 governs responsibilities regarding HIV/AIDS in OASAS is applicable to all OASAS certified programs. It contains the universal requirements for all programs, including written policies and procedures for: HIV prevention, education, testing, counseling, confidentiality, staff access to confidential HIV information, etc. Testing in OASAS moved from doing a screening to recommend an HIV test to just offering an HIV test, as part of the End the Epidemic blueprint work. Programs are mandated to offer testing and have linkages to community-based organizations for linkage to care or referral to testing. Non-discrimination policies prevent denying service to anyone based on their HIV status.\(^{22}\)

Confidentiality and non-discrimination are also included in individual programmatic regulations.

**Requirements Under the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant\(^{23}\)**

Federal funding that comes to OASAS for additional treatment in NYS. Long standing requirements to target specific populations and service areas; to ensure access to specific populations including pregnant women, IV drug users. Requires early intervention services for HIV including pre/post-test counseling and testing.

\(^{18}\) [https://omh.ny.gov/omhweb/bh_services_council/](https://omh.ny.gov/omhweb/bh_services_council/)
\(^{19}\) [https://healthix.org](https://healthix.org) Healthix is the largest public Health Information Exchange (HIE) in the nation, serving New York City and Long Island. We collect data from more than 8,000 Healthcare Facilities for over 20 million patients.
\(^{20}\) [https://www.statenislandpps.org](https://www.statenislandpps.org)
\(^{21}\) [https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf](https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf) Part 2 is intended to ensure that a patient receiving treatment for a SUD in a Part 2 Program does not face adverse consequences in relation to issues such as criminal proceedings and domestic proceedings such as those related to child custody, divorce, or employment.
Discussion:

1. Is there any data from the OASAS side around testing and referrals for HIV?
   Unclear – will take this back to OASAS to find out if this is tracked internally.

2. The required health coordinator for all OASAS programming – does that person have specific mandates across the systems of care represented today?
   A health coordinator is required in every OASAS program regardless of setting.

OASAS Early Intervention Services (EIS) for HIV

In 2015 OASAS developed an RFP to ensure compliance with the SAMSA block grant funding to put early intervention services in place. Fifteen (15) providers funded statewide with a total allocation of $6 million. Six Opioid Treatment Programs and nine Outpatient Community Based Programs. Existing services include pre and post-test counseling, prevention and education groups and referrals for treatment. These 15 providers are coordinating with external agencies to ensure there is a community reach. Delivered services, including materials and staff, are funded by the project. Looking to embed street outreach into this programming, to expand referrals to other resources in addition to treatment programs. This would include incentives and warm hand-offs.

Early Intervention Providers: AIDS Community Resources, Argus Community, Catholic Charities, Evergreen Health Services, Exponents, Fortune Society, Lower Eastside Service Center, Promesa, START, SunRiver Health Services and VIP.

OASAS Programmatic and Clinical Practices for PWH with SMI

Conduct educational sessions for OASAS region and state offices twice a month – recorded and posted online for staff. Covered multiple topics around management and quality of care. Sessions provide continuing education credits. Topics have included – Assessing Readiness for substance use disorder (SUD) Treatment and Applying Appropriate Harm Reduction Strategies; Trauma Informed Care; Using Strength-Based Language. Forthcoming topics include HIV 101, PrEP and PEP, STI Update and more.

NYSDOH also make educational courses available online with continuing education credit.

Have developed local service bulletins (LSBs) that highlight best practices and additional information about a specific topic. The AI has developed recommendations for improving language and establishing stigma-free supportive service delivery environment, that is applicable to multiple domains, i.e., Persons with mental health disorders, persons with substance use disorders, persons with HIV and HCV, etc.

Presentations are frequently made across the state about the importance of language – using non-stigmatizing language helps reduce internalized stigma. How we describe people affects how we think about people. A study was done using a paragraph about an individual described as being a substance abuser, versus a substance user wherein people had more negative reactions to the substance abuser and wanted to punish them.

Best practices for PWH with SMI include allowing for enhanced clinic open access to patients: allotment walk-ins, same-day appointments, partnering with jails and emergency departments for direct linkage for HIV, HCV, and medications services for opioid use disorder, utilizing clinical staff to triage patients to the appropriate level of care, debunking myths around opioid use disorder,
including addressing the internalized stigma, decreasing barriers to engagement in care. Actively addressing stigma, including among staff members. Functioning as a low threshold setting – meeting people where they are. Utilizing peers/people with lived experience across all domains (mental health, HIV, HCV, SUD). Embedding validated screening tools in the EMR and making universal screenings a routine part of care.

