Newark EMA

HIV Health Services Planning Council

NEEDS ASSESSMENT 2019

September 2019

NEWARK EMA HIV HEALTH SERVICES PLANNING COUNCIL NEEDS ASSESSMENT – 2019

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LIST OF ABBREVIATIONS

The following abbreviations and acronyms are used in this Needs Assessment.

ACA	Affordable Care Act of 2010 (Patient Protection and Affordable Care Act)
ADAP	AIDS Drug Assistance Program
ADDP	(New Jersey) AIDS Drug Distribution Program
ARV	Anti-Retroviral (therapies)
BH	Behavioral Health (includes both mental health and substance use disorder (SUD) issues)
BHIP	Behavioral Health Integration Project (of NJDOH)
CARE Act	Comprehensive AIDS Resources Emergency (CARE) Act
CBO	Community Based Organization
CDC	U.S. Centers for Disease Control and Prevention
CHAMP	Comprehensive HIV/AIDS Management Program (the Newark EMA's Client Level Data Base)
CLD	Client Level Data (system)
CM	Case Management
CM-NM	Case Management – Non-Medical (nonmedical case management or managers)
Cmte	Committee
COC	Continuum Of Care Committee of NEMA Planning Council
CQM	Clinical Quality Management
CPC	Comprehensive Planning Committee of NEMA Planning Council
CTR	Counseling, Testing and Referral sites (for early identification of PLWHA)
DAYAM	Division of Adolescent and Young Adult Medicine (formerly at UMDNJ, now at Rutgers University)
DHCW	Newark Department of Health and Community Wellness (formerly Department of Child and Family Well Being)
DMAHS	Division of Medical Assistance and Health Services ("Medicaid Division" within the N.J. Department of Human Services)
DHSTS	Division of HIV/AIDS, STD, and TB Services, formerly the Division of HIV/AIDS Services
EIIHA	Early Identification of Individuals Living with HIV/AIDS
EIRC	Early Intervention and Retention Collaborative (EIRCs as plural)
EIS	Early Intervention Services
EMA	Eligible Metropolitan Area
FG	Focus Group
FQHC	Federally Qualified Health Center
HAART	Highly Active Anti-Retroviral Therapy
HAB	HIV/AIDS Bureau (of HRSA)
HCC	HIV Care Continuum
HIPAA	Health Insurance Portability and Accountability Act

HOPWA	Housing Opportunities for Persons With AIDS
HRSA	Health Resources and Services Administration (of the U.S. Department of Health and Human Services)
IDU	Injection Drug User
IHAP	Integrated HIV/AIDS Prevention and Care Plan 2017-2021
KI	Key Informant [interviews]
LGBTQ	Lesbian, Gay, Bisexual, Transgendered, Questioning
MAI	Minority AIDS Initiative (formerly Congressional Black Caucus – CBC)
MCM	Medical Case Management
MH	Mental Health
MMC	Medicaid Managed Care (NJFC for categorically eligible individuals also receiving Temporary Assistance to Needy Families (TANF) or Supplemental Security Income (SSI))
MNT	Medical Nutritional Therapy
MOA, MOU	Memorandum of Agreement, Memorandum of Understanding
MSM	Men who have Sex with Men
MSW	Morris, Sussex, Warren counties in the Newark EMA
NEMA	Newark Eligible Metropolitan Area
NHAS	National HIV/AIDS Strategy
NJCRI	North Jersey Clinical Research Initiative (New Jersey AIDS Partnership)
NJDHS	N.J. Department of Human Services (administers NJ Medicaid and DMAHS)
NJDOH	N.J. Department of Health
NJDS	New Jersey Dental School (at Rutgers University)
NJFC	New Jersey Family Care (Medicaid Expansion)
NJ-CLAS	New Jersey Culturally and Linguistically Appropriate Standards
PLWHA	People Living With HIV or AIDS
PPACA	Patient Protection and Affordable Care Act (also known as the “Affordable Care Act”
REC	Research and Evaluation Committee of NEMA Planning Council
RIC	Retention In Care
RW	Ryan White [Program]
RWHAP	Ryan White HIV/AIDS Program
RWTEA	Ryan White HIV/AIDS Treatment Extension Act of 2009
RWTMA	Ryan White HIV/AIDS Treatment Modernization Act of 2006
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration (of the U.S. Department of Health and Human Services)
SUD	Substance Use Disorder
TGA	Transitional Grant Area
VLS	Viral Load Suppression
WICY	Women, Infants, Children and Youth
YMSM	Young Men who have Sex with Men

INTRODUCTION

The information below was extracted from the Ryan White Part A Manual published by HRSA/HAB in 2013 on its website. It reflects requirements of the Ryan White HIV/AIDS Treatment Extension Act (RWTEA) of 2009, Public Law 111-87, October 30, 2009. The citations are referenced to the Public Health Service Act (42 U.S.C. 300ff-11).

Legislative Background - Planning Council Duties

Completion of the needs assessment is a significant part of the **eight duties of the planning council**, as shown in federal law, most recently updated by the Ryan White Treatment Extension Act. Five sections - (4)(A), (B), (F), (G) and (H) - speak directly to the needs assessment. The purpose of the needs assessment is to assist the planning council in meeting Section (4)(C) – establish service priorities for the allocation of funds within the eligible area – and (4)(D) - develop a comprehensive plan for the organization and delivery of health and support services.

42 U.S. Code § 300ff–12 - Administration and planning council

(b) HIV health services planning council

(4) Duties: The planning council established or designated under paragraph (1) shall—

(A) determine the size and demographics of the population of individuals with HIV/AIDS, as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status;

(B) determine the needs of such population, with particular attention to—

(i) individuals with HIV/AIDS who know their HIV status and are not receiving HIV-related services;
(ii) disparities in access and services among affected subpopulations and historically underserved communities; and
(iii) individuals with HIV/AIDS who do not know their HIV status;

(C) establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds under a grant based on the—

(i) size and demographics of the population of individuals with HIV/AIDS (as determined under subparagraph (A)) and the needs of such population (as determined under subparagraph (B));
(ii) demonstrated (or probable) cost effectiveness and outcome effectiveness of proposed strategies and interventions, to the extent that data are reasonably available;
(iii) priorities of the communities with HIV/AIDS for whom the services are intended;
(iv) coordination in the provision of services to such individuals with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment for such abuse;
(v) availability of other governmental and non-governmental resources, including the State medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and the State

Children's Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.] to cover health care costs of eligible individuals and families with HIV/AIDS; and
(vi) capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities;

(D) develop a comprehensive plan for the organization and delivery of health and support services described in section 300ff–14 of this title that—
(i) includes a strategy for identifying individuals who know their HIV status and are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds;
(ii) includes a strategy to coordinate the provision of such services with programs for HIV prevention (including outreach and early intervention) and for the prevention and treatment of substance abuse (including programs that provide comprehensive treatment services for such abuse);
(iii) is compatible with any State or local plan for the provision of services to individuals with HIV/AIDS; and
(iv) includes a strategy, coordinated as appropriate with other community strategies and efforts, including discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of such status, and enabling such individuals to use the health and support services described in section 300ff–14 of this title, with particular attention to reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities;

(E) assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area, and at the discretion of the planning council, assess the effectiveness, either directly or through contractual arrangements, of the services offered in meeting the identified needs;

(F) participate in the development of the **statewide coordinated statement of need** initiated by the State public health agency responsible for administering grants under part B of this subchapter;

(G) establish methods for obtaining input on community needs and priorities which may include public meetings (in accordance with paragraph (7)), conducting focus groups, and convening ad-hoc panels; and

(H) coordinate with Federal grantees that provide HIV-related services within the eligible area.

Needs assessment data are critical to conducting other planning tasks. Needs assessment results must be reflected in both the planning council's priority setting and resource allocations and in the EMA's/TGA's comprehensive plan. Planning councils are required to:

- Address coordination with programs for HIV prevention and the prevention and treatment of substance abuse
- Include links with outreach and early intervention services
- Address capacity development needs

- Be closely linked with comprehensive planning and annual implementation plan development, as interconnected parts of an ongoing planning process.

Section 2603(b)(1) specifies that in seeking supplemental funding, the EMA/TGA is expected to include in its application for funding an array of information, including needs assessment data that demonstrate need.

