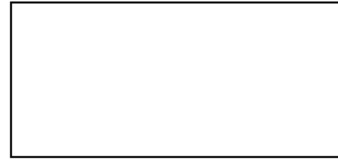

HUMAN SERVICES DEPARTMENT
COMMUNITY PARTNERSHIPS DIVISION
115 S Andrews Avenue, Room A360 • Fort Lauderdale, Florida 33301 • 954-357-8647 • FAX 954-357-8204

BEHAVIORAL HEALTH NETWORK MEETING

Date: February 15th, 2019 @ 2:00PM
Location: Ryan White Part A Program Office
115 S. Andrews Ave., A-337
Ft. Lauderdale, FL 33301

Facilitator: Clinical Quality Management Staff
quality@brhpc.org
(954) 561-9681 ext. 1250,

AGENDA

I. **Welcome & Introductions**

II. **Test & Treat: Intersection with Behavioral Health**

III. **Case Study**
- **Care Resource**

IV. **Complete Meeting Evaluation**

V. **Adjournment**

Next Meeting Date: May 17th, 2019
Please see staff for a Governmental Parking Garage Validation ticket

Broward County Board of County Commissioners
Mark D. Bogen • Beam Furr • Steve Geller • Dale V.C. Holness • Chip LaMarca • Nan H. Rich • Tim Ryan • Barbara Sharief • Michael Udine
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BEHAVIORAL HEALTH NETWORK MEETING
Friday, August 17th, 2018 at 2:00 P.M.
Ryan White Part A Program Office
115 S. Andrews Ave., Ft. Lauderdale 33301

Minutes

PROVIDERS PRESENT
Shelton, C.D. (AHF)
Brown, K. (AHF)
Jones, D., (AHF)
Johnson, E. (SBHD)
Hensly, G. (SunServe)
Powers, J. (Broward House)
Rocchia, H. (Care Resource)

PROVIDERS ABSENT
BCFHC

GUEST
Leonard, C. (HOPWA)

PART A RECIPIENT STAFF
Jones, L. – Part A Grantee
Garcia, E.

CLINICAL QUALITY MANAGEMENT (CQM) STAFF
Dr. Martinez, G.
Johnson, B.
Anyaduba, L.
Guice, M.

I. Welcome/Introductions

The meeting was called to order at 2:13 p.m. CQM staff welcomed everyone and introductions were made.

II. You Asked, We Listened!

HOPWA Presentation—Christopher Leonard, *HOPWA Representative*

- Overview of HOPWA Program/Accessing HOPWA resources

Staff introduced Christopher Leonard, a representative of Housing Opportunities for Persons with AIDS (HOPWA). Mr. Leonard provided an overview of the HOPWA program and community development initiatives within the city of Fort Lauderdale. Providers displayed interest in having more points of contacts from HOPWA due to administrative shortages, efforts to expand client access to housing options, and providing effective navigation of HOPWA services for clients. Mr. Leonard discussed several facets of the HOPWA program such as their statutory of purpose, goals, eligibility requirements, and infrastructure. When individuals are housed, he explained, they are more likely to be compliant to medication adherence. HOPWA services are not for long-term dependence, but to serve as transitional housing resources to help improve clients' access to medical care and supportive services associated with HIV/AIDS.

HOPWA is composed of an assortment of various housing programs. Facility Based Housing (FBH) Assistance generally offers two to three beds per room with Broward Health facilitating client referrals. The service is generally a temporary living situation for PLWH who have been displaced for short periods of time until linked to other resources. Project-Based Rental (PBR) Assistance is rental assistance to nonprofit organizations for eligible persons or families to live in apartment units. PBR housing is generally more independent, subsidized, and has been characterized by an extensive waitlist. The waitlist is open to all HOPWA clients. Tenant based rental vouchers (TBRV) is rental assistance to eligible persons or families to live in private, independent apartment units. Broward

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House and BRHPC help clients navigate this service. TBRV is the most independent option among the subsidies and is an ongoing subsidy. TBRV implements third-party property owners and case managers or housing specialists to help clients access other forms of care. The program is not currently adding more clients. A provider from Sunserve detailed the lack of clarity in navigating clients through the waitlists. Rachel Williams, active administrator of the grant, can be contacted regarding additional information on components of the waitlists. Joyce Nunnaly, jnunnaly@browardhouse.org, can be used as a contact as well.