**What would a clinic that adopted best practices look like?**

- Normalizing asking about substance use – lack of awareness of validated tools, discomfort among providers. Convey can expectation of yes to reduce stigma.
- Assessing risk for overdose and prescribing naloxone – this is for all substances, since opioids can be added to almost all substances
- PEP/PrEP assessment
- Vaccinate for HAV, HBV, Tdap, HPV, etc.
- Test and treat for HIV, HCV. If known PWH, link to care, start ART, educate on U=U
- Dispense condoms
- Refer to syringe exchange program (SEP) or prescribe needles/syringes
- Make a safety plan, counsel on not using alone
- Offer medications for opioid use disorder (MOUD) (buprenorphine is the most easily accessible) to decrease risk of overdose
- Address any other acute needs of the patient
- Above all, listen and be nonjudgmental (a study found that physicians interrupt patients every seven seconds)
- Assess any acute or ongoing mental health needs
- Assess housing needs

**Discussion**

1. **Can anyone attend the mentioned trainings?**
   Must be OASAS staff, but OASAS runs “Learning Thursdays” that are publicly available. CASACs can get credit for watching them.

2. **Is opt-out HIV testing the norm for people served by OASAS?**
   Yes.

3. **Is OASAS conducting the testing, or referring to HIV testing?**
   OASAS state operated in patient facilities conduct opt-out HIV testing. Per the regulations OASAS sites have to offer HIV testing – and sites without onsite testing, must make a referral.

4. **For contracted OASAS programs, is the testing occurring through referral?**
   Certified sites vary with regard to on-site versus referral testing

5. **How integrated is health care into addiction care?** In thinking about the silos, we know that people with SUD often have serious medical risks – which asks, does it make sense to have these siloed programs, where people are unable to get appropriate medical care?
   Over 900 OASAS programs across the state - some of which are fully capable to provide medical care and some of which are not.
PSYCKES

PSYCKES is a secure, HIPAA-compliant online platform for sharing electronic health information, including Medicaid and other state administrative data. It is designed to support care for individual clients, i.e., Work a case manager is doing with a client, but also to support data-driven clinical decision making and care, care coordination, quality improvement, and population health management.

PSYCKES is used by provider agencies – allow agencies to decide who should have access. These are provider agencies licensed by OMH or OASAS, hospital inpatient units, ER/CPEP (Comprehensive Psychiatric Emergency Program), hospital clinics, health homes and care management agencies, FQHCs, freestanding medical clinics. State agencies also have access: OMH, AOSAS, DOH, AI, OPWDD (Office for People with Developmental Disabilities); county local government units, NYC agencies such as H+H Correctional Health Services (Rikers), NYC Department of Homeless Services, NYC Administration for Children Services. Medicaid Managed Care Organizations and various networks, including hospital networks, Behavioral Health Care Collaboratives (BHCC) and Independent Practice Associations (IPAs).

Medicaid Managed Care Organizations are mandated by OMH to look for people with first episode psychosis, people enrolled in ACT programs to focus on high need populations.

The data available in PSYCKES – can get up to 5 years of clinical summary history -updated weekly with available data – anything from the ambulance calls, to medications, diagnoses, etc. Anything Medicaid pays for is represented. Also integrate data from other state health databases with a 0–7-day lag. These include Health Home enrollment & CMA provider, managed care plan & HARP status, MC Plan assigned primary care physician, suicide attempts, safety plans, the state psychiatric EMR and recently the IMT (Intensive Mobile Treatment) and AOT (Assisted Outpatient Treatment) referrals. Multiple types of documents, such as an advance directive plan, can be uploaded to the site.