Section 2603(b)(2)(B) specifies that, in making awards for **demonstrated need**, the Secretary may consider any or all of the following factors:

i. "The unmet need for such services, as determined under section 2602(b)(4) or other community input process as defined under section 2609(d)(1)(A).

ii. An increasing need for HIV/AIDS-related services, including relative rates of increase in the number of cases of HIV/AIDS.

iii. The relative rates of increase in the number of cases of HIV/AIDS within new or emerging subpopulations.

iv. The current prevalence of HIV/AIDS.

v. Relevant factors related to the cost and complexity of delivering health care to individuals with HIV/AIDS in the eligible area.

vi. The impact of co-morbid factors, including co-occurring conditions, determined relevant by the Secretary.

vii. The prevalence of homelessness.

viii. The prevalence of individuals described under section 2602(b)(2)(M).

ix. The relevant factors that limit access to health care, including geographic variation, adequacy of health insurance coverage, and language barriers."

HAB Expectations

Needs assessment is expected to generate information about:

- The size and demographics of the HIV/AIDS population within the service area, including those who are unaware of their HIV status (not tested), and
- The needs of PLWHA, with emphasis on individuals with HIV/AIDS who know their HIV status and are not receiving primary health care, and on disparities in access and services among affected subpopulations and historically underserved communities.

HAB expects Part A needs assessments to meet all legislative requirements and to provide a sound information base for planning and decision making.

PURPOSE, RESEARCH QUESTIONS AND METHODOLOGY

Purpose

The purposes of the Needs Assessment – 2019 were to:

(1) Identify the current gaps and barriers to achieving better integration between prevention and care services for PLWH in the Newark EMA (the latter with a focus on current needs for substance abuse and mental health),

(2) Identify how behavioral health outcomes compare for consumers being served by NEMA-funded agencies participating in the State's Behavioral Health Integration Project (B-HIP) versus those agencies not participating in B-HIP (limiting the analysis to agencies providing primary medical care services), and

(3) Identify the behavioral health (BH) treatment cascade among clients served by the Ryan White Program and to identify how the viral load compares across clients by stage in the BH cascade.

The outcome of this analysis of BH issues among RWHAP clients was/is to better target RWHAP resources to address the comorbidities of mental health and substance use disorder.

Research Questions and Methodology

Research Question #1

What are the current gaps and barriers to achieving better integration between prevention and care services for PLHIV in the Newark EMA (the latter with a focus on current needs for substance abuse and mental health)?

Methodological approach: Finish tabulating data from remaining consumer and provider surveys collected for the FY 2018 Needs Assessment.

Research Question #2

How do behavioral health outcomes compare for consumers being served by NEMA-funded agencies participating in the State's Behavioral Health Integration Project (B-HIP) versus those agencies not participating in B-HIP? (NOTE: Analyses will be limited to agencies providing primary medical care services.)

Sub-questions: (a) How does housing status compare across these two groups of agencies? (b) What is the association between housing and viral load across the two groups of agencies? and (c) Are behavioral health outcomes better for those with more stable housing?

Methodological approach: Analysis of CHAMP data from primary medical care sites to compare behavioral health status and viral load by housing status in B-HIP-participating agencies versus those not participating in B-HIP.

Research Question #3

What are the numbers along the behavioral health (BH) cascade among clients served by the Ryan White Program? How does viral load compare across clients by stage in the BH cascade? Components of the BH cascade include the following:

- Number of clients screened for behavioral health needs
- Number of clients who screen positive for behavioral health needs
- Number of clients who screen positive for behavioral health needs for whom there is a referral documented
- Number of clients for whom a referral is documented with documentation verifying at least one visit to a behavioral health provider (where services they provide could be within the same agency, to another Ryan White-funded agency, or an agency outside the Ryan White system.

Methodological approach: Analysis of CHAMP data for all funded agencies.

Issues for future consideration

- Insurance lapses and how they are handled
- Retention in care gaps by age (particularly for young MSM), income, and drug use

PART 1: BEHAVIORAL HEALTH NEEDS AND SERVICE GAPS

1.1 Introduction

Research Question #1 to be answered is:

What are the current gaps and barriers to achieving better integration between prevention and care services for PLWH in the Newark EMA (the latter with a focus on current needs for substance abuse and mental health)?

Methodological approach: Finish tabulating data from remaining consumer and provider surveys collected for the 2018 Needs Assessment Update. The survey tools are in Appendices A and B.

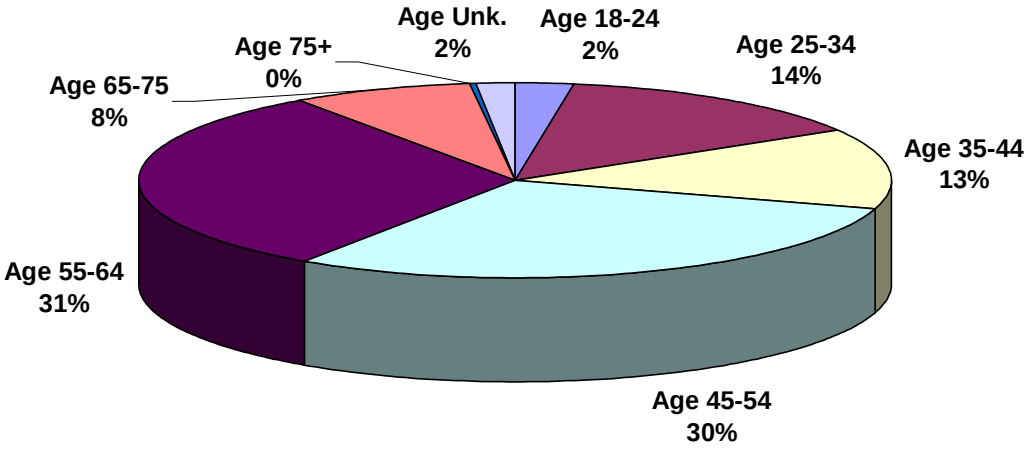
1.2 Findings Regarding Consumer Surveys of Behavioral Healthcare Needs

1.2.1 Characteristics of Consumer Respondents

In general, the **246 consumer respondents were reflective of the HIV epidemic** in the Newark EMA.

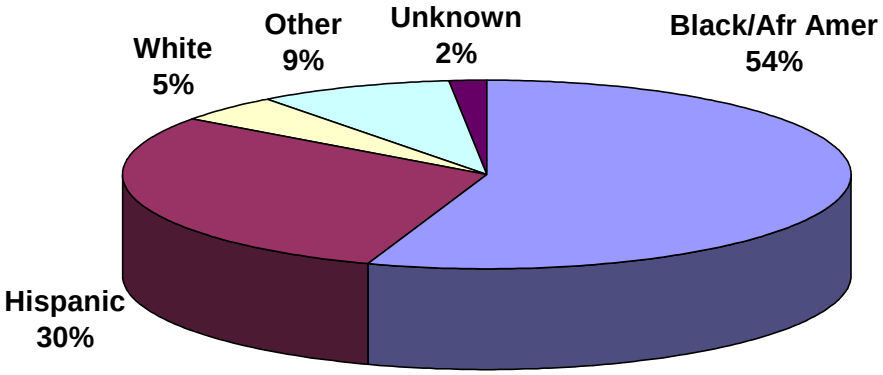
- **AGE = proportional representation – reflects HIV epidemic**

Figure 1: Age of Consumer Survey Respondents



- **RACE/ETHNICITY = higher proportion of Hispanic/Latino than 21% of epidemic.** "Other" is multiple races including Black/African American in combination with others.