Mr. Leonard addressed efforts in expanding more sustainable options for HOPWA. At the state level, there have been discussions of utilizing creative options to expand access. Current discussions are adding more PBR Assistance housing as well as considerations for senior housing. Providers inquired about the ability of clients with SSI or SSDI and limited income to utilize HOPWA independent living situations. Mr. Leonard outlined HOPWA's current shift away from transitional options due to undesirable outcomes. There have been notably limited housing options for clients whose funding does not adequately set them up long-term housing. Increasing rental costs have made providing affordable housing options more perplexing from a systems perspective. One potential solution introduced has been shared room options. Clients are responsible for finding units and housing case managers process the transaction. One provider asked about how HOPWA deals with confidentiality for project-based housing and the stigma associated with PLWH being localized to particular housing facilities. Mr. Leonard noted the state initiative for promoting mixed project-based housing and piecing funding together so that no particular housing facility is a homogenous population of a certain client demographic.

Homelessness and Mental Health

- Discuss assisting homeless clients with behavioral health issues

Patients are often inconsistent in crises where the immediate crisis is a stimulus to seek services but may be lost to care as this crisis diffuses. Providers discussed potential interventions in retaining clients and promoting adherence to services. Providers noted the importance of working closely with case managers, being open, inviting, having a positive attitude and being sensitive to client's situations. One provider noted the importance of self-preservation in congruence with openness. Providers may experience fatigue and frustrations due to the complexity of many clients' situations. Care personnel must know their limitations and capability to minimize their stress. Another provider noted the use of drop-in centers for people to come in for services such as support groups, food, and creative options. The Part A Grantee interjected that half of Ryan White clients do not have permanent housing; a factor that is comorbid with anxiety, stress, uncertainty, depression, substance use, and other adverse behaviors. When clients are struggling with housing and transportation, provider notes that he combines their service appointments to make it more convenient for the client. Additionally, case management is often utilized to people budget and prioritize rather than spend frivolously. Hefty documentation can serve as a barrier in the client's ability to acquire housing. On a daily basis, despite the number of resources, there is a gap in ability for clients to do tasks that are not accounted for among the services.

III. Case Study

- Broward House

Broward House presented a case study for a client diagnosed with schizophrenia, bipolar disorder, major depression, and substance abuse dependence. The female client was underweight, demonstrated a lack of energy, and homeless. The provider detailed an instance where the client was picked up by case manager, however, she claimed to be kidnapped and abandoned when left in care. Providers have set priority for this client to receive medical care. She now has a new set of dentures and has demonstrated a decreased viral load after care. The client has no known family or sober social support. The most critical issue for this case is the procurement of stable housing, particularly since the client has spent most of her life homeless. The client is covered under Medicare and Medicaid, but

needs help to navigate the resources available to her. She is currently eating and taking medication, but suffers from gastrointestinal complications. The client displayed confusion when operating independently and the provider questions whether the client can manage daily activities without case managers, therapists, and other members of her care team. The provider's goals for the client at this time is to manage mental health issues, promote and increase her level of independence, reinforce sobriety, and ensure the procurement of proper medicines. The client is currently an active member in her treatment community and has been more responsive since the providers described the consequences should could face if she did not engage in treatment.

- AHF

The provider from AHF presented a case study regarding a 51-year-old client diagnosed with borderline personality disorder, dysthymia, generalized anxiety disorder, alcohol use disorder, and binge eating disorder. He suffers from chronic health conditions and has attempted suicide, however, his viral load is suppressed and undetectable. The client has demonstrated a significant desire for pharmaceuticals and medical treatment; constantly requesting to be placed in radiology and on stronger medicines despite examinations proving these measures inessential. The client has a lack of family communication and a history of emotional abuse, low self-image, low self-esteem, bullying, and verbal abuse. The client has also been diagnosed with obesity and has noted that he often consumes a massive quantity of sugary foods upon awakening. He has had difficulties coping with HIV contraction, but demonstrates medication compliance. The client has an extensive history of traffic misdemeanors, unemployed, and currently seeking financial support. The client consistently engages in verbal altercations with his medical team, but shows more devotion and communication towards behavioral commission. One ongoing problem in coordinating his care is his codependent behaviors and poor compliance with scheduling. Feedback from other providers note that dialectical behavioral therapy (DBT) has been proven to help with borderline personality disorder. The therapy is traditionally a one-year commitment. A problem noted, however, is Ryan White patients are only entitled to 13 sessions per year, which places refractory gaps in the periods of care. Additionally, some patients who has exacerbated Ryan White funding could possibly be covered under other grants.