PSYCKES collects a lot of data, which would be very difficult to parse without summarized and aggregated data in the form of reports. For individuals – a clinical summary report can be accessed. For users, can review agency performance compared to the rest of the state using a My QI Report function. For a Recipient Search Report – can formulate your own cohort of interest, i.e., PWH who are not well engaged in care and have a schizophrenia diagnosis. Utilization reports look at the data designed to support value-based purchasing (VBP) – i.e., how many people are in a HARP? Also highlights who is caring for these clients to inform partnerships and protocols. PSYCKES Utilization Reports also highlight how clients are using services – even if services aren’t specific to one provider – can help understand total cost of a client(s’) services. Usage Reports allow users to monitor how agency staff are using PSYCKES.

Statewide Reports look at one measure and then compare all programs on that single measure.
PSYCKES and Large-Scale QI Collaboratives (QIC): Current QIC projects in mental health clinics include overdose prevention QIC, Building Capacity for Opioid Use Disorder QIC, Behavioral Health Risk QIC.

The Engaging Clinic QIC helps clinics understand the flow of client engagement. What clients are lost in the process or don’t make it in the door – helps clinics monitor level of engagement.

Overdose Prevention QIC is meant to help article 31 clinics get better at treating people with overdose potential.

Building Capacity for Opioid Use Disorder QIC enhances clinics ability to delivering services to people with SUD – fulfilling the “No wrong door” goal

Behavioral Health High Risk QIC focuses on suicide prevention

PSYCKES features related to HIV: Can use the clinical summary to identify, with client consent, that a client has HIV or is at risk for HIV. Can see the pattern of treatment engagement – are they taking their meds whether for HIV or psychotropics. Clinical summary includes messaging to facilitate provider identification of services or resources the patient qualifies for. Flags high utilization and diagnoses.

In a five-year report, can look at medication adherence, either as a table or a graph – which can highlight how well a person is adhering to HIV treatment.

Summary also shows who else the client is working with and how well engaged they are with those services, i.e., many inpatient versus few outpatient services.

Recipient Search for Population Health Management: Can search by diagnoses, medications received, managed care such as a Special Needs Plan, etc.

Can get a numerator for clients with HIV in a clinic. Can see who you have consent is – can only see HIV status and name of client with consent.

Future Enhancements to PSYCKES: Can create new quality measures or flags, alerts, or messages.

Potential to flag people with high viral loads, or track prescription refills.

Potential to roll out quality management support to increase number of clients giving consent to access HIV information.

Discussion:

1. Who coordinated HIV services and policy at OMH?
   No specific person who coordinates HIV related issues. In OMH on the community side, Dr. Casoy looks at more of these issues, but there are no disease specific focused providers, except for things like suicide.

2. Why are only 5 years of data available in PSYCKES?
   Since creating the Medicaid version 12 years ago there were concerns about too much data. From a clinical perspective would love to see someone’s whole life – but the quality of the Medicaid data has evolved, and if you pull in the old data, the actual data changes, and is more difficult to work with. Question of server capacity. Right now, looking at getting better servers as the servers are currently maxed out. Challenged by how to provide all the data without overwhelming people – one-page summaries of the data was asked for by ER and
other providers – different levels of detail are important to different types of providers. More data is better, but how to present that in a way that is useful.

3. Are shelters able to access data in PSYCKES?
   Currently in a conversation with DHS. Back in 2016, we created a special DHS view and application for people in DHS, so they could identify if someone had an ACT team, or Health Home looking for them. Trying to expand it so that we can also pull the shelter data into the application – because it is such an important risk and is an outcome that signals things are not going well for a person. Currently working on an MOU.

4. Can the database produce line level and aggregate reports for PWH based on their Medicaid billing for the past five years and are there limitations or constraints that are not clear?
   It can currently show you the people with HIV diagnoses in the past year/3 years in any setting – and can then refine it by psychiatric diagnoses. In the database can design a study to answer a lot of questions – if there were a study question that we sit down and design, to really get at an answer.

5. Can you clarify the role of consent, or not having consent, impacts the view of the data?
   No provider is allowed to see HIV info or HIV medication/treatment info in the absence of a consent. The single exception would be if they had an emergency, and they must attest that they had such an emergency. But can use recipient search to get a number on how many people have HIV. May only see names of those who have consented to be seen.

6. Can PSYCKES provide counts on number of people served with HIV and SMI?
   Yes – but if there was a question, such as a study question – where it is precisely defined and publishable, a search would not be the best way to get that. PSYKES data is good for quick and dirty analysis. Can say it would be good for all providers to do these searches – so they can understand what population has co-morbidities.