Figure 2: Race/Ethnicity of Consumer Survey Respondents

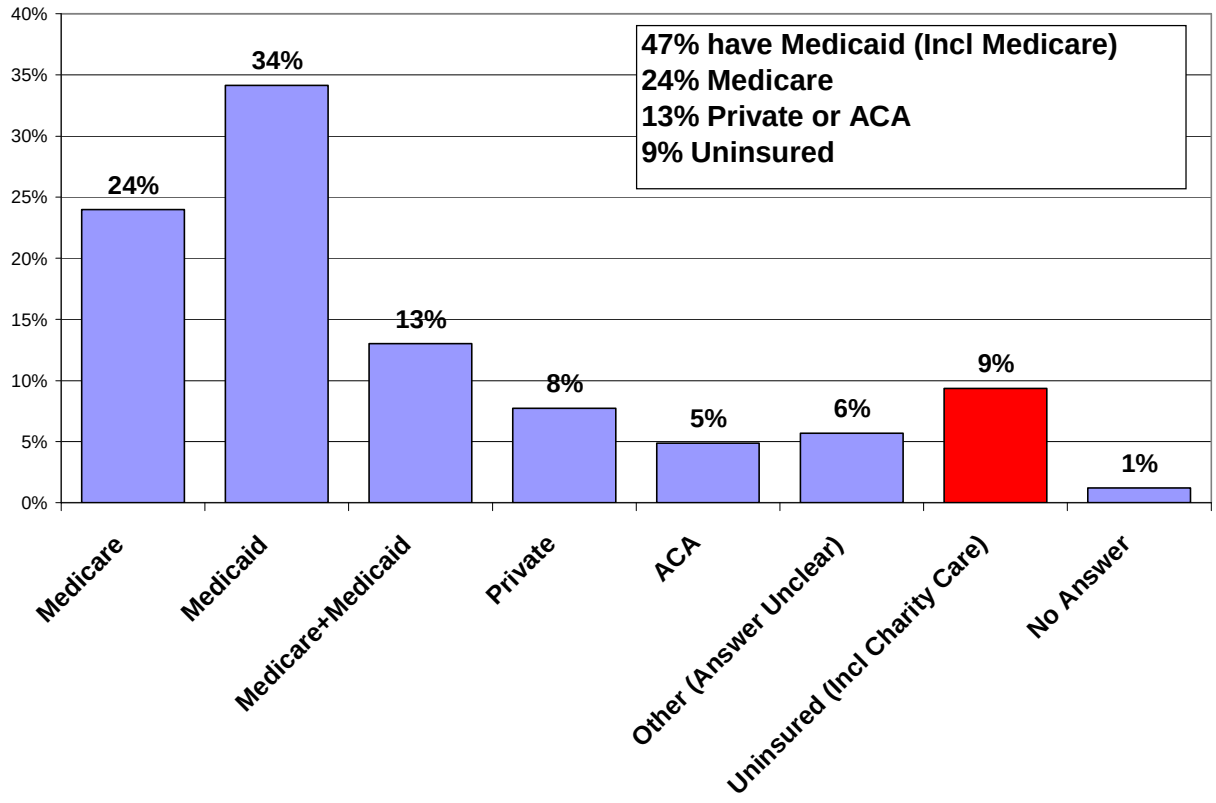


- **GENDER = proportional to epidemic.** 62% male, 36% female, 1% transgender, 1% No answer.
- **SEXUAL ORIENTATION =** 70% heterosexual, 20% gay/lesbian, 4% bisexual, 6% other/no answer.
- **RESIDENCE =** proportional to epidemic. 71% Essex, 16% Union, 8% Morris/Sussex/Warren, 5% outside EMA.
- **EDUCATION = new category**. 61% have high school education or less, 38% some college or college degree.

20%	Some high school or less
41%	H.S. diploma or GED
24%	Some college
14%	College degree
1%	No answer

- **HEALTH INSURANCE = 87% had some form of health insurance including Medicaid.** 9% were uninsured including Ryan White and Charity Care.

Figure 3: Health Insurance Status of Consumer Survey Respondents



- **YEARS LIVING WITH HIV = Respondents had a wide range of years living with HIV** – from 19 individuals (8%) newly diagnosed including three in the survey year of 2018, through 24 (10%) living with HIV for 31+ years.

Range of Years Living with HIV	#	%
0-2 yrs New Diagnosis	19	8%
3-5 Yrs	11	5%
6-10 Yrs	32	13%
11-15 Yrs	28	11%
16-20 Yrs	35	14%
21-25 Yrs	36	15%
26-30 Yrs	25	10%
31+ Yrs	24	10%
Do not Remember	1	0%
No Answer	35	14%
Total	**246**	**100%**

- **AIDS DIAGNOSIS = 29% had been diagnosed with AIDS, 71% had not**.

- **TRANSMISSION MODE – SOURCE OF HIV INFECTION** = Most respondents (70%) reported that sex with an HIV-infected partner was the source of their HIV infection.

Sex with an infected partner	70%
Sharing injection drug equipment	8%
Born with HIV	4%
Sex w/ Infected Partner + Sharing ID Equipment	3%
Unknown/Other or No Answer	15%
Total	100%

- **MOST RECENT VISIT TO DOCTOR FOR HIV CARE** = The majority of respondents (75%) said that their most recent visit to the doctor for HIV care was within the past 3 months. Another 19% reported a visit 3-6 months ago. **At least 94% appear to be receiving regular HIV medical care.**

Most Recent HIV Medical Visit	#	%
Within past 3 months	183	75%
Between 3 and 6 months ago	45	19%
6 months to 1 year ago	10	3%
More than 1 Year ago	3	1%
I have never received HIV medical care	2	1%
No Answer	3	1%
Total	**246**	**100%**

- **CURRENTLY TAKING HIV MEDICATIONS** = **94% (232) reported taking HIV medications (antiretrovirals or "ARV").** **5**% (12) reported they were not currently taking HIV medications and 1% (2) did not answer.

- **UNDETECTABLE VIRAL LOAD (VL)** = **75% (185) reported that their Viral Load (VL) was undetectable (at least < 200 copies/mL of blood).** 17% (41) reported that their VL was NOT undetectable. 6% (14) did not know and 2% (6) did not answer.

- **CURRENT VIRAL LOAD (VL)** = **Only 45% (111) answered this question.** 30% (74) self-reported their VL as "undetectable" and another 1% (3) as below 200 – for a total of 31% (77) Virally Suppressed. Another 11% (26) reported VL of 200-999 and 2% (5) VL of 1,000 or above. 1% (3) did not know their VL and 55% (135) did not answer.

Self-Reported Viral Load (VL)

VL Range	#	%
Undetectable	74	30%
<200 (Not "Undetectable")	3	1%
200-999	26	11%
1000+	5	2%
Do Not Know	3	1%
No Answer	135	55%
Total	**246**	**100%**

PREVENTION SERVICES:

- **U=U (UNDETECTABLE =UNTRANSMITTABLE)** = **65% (160) reported they had heard about U=U and 28% (70) had not.** 5% (12) did not know and 2% (4) did not answer.

- **PrEP (PRE-EXPOSURE PROPHYLAXIS)** = **68% (168) reported they had heard about PrEP and 27% (66) had not.** 4% (9) did not know and 1% (3) did not answer.

- **PEP (POST-EXPOSURE PROPHYLAXIS)** = **56% (168) reported they had heard about PEP and 35% (87) had not.** 7% (17) did not know and 2% (4) did not answer.

1.2.2 Behavioral Issues – Substance Use and Mental Health

This section summarizes responses by 246 consumers to the Consumer Survey in Appendix A. A number of consumers did not answer some of the questions. The percentages are based on the total 246 consumers.

Substance Use

Nearly 1/3 (75) of consumers use tobacco on a daily basis. 10% consume alcohol frequently (3-5 times per week or daily). 11% use marijuana frequently at 3-5 days per week or daily (6%). 5% reported frequent use of cocaine and 6% reported frequent use of heroin – both at 4% daily use. Another 4% reported frequent use of other illegal drugs. 5% reported frequent use of pain killers (Oxycontin or Oxycodone) that were not prescribed to you.

13% reported feeling the need to cut down on their drug use or drinking but were not able to, even though it was causing problems with family/friends or school/work.

Mental Health Issues

A higher percent of consumers reported mental health issues compared to those reporting substance use.

Consumers reporting the following in the last 12 months. One in five reported feeling extremely energetic, irritable or more talkative than usual. Over one-third (35%-37%) reported depression – including losing interest in most things – for more than two weeks in a row. One-third reported periods of anxiety lasting more than one month. One quarter reported anxiety attacks or heart racing.

Trauma

One third (77) of respondents reported experiencing trauma in their lifetime – traumatic events that involved harm to yourself or to others. 20% reported flashbacks, nightmares or thoughts of the trauma in the past year.

Behavioral Screening – Case Management

Consumers reported varying rates of case managers asking them about their mental health and substance use issues within the past 12 months. This series of questions relies on consumer perceptions and memory and is not a survey of case managers, so responses cannot be used as an evaluation of the case management system.

Two-thirds reported that their case manager (CM) had asked them about their sadness, loneliness or depression in the past 12 months - also, about their tobacco use. Half reported that their CM had asked if they were having trouble focusing, and asked about their substance use including alcohol, recreational drugs (heroin, cocaine, etc.). Two in five (40%) reported that their CM had asked about prescription drug misuse and use of other substances, and whether they felt safe in their home. Nearly half (44%) of CM had asked if they experienced stigma due to their HIV.

Behavioral Service Needs

Consumers reported whether they had needed various types of behavioral services and whether they had received those services. The difference between the need and receipt of services is a possible service gap, which is shown in the tables below.