IV. Importance of Viral Load Suppression for Providers

The CQM staff gave a brief overview of the importance for Ryan White Part A subrecipients to monitor clients' viral loads. A counterpoint is that in some cases, clinicians practice using their unique methodologies and it is not their focus to monitor viral loads when there are other comorbid factors involved when engaging clients with mental illness. Behavioral services often provide more of a therapy role and discussing medical terminology at initial contact could have the potential to distract from the services that clients are offered. It was noted that oftentimes, mental health counselors develop more intimate relationships with clients than the traditional physician-patient relationship.

V. Meeting Date Poll

At the previous meeting, the CQM staff and providers discussed the possibility of rescheduling future meetings at a different day and time. The CQM staff formulated a survey and distributed it among the providers. The providers were able to select their availability for the third quarter network meetings. Surveys were thereby collected and results were recorded.

VI. Complete Meeting Evaluation

Staff reminded the Network to complete the meeting evaluation and provide suggestions for topics they are interested in discussing at future Network meetings.

VII. Adjournment

The meeting was adjourned at 4:04 p.m.

Next Meeting Date: November 16th, 2018

Test and Treat Discussion Questions

- What is the process for Test & Treat clients entering Behavioral Health services?
  ____
  ____
  - How are Test & Treat clients tracked among Behavioral Health providers?
    ____
    ____
- Has there been a notable increase in volume of patients since the initiation of Test & Treat?
  ____
  ____
- How do the Behavioral Health needs of someone newly engaged through Test & Treat differ from retained patients?
  ____
  ____
  - What are particular barriers for new/Test & Treat clients?
    ____
    ____
  - What Behavioral Health practices are used toward retaining new clients in care?
    ____
    ____
- To what degree is care coordinated with providers in other service categories for Test & Treat clients?
  ____
  ____
  - How can providers in other service categories be further integrated to promote retention in and adherence to mental health and substance abuse services?
    ____
    ____

Case Study

Viral Load:	1/31/19- 74
History of Viral Load:	11/27/18- 718
Mode of Transportation:	Client owns a car
Housing Status:	Client rents a room in an apartment with a roommate
Insurance Status:	Ryan White
Length of Time in Care:	2 months
Other Medical Conditions:	no
Support System (Family, Friends, etc.):	Client relies primarily on his roomate and a few other friends as support
Other Barriers to Care:	Client was in a financial hardhsip, unemployed, homeless and recently ended a relationship when beginning care.

Client History:

Client is a 30 year old Vietnamese American man who identifies as gay. He denies any current or history of substance abuse.
Client entered into medical care in November, 2018 after testing positive for HIV. He had recently broken up with his partner, was sleeping on a friend's couch, and was unemployed. He also was experiencing feelings of depression related to his diagnosis, his breakup, and stress related to his financial situation. His mother who had been dependent on him also left Fort Lauderdale to live with other family members at that time. He did not feel as though he could share his HIV status with his mother or other family members due to their negative assumptions about his lifestyle. He was not eating or sleeping regularly and was frequently aggressive with others. He reported feeling depressed and angry. Client began engaging in Behavioral Health Integration services through the Ryan White Test and Treat Program at Care Resource. He has regularly attended both medical and behavioral health appointments. He now is living independently, has employment, is making progress towards paying off personal debts acrued during his unemployment, and is becoming involved in local HIV awareness and prevention initiaitves. He still reports some feelings of sadness related to his break-up, but reports improved acceptance of his diagnosis, has shared his diagnosis with his friends, aunt and mother, and is proud of his financial and occupational improvement.

Client Treatment Plan:

1. Goal: To adhere to medical care
   Objective: To attend all appointments and take medications as prescribed
   Comment: Client has improved medical adherence as evidenced by him attending recent appointments, creating a medication schedule and buying a pill box.

2. Goal: To decrease negative moods
   Objective: To develop and implement effective anger management skills by discussing past experiences and recent stressors of relationship and diagnosis
   Comment: Client has had less anger outbursts due to being able to express self more frequently in therapy and with friends

3. Goal: To consistently engage in goal directed behavior
   Objective: To set realistc weekly and monthy goals and timelines for completing them.
   Commen: Client has been consistetly setting and meeting weekly goals related to employment and financial planning

Client Issues:

Client continues to adjust to HIV diagnosis, however he has been consistent with medication and medical and behavioral helath appointments. He will continue to meet weekly for behavioral health appointments in order to further improve mood, maintain consistency of behavior, and further acceptance and care of HIV diagnosis.