   We struggle with the definition of SMI and how to get that from claims data – SMI is a psychiatric diagnosis and a dysfunctional criterion. Figuring that out is always a struggle – easier to talk about a psychiatric diagnosis than a designation of serious mental illness.

7. Because testing rates for HIV are so low among people with SMI, a diagnosis may not be the best indicator, unless it is coupled with bolstered HIV testing. The entire literature of people with SMI is based on the inclusion of functionality – there is a need to get a fuller picture of the numbers.
   Can only capture what is diagnosed with this database, so that is a good point.
Existing Regulations

Regulations are public and available online. [Presentation advanced to discussion in interest of time.

Discussion

1. OASAS: Is the Health Coordinator’s job to address HIV, medical and other issues for the person who is coming into the door for care? What is involved – do they coordinate all aspects of health across multiple domains or substance use care?

   Not defined in regulations what the Health Coordinators qualifications need to be. The Health Coordinators primary responsibilities are related to communicable diseases and referrals for treatment – that’s what’s listed in the regulatory requirement, but is not all they do, and staff functions vary from program to program. In a regulatory context it is related to communicable diseases.

2. HIV testing in OMH in-patient and outpatient facilities. The policy states that written informed consent is required for HIV testing, but state law got rid of that requirement in 2016. It is currently opt-out testing – is that being conducted in inpatient OMH operated facilities? And do you know what is happening in outpatient facilities?

   There is no rule for opt-out testing right now. Providers need to obtain consent to do an HIV test. There is no guidance on that being a requirement for operating. There are state operated hospitals, over 20 psych centers around the state. For those that take care of civilians, those patients come from article 28 hospitals, and when there is a referral packet - these are psychiatric units in referral hospitals. There are required labs, but not for HIV. There are no specific requirements for which tests come. Conduct a clinical eval of the packet and if there are specific medical concerns, we ask for a consult or medical work-up to assure that we have the capacity to take care of them, and that we inform the medical care providers to continue care. When I was a medical director, I was able to re-start many people on their HIV meds. But these state operated in-patient hospitals are not the same as acute psychiatric units you find in a hospital. Generally, these are people who are in need of longer-term care and are referred by hospitals. Have a relationship with several forensic hospitals and receive patients from jails and prisons. There is a lot of heterogeneity of the types of clients and care in the system. Most OMH clinics lack capacity and do not have onsite labs. Between 6-700,000 patients are seen – and there is no specific requirement of a health assessment – give the clinics an option of doing that, but not all do and not all have the capacity – and those should be working with a primary care provider.

3. There are 700,000 people in the system – maybe there is more we can do to get people tested for HIV and into care.

   That’s the conversation we are having. People with SMI die on average 20-25 years earlier than the general population due to medical conditions and tobacco use. We are interested in implementing programs to address those needs. We are doing a good deal on opioid use and tobacco use.

4. Maybe a helpful next step would be to have OMH work on modernizing their approach to HIV – moving away from the model of consent that shifted in 2016. OMH should recognize that HIV is just another chronic illness – shouldn’t be so hard to get this info. Many of these systems are set up with the idea of stigma in a way that further stigmatizes the population because the issues do not get discussed. Clients accessing services in OMH are subject to the luck of the
draw. When we think about people with SUD or a mental health diagnosis. Should we be running these services without integrating medical care. The issue of HIV is different from other issues because it is a transmissible illness. Need OASAS and OMH to participate and facilitate ending the epidemic – that requires a level of tracking that other illnesses do not.

Richard from the AI: Point of clarification on peer workers – peer certification bodies are several months into a process to facilitate cross certification. The AI worked with OASAS a few years ago to do a road show to help HIV and SUD providers better understand each other’s systems under the rubric of helping HIV providers understand how to make referrals – something to this effect could be very helpful for HIV providers to know how to make effective OMH referrals. Trauma informed care is different from trauma treatment – a better understanding of this resource would be incredibly helpful.

5. **What role does ACES and harm reduction play in OMH?**

**OMH:** Any individual who presents with acute stress disorder or post stress disorder is extremely important. OMH has adopted ACES across the board. Question of how to help patients in more complex settings be able to recognize these. OMH has focused on training up staff and providers on the impact of trauma and the impact of child trauma. Not a new initiative.