The following services are listed in order of need: individual counseling (50%), group counseling (44%), psychiatric services (34%), outpatient drug treatment (20%), relapse prevention (19%), crisis intervention (16%), inpatient drug treatment (14%), methadone treatment (11%), inpatient drug detoxification (11%), suboxone treatment (9%), and shelter for victims of interpersonal violence (9%).

Opioids

Less than one in seven (13%) reported that they were currently prescribed any narcotic medications (that is, pain killers, opioids – Oxycodone or Oxycontin).

Substance Use, Trends, Needs

A total of 174 (71%) of the 246 consumers identified the **most commonly use substances within their community**. Many listed more than one substance. In order, they are Heroin (45%), cocaine including crack cocaine (44%), alcohol (25%), pills/opiates/painkillers (24%), and marijuana (21%). Tobacco was cited last at 1%.

81% of respondents reported that the **trends in substance use have gotten worse over the past 5 years.**

The types of services/resources most needed to address community substance use issues in order are:

(1) More Funding for SA Programs, (2) Supportive Services, (3) Education, (4) Outpatient Counseling, (5) Police, (6) Outreach, (7) Rehabilitation, and (8) Mental Health Services. Additional services are needed as well, as shown in the tables below.

1.2.3 Data Tables for Behavioral Issues – Substance Use and Mental Health

TABLE OF CONTENTS - CONSUMER SURVEY TABLES

1.2.3 Data Tables for Behavioral Issues – Substance Use and Mental Health

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TABULATIONS - CONSUMER SURVEY RESPONSES

#1 DEMOGRAPHICS

Table 1: Age Category

	#	%
Age 18-24	6	2.4%
Age 25-34	34	13.8%
Age 35-44	33	13.4%
Age 45-54	73	29.7%
Age 55-64	76	30.9%
Age 65-75	19	7.7%
Age 75+	1	0.4%
Age Unknown	4	1.6%
Total	**246**	**100.0%**

Table 2: County of Residence

Essex	175	71.1%
Union	39	15.9%
Morris	16	6.5%
Sussex	1	0.4%
Warren	1	0.4%
Bergen	1	0.4%
Hudson	6	2.4%
Somerset	7	2.8%
Total	**246**	**100.0%**

Table 3: Race/Ethnicity

Black Not Hispanic	136	**55.3%**
Hispanic	73	**29.7%**
White Not Hispanic	12	4.9%
Other Not Hispanic	21	8.5%
Race/Ethnicity Missing	4	1.6%
Total	**246**	**100.0%**

Table 4: Gender

Male	151	61.4%
Female	89	36.2%
Transgender: Male-to-Female	3	1.2%
No Answer	3	1.2%
Total	**246**	**100.0%**

Table 5: Sexual Orientation

Heterosexual	170	**69.1%**
Gay/Lesbian	46	**18.7%**
Bisexual	12	**4.9%**
Men non gay	2	0.8%
Love Men	1	0.4%
No Answer	15	6.1%
Total	246	**100.0%**

Table 6: Cross Tabulation of Gender and Sexual Orientation

	Gender					
Sexual Orientation	Male	Female	Transgender: Male-to-Female	No Answer	Total	
Heterosexual	98	72	0	0	170	**69.1%**
Gay/Lesbian	41	4	1	0	46	**18.7%**
Bisexual	7	4	1	0	12	**4.9%**
Men non gay	0	1	0	1	2	0.8%
Love Men	0	1	0	0	1	0.4%
No Answer	5	7	1	2	15	6.1%
Total	**151**	**89**	**3**	**3**	**246**	100.0%

Table 7: Education Level

Some high school or less	50	20.3%
High school diploma or GED	100	40.7%
Some college	58	23.6%
Associate's degree	17	6.9%
Bachelor's degree	9	3.7%
Graduate degree	8	3.3%
No Answer	4	1.6%
Total	**246**	**100.0%**

Table 8: Health Insurance

None (Incl Charity Care)	**23**	**9.3%**	
Private insurance (self-pay or through an employer)	19	7.7%	
Obamacare plan/plan through the ACA Marketplace	11	4.5%	
Medicare	**59**	**24.0%**	
Medicaid	**81**	**32.9%**	
Wellcare	1	0.4%	
United Healthcare	4	1.6%	
Horizon	5	2.0%	
Aetna	2	0.8%	
Amerigroup	2	0.8%	
Private Ins+Obamacare	1	0.4%	
Private Ins+Medicaid	1	0.4%	
Obamacare+Medicaid	2	0.8%	
Medicare+Medicaid	**31**	**12.6%**	**69.5%**
Medicare+Medicaid+VA	1	0.4%	
No Answer	3	1.2%	
Total	**246**	**100.0%**	

#2 HIV STATUS

Table 9: Years Living with HIV

Range of Years	#	%
0-2 yrs New Diagnosis	19	7.7%
3-5 Yrs	11	4.5%
6-10 Yrs	32	13.0%
11-15 Yrs	28	11.4%
16-20 Yrs	35	14.2%
21-25 Yrs	36	14.6%
26-30 Yrs	25	10.2%
31+ Yrs	24	9.8%
Do not Remember	1	0.4%
No Answer	35	14.2%
Total	**246**	**100.0%**

Years Reported (n = 210)		
</= 10 Years	62	**29.5%**
11-20 Years	63	**30.0%**
21-30 Years	61	**29.0%**
31+ Yrs	24	**11.4%**
Total	**210**	**100.0%**

Table 10: Have you ever been diagnosed with AIDS?

Yes	71	28.9%
No	174	70.7%
No Answer	1	0.4%
Total	246	**100.0%**

Table 11: How do you believe you were infected with HIV?

Born with HIV	10	4.1%
Sex with an infected partner	**173**	**70.3%**
Sharing injection drug equipment	21	8.5%
Sex w/ Infected Partner + Sharing ID Equipment	6	2.4%
Unknown/Other	28	11.4%
No Answer	8	3.3%
Total	**246**	**100.0%**

Table 12: When was your most recent visit to your doctor for HIV care?

Within past 3 months	**183**	**74.4%**
Between 3 and 6 months ago	**45**	**18.3%**
6 months to 1 year ago	10	4.1%
More than 1 Year ago	3	1.2%
I have never received HIV medical care	2	0.8%
No Answer	3	1.2%
Total	**246**	**100.0%**

92.7% Past 6 months

Table 13: Do you currently take HIV medications?

Yes	**232**	**94.3%**
No	12	4.9%
No Answer	2	0.8%
Total	246	100.0%

Table 14: Is your viral load currently undetectable?

Yes	**185**	**75.2%**
No	41	16.7%
Don't Know	14	5.7%
No Answer	6	2.4%
Total	**246**	**100.0%**

Table 15: Current Viral Load (Range in 2018)

Undetectable	74	30.1%
VL Suppressed	3	1.2%
VL 200-499	10	4.1%
VL 500-999	16	6.5%
VL 1,000+	5	2.0%
Do Not Know/Unsure VL	3	1.2%
No Answer/Missing	135	54.9%
Total	246	100.0%

44% Knew Viral Load

Table 16: Have you ever heard of U=U (undetectable = untransmittable)?

Yes	160	65.0%
No	70	28.5%
Don't Know	12	4.9%
No Answer	4	1.6%
Total	246	100.0%

Table 17: Have you ever heard of PrEP (pre-exposure prophylaxis)?

Yes	168	68.3%
No	66	26.8%
Don't Know	9	3.7%
No Answer	3	1.2%
Total	**246**	**100.0%**

Table 18: Have you ever heard of PEP (post-exposure prophylaxis)?

Yes	138	56.1%
No	87	35.4%
Don't Know	17	6.9%
No Answer	4	1.6%
Total	246	100.0%

#3 BEHAVIORAL ISSUES - SUBSTANCE USE AND MENTAL HEALTH

SUBSTANCE USE

Table 19: How Often Do You… Use tobacco products

Never	113	45.9%
Once or Twice a Month	16	6.5%
On Weekends Only	3	1.2%
3-5 Days Per Week	25	10.2%
Daily	**75**	**30.5%**
No Answer	14	5.7%
Total	246	100.0%

Table 20: How Often Do You… Have more than 3 (for women) or 4 (for men) alcoholic drinks in a day?

Never	141	57.3%
Once or Twice a Month	33	13.4%
On Weekends Only	25	10.2%
3-5 Days Per Week	11	4.5%
Daily	10	4.1%
No Answer	26	10.6%
Total	246	100.0%

Table 21: How Often Do You… Use marijuana?