**OASAS:** Conduct a lot of TA with providers to facilitate harm reduction. There will be an upcoming training in a box on this. There is wide variability across all systems – not every SUD treatment facility has the same competency. The Office of the Medical Director is trying to increase competency around HIV and HCV across the system.

6. **What does justice for patients look like – what is the minimum standard of care.**

**OMH:** Important to remember that different levels of resources are available across the system – creates difficulty. Would be ideal if all staff were paid in response to the value they bring to the clients – our system is complex – how do you help these programs is a long term and important process.

7. **This is why PWH migrate out of the mental health service system.** This forum was very informative – it would not be a huge lift to track people with SMI and HIV to have a clear understanding of their outcomes. If we look at it from a patient issue – know the difference between public and private standards of care. Maybe all people with SMI should be in the medical system since they are dying 20-25 years before the general population

8. **Several bridges have the potential to be built across our systems of care.** The things OMH doesn’t do for its client population highlights the voids in the service system. It is possible to strengthen capacity across the service system – need to direct the EHE funding to address the gaps, pay for front line providers to do extra work, embed HIV testing onsite, ensure HIV medication continuity in psych care/re-start HIV meds in psychiatric care.

9. **Would it be helpful to create a special group to address the social justice and equity issues present?**
Acronyms

2016 FINAL RULE 42 CFR 438 Service Authorization and Appeals. More info here

ACT Teams: Assertive Community Treatment. More here and here

AI: New York State AIDS Institute

AOT: Assisted Outpatient Treatment. More here and here

CBOs: Community Based Organizations

DOH: New York State Department of Health

EHE: Ending the HIV Epidemic – federal initiative. More info here

EMA: Eligible Metropolitan Area – refers to Ryan White funding jurisdictions

HARP: Health and Recovery Plans. More here

HCBS: Home and Community Based Services. More info here

HCV: Hepatitis C Virus

HCW: Health Care Worker, can be, but is not necessarily, a peer worker

HIV Care Continuum: A visual method for illustrating key metrics related to care. More here

HIV Status Neutral Approach: People at risk of HIV exposure taking daily PrEP and people with HIV with sustained viral load suppression do not acquire or transmit HIV. More information here

Intersectionality: Describes the way people’s social identities can overlap. More info here and here

mDOT: Modified Directly Observed Therapy. More here

NYS Blueprint to End the Epidemic: Often referred to as ETE. More info here

NYS Public Facing ETE Dashboard: Tracks metrics related to the NYS HIV epidemic. Found here.

OASAS: New York State Office of Addiction Services and Supports

OMH: New York State Office of Mental Health

Peer Certification: NYS currently operates three non-overlapping peer certification programs through OMH, OASAS and the AI.

PEP & PrEP: Using HIV drugs to prevent HIV transmission. More here

PHS’s Enhanced Data to Care Concept Paper found here

PLMHD: People living with a Mental Health Diagnosis

Psycho-social Rehabilitation: helps people develop the social, emotional and intellectual skills they need in order to live happily with the smallest amount of professional assistance they can manage. More here

PSYCKES (Psychiatric Services and Clinical Knowledge Enhancement System): Developed by the New York State Office of Mental Health (OMH), PSYCKES uses administrative data from the
NYS Medicaid claims database to generate quality indicators and summarize treatment histories. More info [here](#)

**PWH**: People with HIV

**RHIO**: Regional Health Information Organization. More info [here](#)

**RWPA**: Ryan White Part A (Other parts are B, C, E and F) More info [here](#)

**SHIN-NY**: Statewide Health Information Network for New York. More info [here](#)

**SMI**: Serious Mental Illness

**SPOA**: Single Point of Access to help providers connect people with serious mental illness to mental health services that can accommodate them. More [here](#)

**STIRR Model**: Screen, Test, Immunize, Reduce risk, and Refer. More info [here](#) and [here](#)

**TG/NC**: Transgender/Non-Conforming ([NB]: Non-Binary)
### Appendix 1: NYS Partner Key Activities

<table>
<thead>
<tr>
<th>KEY AGENCIES</th>
<th>TASK</th>
<th>PRIORITY</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OHIP, DOH</strong></td>
<td>Care continuum on PWH with SMI for NYS, with break out by region including NYC Boroughs and Tri-County/NYS (data match)</td>
<td>High</td>
<td>Identify champions at OHIP, DOH and AI. Find funding to support match work</td>
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<tr>
<td><strong>AI</strong></td>
<td>Inclusion of PWH with SMI as a priority population in the NY ETE Dashboard</td>
<td>High</td>
<td>This would serve as an intersectional marker that highlights how well systems are working together to support people with multiple co-morbidities</td>
</tr>
<tr>
<td><strong>OMH</strong></td>
<td>Implementation of a comprehensive HIV testing, treatment prevention policy throughout OMH licensed and operated programs</td>
<td>High</td>
<td>Facilitate linkage agreements that support testing, medication access and prevention support. Collaborate with the NY Ryan White Part A program (and other Ryan White programs as appropriate) to build OMH provider capacity through training and technical assistance to support policy and protocol implementation for improved physical and behavioral health outcomes for those at risk for and those living with HIV and SMI.</td>
</tr>
<tr>
<td><strong>OMH, AI, and DOHMH</strong></td>
<td>Identification and implementation of pilots that enhance the capacity of providers to deliver/support psychiatric care, i.e., STIRR Model, Telepsychiatry, Collaborative Care, Psychiatric Nurse Practitioners</td>
<td>Normal</td>
<td>Identify additional funding to support STIRR intervention</td>
</tr>
<tr>
<td><strong>DOH, AI, OMH, OASAS, DOHMH</strong></td>
<td>Structural multi-disciplinary stigma intervention focused on mental health, SMI and HIV</td>
<td>Normal</td>
<td>Identify additional funding to support a collaborative stigma intervention</td>
</tr>
<tr>
<td><strong>DOH, AI, OMH, OASAS, DOHMH</strong></td>
<td>Integration of data systems to improve identification of PWH with SMI who have fallen out of care/are in crisis:</td>
<td>Normal</td>
<td>Clarification of function, limits and challenges for the various systems used to collect data: PSYCKES, RHIOs, SHIN-NY, HEALTHIX, etc. Clarification of data agreements that govern these entities Create a graphic that illustrates this</td>
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<tr>
<td><strong>AI</strong></td>
<td>Health homes: Develop and track reportable HIV indicators</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Agency</td>
<td>Action</td>
<td>Priority</td>
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<tr>
<td>OMH, AI</td>
<td>Assess and build up the capacity of care centers, including psychiatric hospitals, for people with SMI to administer, support &amp; measure HIV testing, HIV treatment access, PrEP/PEP support</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>DOH, AI, OMH, OASAS, DOHMH</td>
<td>Assess cost and client benefit for developing a state and city-wide integrated electronic medical record system or leveraging existing systems such as the RHIOs/SHINY to facilitate the coordination of care among people with HIV who receive funded services.</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>DOH, AI, OMH, OASAS, DOHMH</td>
<td>Expand implementation of an HIV status neutral approach to prevention and treatment</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>DOHMH, AI</td>
<td>Build strategic partnerships to enhance capacity and establish routine HIV testing at sites where people with SMI regularly access care</td>
<td>High</td>
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<tr>
<td>OMH</td>
<td>Facilitate HIV testing at all OMH facilities. Adapt the STIRR model* to routinize opt-out HIV testing, during annual medical assessments for all clients that access outpatient mental health programs</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>DOHMH, AI</td>
<td>Build capacity of mental health providers and institutions, including in-patient sites, to support HIV medication access and adherence among clients</td>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>RWPA, OMH, OASAS</td>
<td>Expand access to Modified Directly Observed Therapy (MDOT) for HIV, HCV, and psychiatric medications</td>
<td>Normal</td>
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</tbody>
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Note: *STIRR model: Screening, Testing, Immunization, Referral, Response.
| DOHMH, Ai, RWPA | Improve capacity of CBOs (Community Based Organizations) to identify and manage people with HIV who may have SMI | Normal | Develop best practices to inform agency specific crisis action plans Streamline & accelerate access to additional support services, i.e., HARP, AOT, inpatient stays and other appropriate interventions, support, and referrals Build effective referral pathways, guidance, and capacity to ensure people with HIV and SMI can access needed care from the full range of OMH operated and/or funded programs Reduce staff turnover to strengthen client trust and engagement |
| OMH, Ai DOHMH | Implement programs that improve viral load suppression for PWH with SMI and can be expanded with proof of concept. | Normal | Psychiatrists that train medical providers on how to prescribe psychotropic medicine, currently used to help alleviate cost and create access in rural areas Establishment of a NYC and NYS ombudsman for serious mental illness, who can facilitate and address clients’ crisis issues immediately Focus on resources for psycho-social rehab and assistance to navigate interpersonal relationships - how to live your best life with serious mental illness |
| DOHMH, DOH, OMH, OASAS | Improve cultural humility among behavioral health staff (psychiatrists, psychologists, social workers, counselors, and other licensed staff) | Normal | Coordinate and incentivize a dual/triple peer certification program: HIV, Behavioral Health, and substance use Promote pathways to full time positions for peer community health workers |
| DOH, Ai OMH, OASAS, DOHMH | Incentivize the inclusion of community health workers, ideally peers with lived experience | Normal | Create a tax or payment structure for peer community health workers that ensures maintenance of benefits, financial stability, and appropriate remuneration |
| DOH, Ai HASA | Create a tax or payment structure for peer community health workers that ensures maintenance of benefits, financial stability, and appropriate remuneration | Normal | Pilot development of internal care coordination dashboards that highlight clients’ care status through medication prescriptions, ART access/adherence, and viral load measures |
| OMH, Ai DOHMH | Further integrate and coordinate care for behavioral health, substance use and HIV care through the development of single site access for all services | Normal | RWPA facilitates these for providers: Request report from REU on lessons learned, best practices |
| DOHMH, Ai, DOH, OMH | | Normal | Identify regulatory challenges Identify best practices/workarounds |
### Findings from the Forum on HIV & SMI: Fostering a Cooperative Approach to Addressing Unmet Needs