Never	179	72.8%
Once or Twice a Month	12	4.9%
On Weekends Only	13	5.3%
3-5 Days Per Week	12	4.9%
Daily	15	6.1%
No Answer	15	6.1%
Total	246	100.0%

Table 22: How Often Do You… Use cocaine?

Never	204	82.9%
Once or Twice a Month	9	3.7%
On Weekends Only	1	0.4%
3-5 Days Per Week	3	1.2%
Daily	10	4.1%
No Answer	19	7.7%
Total	246	100.0%

Table 23: How Often Do You… Use heroin?

Never	205	83.3%
Once or Twice a Month	4	1.6%
On Weekends Only	4	1.6%
3-5 Days Per Week	3	1.2%
Daily	11	4.5%
No Answer	19	7.7%
Total	246	100.0%

Table 24: How Often Do You… Use other illegal drugs?

Never	210	85.4%
Once or Twice a Month	6	2.4%
On Weekends Only	0	0.0%
3-5 Days Per Week	5	2.0%
Daily	5	2.0%
No Answer	20	8.1%
Total	246	100.0%

Table 25: How Often Do You… Use pain killers (oxycontin/oxycodone) that were not prescribed to you or for the feeling it caused?

Never	210	85.4%
Once or Twice a Month	4	1.6%
On Weekends Only	3	1.2%
3-5 Days Per Week	3	1.2%
Daily	9	3.7%
No Answer	17	6.9%
Total	246	100.0%

Table 26: **In the last 12 months, how often did you feel you wanted or needed to cut down on your drinking or drug use but were not able to?**

Never	160	65.0%
Once	20	8.1%
Twice or More	33	13.4%
No Answer	33	13.4%
Total	246	100.0%

Table 27: **In the last 12 months, how often did you continue to drink even though it was causing problems with your family/friends or school/work?**

Never	177	72.0%
Once	12	4.9%
Twice or More	27	11.0%
No Answer	30	12.2%
Total	246	100.0%

MENTAL HEALTH

In the last 12 months did you ever experienced any of the following:

Table 28: **When not high or intoxicated, felt extremely energetic or irritable and more talkative than usual?**

Yes	46	18.7%
No	174	70.7%
No Answer	26	10.6%
Total	246	100.0%

Table 29: **Experienced a time where you felt sad, blue, or depressed for more than 2 weeks in a row?**

Yes	91	37.0%
No	134	54.5%
No Answer	21	8.5%
Total	246	100.0%

Table 30: **Lost interest in most things (like hobbies, work, or activities that usually give you pleasure) for more than 2 weeks in a row?**

Yes	87	35.4%
No	136	55.3%
No Answer	23	9.3%
Total	246	100.0%

Table 31: **Had a period lasting more than one month when most of the time you felt worried or anxious?**

Yes	82	33.3%
No	141	57.3%
No Answer	23	9.3%
Total	246	100.0%

Table 32: **Had a spell or attack when all of a sudden you felt frightened, anxious or very uneasy when most people would not be afraid or anxious?**

Yes	62	25.2%
No	161	65.4%
No Answer	23	9.3%
Total	246	100.0%

Table 33: **Had a spell or attack when, for no reason, your heart suddenly started to race, you felt faint, or you couldn't catch your breath?**

Yes	61	24.8%
No	162	65.9%
No Answer	23	9.3%
Total	246	100.0%

TRAUMA

Table 34: **During your lifetime, as a child or adult, have you experienced or witnessed traumatic events that involved harm to yourself or to others?**

Yes	77	31.3%
No	93	37.8%
No Answer	76	30.9%
Total	246	100.0%

Table 35: **In the past year, have you been troubled by flashbacks, nightmares, or thoughts of the trauma?**

Yes	49	19.9%
No	54	22.0%
Not Applicable	90	36.6%
No Answer	53	21.5%
Total	246	100.0%

#4 BEHAVIORAL SCREENING - CASE MANAGEMENT

In the last 12 months has your case manager asked you…

Table 36: **If you were feeling sad, lonely or depressed?**

Yes	164	66.7%
No	51	20.7%
Don't Know/Remember	11	4.5%
No Answer	20	8.1%
Total	246	100.0%

Table 37: If you were having trouble focusing?

Yes	129	52.4%
No	84	34.1%
Don't Know/Remember	12	4.9%
No Answer	21	8.5%
Total	246	100.0%

Table 38: How frequently you were using alcohol?

Yes	116	47.2%
No	87	35.4%
Don't Know/Remember	11	4.5%
No Answer	32	13.0%
Total	246	100.0%

Table 39: If you were using recreational drugs (cocaine, heroin, etc.)?

Yes	123	50.0%
No	89	36.2%
Don't Know/Remember	9	3.7%
No Answer	25	10.2%
Total	246	100.0%

Table 40: If you were misusing prescription drugs (pain medications)?

Yes	107	43.5%
No	103	41.9%
Don't Know/Remember	11	4.5%
No Answer	25	10.2%
Total	246	100.0%

Table 41: If you were misusing any other substances (sniffing glue)

Yes	94	38.2%
No	118	48.0%
Don't Know/Remember	13	5.3%
No Answer	21	8.5%
Total	246	100.0%

Table 42: If you use tobacco/smoke?

Yes	156	63.4%
No	62	25.2%
Don't Know/Remember	6	2.4%
No Answer	22	8.9%
Total	246	100.0%

Table 43: If you have felt unsafe in your home?

Yes	95	38.6%
No	112	45.5%
Don't Know/Remember	16	6.5%
No Answer	23	9.3%
Total	246	100.0%

Table 44: If you felt stigmatized (made to feel bad about your HIV status)?

Yes	109	44.3%
No	99	40.2%
Don't Know/Remember	15	6.1%
No Answer	23	9.3%
Total	246	100.0%

#5 BEHAVIORAL SERVICE NEEDS

In the last 12 months, did you ever need any of the following services?

Table 45: Crisis intervention

No	177	72.0%
Yes-From My Primary Care site	20	8.1%
Yes-Referral to Outside Agency	15	6.1%
Yes-Primary Care Site + Outside Agency	0	0.0%
Yes-I did not receive the service	5	2.0%
No Answer	29	11.8%
Total	246	100.0%

16.3% Needed Service
14.2% Received Service
2.0% Possible Service Gap

Table 46: Individual Counseling

No	96	39.0%
Yes-From My Primary Care site	89	36.2%
Yes-Referral to Outside Agency	26	10.6%
Yes-Primary Care Site + Outside Agency	3	1.2%
Yes-I did not receive the service	6	2.4%
No Answer	26	10.6%
Total	246	100.0%

50.4% Needed Service
48.0% Received Service
2.4% Possible Service Gap

Table 47: Group counseling

No	114	46.3%
Yes-From My Primary Care site	70	28.5%
Yes-Referral to Outside Agency	28	11.4%
Yes-Primary Care Site + Outside Agency	2	0.8%
Yes-I did not receive the service	7	2.8%
No Answer	25	10.2%
Total	246	100.0%

43.5% Needed Service
40.7% Received Service
2.8% Possible Service Gap

Table 48: Psychiatric services (prescription drugs)

No	135	54.9%
Yes-From My Primary Care site	56	22.8%
Yes-Referral to Outside Agency	21	8.5%
Yes-Primary Care Site + Outside Agency	0	0.0%
Yes-I did not receive the service	6	2.4%
No Answer	28	11.4%
Total	246	100.0%

33.7% **Needed Service**
31.3% **Received Service**
2.4% ***Possible Service Gap***

Table 49: Methadone treatment

No	193	78.5%
Yes-From My Primary Care site	11	4.5%
Yes-Referral to Outside Agency	7	2.8%
Yes-Primary Care Site + Outside Agency	1	0.4%
Yes-I did not receive the service	9	3.7%
No Answer	25	10.2%
Total	246	100.0%

11.4% **Needed Service**
7.7% **Received Service**
3.7% ***Possible Service Gap***

Table 50: Suboxone treatment

No	193	78.5%
Yes-From My Primary Care site	10	4.1%
Yes-Referral to Outside Agency	5	2.0%
Yes-Primary Care Site + Outside Agency	0	0.0%
Yes-I did not receive the service	8	3.3%
No Answer	30	12.2%
Total	246	100.0%

9.3% **Needed Service**
6.1% **Received Service**
3.3% ***Possible Service Gap***

Table 51: Drug detoxification (inpatient)