**A Report by the Needs Assessment Committee of the NY HIV Health & Human Services Planning Council**

<table>
<thead>
<tr>
<th>DOHMH</th>
<th>Designate people with HIV and SMI with unsuppressed viral loads as a priority population for outreach services that re-connect clients to care based on missed/high viral loads and missed prescription refills.</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOHMH, OMH</td>
<td>Coordinate existing BH programs throughout NYS and NYC, i.e., NYC HRA, Comprehensive Psychiatric Emergency Programs (CPEP), Day Treatment, ACT Teams (many institutions conduct ACT teams - funded by DOHMH and OMH to facilitate client support) with existing HIV Care and Prevention services</td>
<td>Normal</td>
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</tbody>
</table>
## Appendix 2: NYC Specific Key Activities

<table>
<thead>
<tr>
<th>KEY AGENCIES</th>
<th>TASK</th>
<th>PRIORITY</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>HASA</td>
<td>Clarification on funding for MH in HASA.</td>
<td>Normal</td>
<td>Includes NY/NY 3, congregate housing sites, SROs How do various funding entities/providers collaborate (or divide the work) to support clients with SMI and clients with SMI &amp; substance use disorders?</td>
</tr>
<tr>
<td>DOHMH, OMH/BMH</td>
<td>Identification of HIV care sites most utilized by PWH with SMI to strengthen crisis management, linkage to psychiatric care and rehabilitative therapy, as well as coordination and additional support</td>
<td>Normal</td>
<td>Survey HIV care providers to assess need for additional support. Utilize Medicaid match to populate list of care sites to inform targeting of TA and capacity building for both HIV prevention &amp; care depending on site</td>
</tr>
<tr>
<td>RWPA</td>
<td>Expand availability of low threshold services to facilitate client readiness for treatment: walk-in, late &amp; weekend hours, etc.</td>
<td>Normal</td>
<td>Strengthen linkages &amp; availability of readily available psychiatric care</td>
</tr>
<tr>
<td>RWPA, OMH, OASAS</td>
<td>Expand access to Modified Directly Observed Therapy (MDOT) for HIV, HCV, and psychiatric medications</td>
<td>Normal</td>
<td>Duplicated in both tabs</td>
</tr>
<tr>
<td>HASA, AI, DOHMH HIV HOUSING</td>
<td>Prioritize and improve supportive housing access for PWH with SMI*</td>
<td>Normal</td>
<td>Streamline access to supportive housing for PWH with SMI with a client centered process Additional funding for supportive housing</td>
</tr>
</tbody>
</table>