No	191	77.6%
Yes-From My Primary Care site	10	4.1%
Yes-Referral to Outside Agency	9	3.7%
Yes-Primary Care Site + Outside Agency	0	0.0%
Yes-I did not receive the service	8	3.3%
No Answer	28	11.4%
Total	246	100.0%

11.0% **Needed Service**
7.7% **Received Service**
3.3% ***Possible Service Gap***

Table 52: Inpatient drug treatment

No	185	75.2%
Yes-From My Primary Care site	11	4.5%
Yes-Referral to Outside Agency	13	5.3%
Yes-Primary Care Site + Outside Agency	0	0.0%
Yes-I did not receive the service	11	4.5%
No Answer	26	10.6%
Total	246	100.0%

14.2% **Needed Service**
9.8% **Received Service**
4.5% ***Possible Service Gap***

Table 53: Outpatient drug treatment

No	168	68.3%
Yes-From My Primary Care site	24	9.8%
Yes-Referral to Outside Agency	17	6.9%
Yes-Primary Care Site + Outside Agency	0	0.0%
Yes-I did not receive the service	9	3.7%
No Answer	28	11.4%
Total	246	100.0%

20.3% Needed Service
16.7% Received Service
3.7% Possible Service Gap

Table 54: Relapse prevention

No	163	66.3%
Yes-From My Primary Care site	23	9.3%
Yes-Referral to Outside Agency	16	6.5%
Yes-Primary Care Site + Outside Agency	0	0.0%
Yes-I did not receive the service	8	3.3%
No Answer	36	14.6%
Total	246	100.0%

19.1% Needed Service
15.9% Received Service
3.3% Possible Service Gap

Table 55: Shelter for victims of interpersonal violence

No	194	78.9%
Yes-From My Primary Care site	9	3.7%
Yes-Referral to Outside Agency	6	2.4%
Yes-Primary Care Site + Outside Agency	0	0.0%
Yes-I did not receive the service	8	3.3%
No Answer	26	10.6%
Total	246	98.8%

9.3% Needed Service
6.1% Received Service
3.3% Possible Service Gap

OPIOIDS

Table 56: Are you currently prescribed any narcotic medications (that is, pain killers, opioids – oxycodone or oxycontin)?

Yes	31	12.6%
No	181	73.6%
No Answer	34	13.8%
Total	246	100.0%

#6 SUBSTANCE USE, TRENDS, NEEDS

Question 28: What are the most commonly abused substances within your community?

A total of 174 (71%) of the 246 consumers responded. Many listed more than one substance.
The top 3 substances abused are Heroin, Cocaine, Alcohol.

Substance Listed	# Responses	% (of 174)
Heroin	78	45%
Cocaine	56	32%
Alcohol	44	25%
Pills/Opiates/Rx Drugs/Pain Killers	41	24%
Marijuana/Weed	37	21%
Crack [cocaine]	20	11%
"Drugs"	15	9%
All	9	5%
Crystal Meth	9	5%
Oxycodone/Oxycontin	5	3%
Xanax	4	2%
Tobacco	2	1%
Subtotal Responses	320	
Total Respondents	174	
No Answer/Don't Know	72	
Total Consumers	246	

Question 28A: How have trends in substance abuse changed within your community over the past five years?

A total of 91 (37%) of the 246 consumers responded. 155 (63%) did not respond.
81% of respondents stated that the substance abuse trends have gotten worse.

Trends in Substance Abuse	#	%
Increased/Got Worse	74	81%
No Change	10	11%
Improved with Specific Programs	7	8%
	91	100%

#6 SUBSTANCE USE, TRENDS, NEEDS

Question 28B: What types of services or resources are most needed to better address the substance abuse problems faced by members of your community?

A total of 136 (55%) of the 246 consumers responded. 110 (45%) did not.
The responses are listed by general category. Many consumers listed more than one response as indicated.

Types of Services/Resources Most Needed to Address Community Substance Use Issues

	#	% (of 136)
More Funding for SA Programs	32	24%
Supportive Services	22	16%
Education	21	15%
Outpatient Counseling	16	12%
Police	16	12%
Outreach	13	10%
Rehabilitation	7	5%
Mental Health Services	7	5%
Special Care	7	5%
Faith Services	5	4%
More info for SUD avoidance	4	3%
Detox	4	3%
Methadone	3	2%
Inpatient SA Services	3	2%
SA Management/Control	2	1%
Institutions	2	1%
Syringe Exchange	1	1%
Youth Services	1	1%
Subtotal Responses	166	
Total Respondents		136
No Answer/Don't Know		110
Total Consumers		246

1.3 Findings Regarding Agency Surveys of Behavioral Healthcare Needs

1.3.1 Agency Characteristics

A total of 25 of 34 agencies (74%) responded to this survey and questions. They ranged from providers of medical care only or coupled with either or both mental health and outpatient substance use services, agencies receiving only mental health or substance use funding or both, and agencies providing only support services (non-medical case management (NM-CM), housing, Emergency Financial Assistance (EFA), psychosocial, legal, including 1 that provided dental/oral health care).

# Agencies	%	Services Provided
2	8.0%	Medical care (no Behavioral)
5	20.0%	Medical care + mental health
6	24.0%	Medical care + mental health + outpatient substance use
1	4.0%	Mental Health Only
2	8.0%	OP Substance Use Only
9	36.0%	Support Services Only (including 1 Dental)
25	**100.0%**	**Total**

1.3.2 Agency Survey – Summary of Findings

- **Behavioral Screening Frequency** – Most agencies screen clients every 6 months for behavioral issues.
- **Behavioral Screening Tools** – Many agencies use evidence-based tools for behavioral health (BH) screening. Others use agency-specific tools which may not be evidence-based.
- **Further Behavioral Assessment/Follow Up** – For clients with positive BH screens, agencies provide BH services on site, or [mostly] refer out to other agencies for further assessment or treatment.
- **Ability To Meet Behavioral Needs Onsite/By Referral** – Agencies are able to meet 80%-96% of client needs. The unmet need of 20% is for drug detoxification and 16% for inpatient drug treatment.
- **Substance Use Issues, Needs, Challenges, Gaps –** Most commonly used substances are heroin, cocaine, marijuana. Trends have increased by specific substances. Lack of access to treatment is the biggest challenge, followed by patient barriers. Gaps are lack of sufficient substance use treatment resources.
- **Mental Health Issues, Needs, Challenges, Gaps** – Most common mental health problems are depression, anxiety, bipolar disorder. Trends have increased in mental health diagnosis or clients acknowledging their mental health issues. Inadequate mental health resources including psychiatrists is the biggest challenge, followed by patient behavior/issues. Gaps are inadequate mental health/psychiatric resources, followed by lack of access.
- **Emerging Substance Use and Mental Health Needs** – There is continuing need for behavioral health services overall as well as need for specific services.
- **Behavioral Health Resource Needs** – Specific services and staffing were cited.

1.3.3 Agency Survey of Behavioral Issues

AGENCY SURVEY

TABLE OF CONTENTS

1.3.3 Agency Survey of Behavioral Issues

AGENCY SURVEY OF BEHAVIORAL ISSUES

A total of 25 of 34 agencies (74%) responded to this survey and questions. They ranged from providers of medical care only or coupled with either or both mental health and outpatient substance use, agencies receiving only mental health or substance use funding or both, and agencies providing only support services (non-medical case management (NM-CM), housing, Emergency Financial Assistance (EFA), psychosocial, legal, including 1 that provided dental/oral health care).

# Agencies		
2	8.0%	Medical care (no Behavioral)
5	20.0%	Medical care + mental health
6	24.0%	Medical care + mental health + outpatient substance use
1	4.0%	Mental Health Only
2	8.0%	OP Substance Use Only
9	36.0%	Support Services Only (including 1 Dental)
25	**100.0%**	**Total**

#1 BEHAVIORAL SCREENING FREQUENCY

Question 12: How often do you screen your clients for each of the following:

For the most part, agencies screen clients for 8 behavioral issues - depression, substance use including tobacco, and HIV stigma - at every visit, every six months, and when signs or symptoms are present.
See the results in the attached tables.
Additional screening occurs:
If the client mentions it, more often if suspected, and at support groups.

#2 BEHAVIORAL SCREENING TOOLS

Question 13: For each of the following problems, please indicate what tool you use to screen clients (e.g., an evidence-based tool like the CAGE for alcohol abuse or a screening question created by staff – if the latter, please provide the wording of the screening question you use). If you do not know which screening tool you use, please indicate as such:

The data for Questions 13A-13H were cross-tabulated with the types of RWHAP services the agencies were funded for in 2018 - primary medical care, mental health services, outpatient substance abuse, support services (including 1 Dental).
The purpose was to see if there were any differences in the tools used for medical versus non-medical provider agencies. **For depression and alcohol abuse screening, the medical agencies used more standardized or evidence-based tools, but for the remaining services, the tools were more agency-based.**

Question 13A: DEPRESSION

10 or 37%	Used Standardized or Evidence-based Tools (1 agency used 3 tools)
11 or 41%	Used Agency-specific tools.
6 or 22%	Screening was not applicable for agency services. Observation; referral if symptoms present.

1.3.3 Agency Survey of Behavioral Issues

AGENCY SURVEY OF BEHAVIORAL ISSUES

Question 13B: ALCOHOL ABUSE

13 or 48%	Used Standardized or Evidence-based Tools (1 agency used 3 tools)
9 or 33%	Used Agency-specific tools.
5 or 19%	Screening was not applicable for agency services. Referral if symptoms present.

Question 13C: ABUSE OF RECREATIONAL DRUGS (E.G., HEROIN, COCAINE, ETC.)

12 or 44%	Used Standardized or Evidence-based Tools (1 agency used 3 tools)
10 or 37%	Used Agency-specific tools.
5 or 19%	Screening was not applicable for agency services. Referral if symptoms present.

Question 13D: ABUSE OF PRESCRIPTION DRUGS (E.G., OPIOIDS)

Use of standardized or evidence-based tools is starting to decline. Also, two agencies reported they did not perform analysis of prescription drug use.

10 or 37%	Used Standardized or Evidence-based Tools (1 agency used 3 tools)
11 or 41%	Used Agency-specific tools.
4 or 15%	Screening was not applicable for agency services. Referral if symptoms present.
2 or 7%	Do not do/No Answer.

Question 13E: ABUSE OF OTHER SUBSTANCES

Responses were almost identical to Question 13D re use of prescription drugs.

10 or 37%	Used Standardized or Evidence-based Tools (1 agency used 3 tools)
12 or 44%	Used Agency-specific tools.
4 or 15%	Screening was not applicable for agency services. Referral if symptoms present.
1 or 4%	No Answer.

Question 13F: TOBACCO USE

Only a few agencies used an evidence-based tool for screening for tobacco use.

6 or 20%	Used Standardized or Evidence-based Tools (1 agency used 3 tools)
11 or 37%	Used Agency-specific tools.
7 or 23%	Direct questioning by staff.
5 or 17%	Screening was not applicable for agency services. Referral if symptoms present.
1 or 3%	No Answer.

1.3.3 Agency Survey of Behavioral Issues

AGENCY SURVEY OF BEHAVIORAL ISSUES

Question 13G: INTERPERSONAL VIOLENCE

Most agencies use an agency biopsychosocial assessment or other tool to assess interpersonal violence.

2 or 8%	Used Standardized or Evidence-based Tools (1 agency used 2 tools)
14 or 54%	Used Agency-specific tools.
2 or 8%	Direct questioning by staff.
5 or 19%	Screening was not applicable for agency services. Referral if symptoms present.
3 or 12%	No Answer.

Question 13H: HIV STIGMA

Most agencies use agency tools or discussion with client individually or in support groups to assess HIV Stigma.

1 or 4%	Used Standardized or Evidence-based Tools
8 or 32%	Used Agency-specific tools.
8 or 32%	Discussion with clients individually or in support groups.
5 or 20%	Screening was not applicable for agency services. Referral if symptoms present.
3 or 12%	No Answer.

#3 FURTHER BEHAVIORAL ASSESSMENT/FOLLOW UP

Question 14: If a client has a positive screening for any of the following conditions, what is your procedure for providing further assessment/follow-up?

Responses were categorized by whether (1) agency performs services on site, including referral out for specialized services, (2) Refers out all the time (does not provide services on site), and (3) Not Applicable (service is not within agency's scope of service). Other categories are noted based on the question.

Question 14A: DEPRESSION

12 or 48%	Provide Mental Health/Psychiatric Services On Site/Refer
9 or 36%	Refer out for Mental Health Services
4 or 16%	Not Applicable (Not within Agency Services)

Question 14B: ALCOHOL ABUSE

10 or 40%	Provide Substance Use Disorder Services On Site/Refer
10 or 40%	Refer out for Substance Use Disorder Services
4 or 16%	Not Applicable (Not within Agency Services)
1 or 4%	No Answer

1.3.3 Agency Survey of Behavioral Issues

AGENCY SURVEY OF BEHAVIORAL ISSUES

Responses to Questions 14C through 14E are similar to those for alcohol abuse.

Question 14C: ABUSE OF RECREATIONAL DRUGS (E.G., HEROIN, COCAINE, ETC.)

10 or 40%	Provide Substance Use Disorder Services On Site/Refer
10 or 40%	Refer out for Substance Use Disorder Services
4 or 16%	Not Applicable (Not within Agency Services)
1 or 4%	No Answer

Question 14D: ABUSE OF PRESCRIPTION DRUGS

10 or 40%	Provide Substance Use Disorder Services On-Site/Refer
10 or 40%	Refer Out for Substance Use Disorder Services
4 or 16%	Not Applicable (Not Within Agency Services)
1 or 4%	No Answer

Question 14E: ABUSE OF OTHER DRUGS

10 or 40%	Provide Substance Use Disorder Services On-Site/Refer
10 or 40%	Refer Out for Substance Use Disorder Services
4 or 16%	Not Applicable (Not Within Agency Services)
1 or 4%	No Answer

Question 14F: TOBACCO USE

11 or 44%	Provide Tobacco Use Services On-Site/Refer
9 or 36%	Refer Out for Tobacco Use Services
3 or 12%	Not Applicable (Not Within Agency Services)
2 or 8%	No Answer

Question 14G: INTERPERSONAL VIOLENCE

10 or 40%	Provide Appropriate Services On Site/Refer
8 or 32%	Refer Out for Appropriate Services.
4 or 16%	Not Applicable (Not within Agency Services)
3 or 12%	No Answer.

Question 14H: HIV-RELATED STIGMA

13 or 52%	Provide Appropriate Services On Site/Refer
6 or 24%	Refer Out for Appropriate Services.
4 or 16%	Not Applicable (Not within Agency Services)
2 or 8%	No Answer.

1.3.3 Agency Survey of Behavioral Issues

AGENCY SURVEY OF BEHAVIORAL ISSUES

#4 ABILITY TO MEET BEHAVIORAL NEEDS ONSITE/BY REFERRAL

Question 15: **For each of the following services, please indicate whether you are able to adequately meet the needs of your clients onsite/within your organization or whether (1) you have to refer clients out for those services or (2) you feel there is an unmet need for the service within the EMA. For services for which you provide referrals, please indicate whether you have a written referral agreement in place with an outside agency.**

Met need of the specified services ranges from 80% to 96%.
The **unmet need** of 20% is for drug detoxification and 16% for inpatient drug treatment.

#5 SUBSTANCE USE ISSUES, NEEDS, CHALLENGES, GAPS

Question 16: **What are the most commonly abused substances among your clients?**

A total of 20 of 25 agencies responded. The top three substances used are:

Heroin	13	22%
Cocaine	10	17%
Marijuana	9	16%
	32	**55%**

Question 16A: **How have trends in substance abuse changed among your clients over the past five years?**

Half of agencies responding reported increased trends in substance abuse and by specifics substances - heroin, crystal meth, opioids.

Increasing Trends	**1**	**4%**
Increase by Specific Substances	**10**	**40%**
Not Much Change	**5**	**20%**
Decreasing Trends	**1**	**4%**
Not Applicable	**4**	**16%**
No Answer	**4**	**16%**
	25	**100%**

Question 16B: **What challenges have you faced in addressing the needs for substance abuse services as patterns of abuse have changed?**

Respondents cited lack of substance abuse resources, patient barriers (denial of substance use disorder), and specific issues in the health system.

Access to Treatment	**9**	**36%**
Patient Challenges	**1**	**4%**
Patient Barriers	**8**	**32%**
Systems Issues	**2**	**8%**
No Challenges	**1**	**4%**
Not Applicable	**3**	**12%**
No Answer	**1**	**4%**

1.3.3 Agency Survey of Behavioral Issues

AGENCY SURVEY OF BEHAVIORAL ISSUES

	25	**100%**

Question 16C: **What are the most significant gaps in services for substance abuse problems within the Newark EMA?**

The gaps are lack of drug treatment, and specifically the lack of inpatient treatment beds.

Insufficient Drug Treatment	**9**	**36%**
Lack of Inpatient Treatment/Beds	**4**	**16%**
Funding	**2**	**8%**
Systems Issues	**1**	**4%**
Access	**1**	**4%**
Not Applicable	**5**	**20%**
No Answer	**3**	**12%**
	25	**100%**

#6 MENTAL HEALTH ISSUES, NEEDS, CHALLENGES, GAPS

Question 17: **What are the most common mental health problems among your clients?**

Depression, anxiety and bipolar disorder are experienced most.

20 or 39%	**Depression**
9 or 18%	**Anxiety**
9 or 18%	**Bipolar Disorder**
38 or 75%	

Question 17A: **How have trends in mental health needs changed among your clients over the past five years?**
Nearly half of agencies said needs have increased, and additional agencies cited "no change" meaning that the need was still great.

Changed As Follows	**11**	**44%**
No Change/Remained Same	**6**	**24%**
None	**1**	**4%**
Not Applicable	**4**	**16%**
No Answer	**3**	**12%**
	25	**100%**

Question 17B: **What challenges have you faced in addressing the needs for mental health services as patterns have changed?**
The major challenges are inadequate psychiatrists, followed by patient behavior.

Inadequate MH Providers/Psychiatrists	**7**	**28%**
Access to Services	**4**	**16%**
Special Service Needs	**2**	**8%**
Patient Behavior/Issues	**7**	**28%**
None/No Challenges	**2**	**8%**
Not Applicable	**3**	**12%**

1.3.3 Agency Survey of Behavioral Issues

AGENCY SURVEY OF BEHAVIORAL ISSUES

	25	**100%**

Question 17C: What are the most significant gaps in services for mental health needs within the Newark EMA?

The gaps continue to be lack of MH providers particularly psychiatrists and bilingual MH professionals, access to MH services, systems and communication issues, and client behavior.

Inadequate MH Providers/Psychiatrists	**5**	**20%**
Access	**4**	**16%**
Systems and Communication	**3**	**12%**
Support Services	**1**	**4%**
Client Behavior	**2**	**8%**
None	**1**	**4%**
Not Applicable	**4**	**16%**
No Answer	**5**	**20%**
	25	**100%**

#7 EMERGING SUBSTANCE USE AND MENTAL HEALTH NEEDS

Question 18: What do you see as the emerging substance abuse and/or mental health needs among your clients?

No Change - Continuing Need	**5**	**20%**
Access to MH Care	**4**	**16%**
Specialized Services & Care	**5**	**20%**
Support Services	**3**	**12%**
Not Applicable (Not Within Agency Servic	**4**	**16%**
No Answer	**4**	**16%**
	25	**100%**

#8 BEHAVIORAL HEALTH RESOURCE NEEDS

Question 19: What resources are needed within the Newark EMA to address the emerging needs you identified in question 18?

More Funding (In General)	**3**	**12%**
Specific Staff & Staff Resources	**7**	**28%**
Housing & Related Services	**4**	**16%**
Specific Services	**5**	**20%**
Not Applicable	**2**	**8%**
No Answer	**4**	**16%**
	25	**100%**

#1 BEHAVIORAL SCREENING FREQUENCY

Question 12: **How often do you screen your clients for each of the following:**

Behavioral Issue	No Answer	At Every Visit	Every 6 Mos.	Annually	If Symptoms/ Signs Are Present	Only At Intake	Other (See Below)	We Do Not Do This Assessment	Total
1. Depression	1	5	5	3	1		7	3	25
2. Alcohol Abuse	1	4	6	3	2		7	2	25
3. Abuse of recreational drugs (e.g., heroin, cocaine, etc.)	1	4	7	2	2		7	2	25
4. Abuse of prescription drugs (e.g., opioids)	1	3	5	2	5		7	2	25
5. Abuse of other substances	1	5	5	1	4		7	2	25
6. Tobacco use	1	9	5	1	2		6	1	25
7. Interpersonal violence	2	4	3	2	6		7	1	25
8. HIV-related stigma	1	5	4		5	1	4	5	25
TOTAL	**9**	**39**	**40**	**14**	**27**	**1**	**52**	**18**	**200**
	4.5%	**19.5%**	**20.0%**	**7.0%**	**13.5%**	**0.5%**	**26.0%**	**9.0%**	**100.0%**

"OTHER" FREQUENCIES/INTERVALS

Behavioral Issue	Every Visit + Symptoms	Every 6 Mos + Symptoms	Annually + Symptoms	Every Visit + 6 Mos + Symptoms	6 Months + Symptoms + Other	"Other" Subtotal
1. Depression	1	2	2	1	1	7
2. Alcohol Abuse	1	3	1	1	1	7
3. Abuse of recreational drugs (e.g., heroin, cocaine, etc.)		3	1	2	1	7
4. Abuse of prescription drugs (e.g., opioids)	1	3	1	1	1	7
5. Abuse of other substances	1	3	1	1	1	7
6. Tobacco use	3	2		1		6
7. Interpersonal violence	3	3			1	7
8. HIV-related stigma	2	1			1	4
TOTAL	**12**	**20**	**6**	**7**	**7**	**52**
	6.0%	**10.0%**	**3.0%**	**3.5%**	**3.5%**	**26.0%**

#1 BEHAVIORAL SCREENING FREQUENCY

PERCENT DISTRIBUTIONS WITHIN EACH BEHAVIORAL ISSUE

Behavioral Issue	No Answer	At Every Visit	Every 6 Mos.	Annually	If Symptoms/ Signs Are Present	Only At Intake	Other (See Below)	We Do Not Do This Assessment	Total
1. Depression	4.0%	20.0%	20.0%	12.0%	4.0%		28.0%	12.0%	100%
2. Alcohol Abuse	4.0%	16.0%	24.0%	12.0%	8.0%		28.0%	8.0%	100%
3. Abuse of recreational drugs (e.g., heroin, cocaine, etc.)	4.0%	16.0%	28.0%	8.0%	8.0%		28.0%	8.0%	100%
4. Abuse of prescription drugs (e.g., opioids)	4.0%	12.0%	20.0%	8.0%	20.0%		28.0%	8.0%	100%
5. Abuse of other substances	4.0%	20.0%	20.0%	4.0%	16.0%		28.0%	8.0%	100%
6. Tobacco use	4.0%	36.0%	20.0%	4.0%	8.0%		24.0%	4.0%	100%
7. Interpersonal violence	8.0%	16.0%	12.0%	8.0%	24.0%		28.0%	4.0%	100%
8. HIV-related stigma	4.0%	20.0%	16.0%	0.0%	20.0%	4.0%	16.0%	20.0%	100%
TOTAL	**4.5%**	**19.5%**	**20.0%**	**7.0%**	**13.5%**	**0.5%**	**26.0%**	**9.0%**	100%

"OTHER" FREQUENCIES/INTERVALS

Behavioral Issue	Every Visit + Symptoms	Every 6 Mos + Symptoms	Annually + Symptoms	Every Visit + 6 Mos + Symptoms	6 Months + Symptoms + Other	"Other" Subtotal
1. Depression	4.0%	8.0%	8.0%	4.0%	4.0%	28.0%
2. Alcohol Abuse	4.0%	12.0%	4.0%	4.0%	4.0%	28.0%
3. Abuse of recreational drugs (e.g., heroin, cocaine, etc.)	0.0%	12.0%	4.0%	8.0%	4.0%	28.0%
4. Abuse of prescription drugs (e.g., opioids)	4.0%	12.0%	4.0%	4.0%	4.0%	28.0%
5. Abuse of other substances	4.0%	12.0%	4.0%	4.0%	4.0%	28.0%
6. Tobacco use	12.0%	8.0%	0.0%	4.0%	0.0%	24.0%
7. Interpersonal violence	12.0%	12.0%	0.0%	0.0%	4.0%	28.0%
8. HIV-related stigma	8.0%	4.0%	0.0%	0.0%	4.0%	16.0%
TOTAL	**6.0%**	**10.0%**	**3.0%**	**3.5%**	**3.5%**	**26.0%**

#2 BEHAVIORAL SCREENING TOOLS

Question 13: **For each of the following problems, please indicate what tool you use to screen clients (e.g., an evidence-based tool like the CAGE for alcohol abuse or a screening question created by staff – if the latter, please provide the wording of the screening question you use). If you do not know which screening tool you use, please indicate as such:**

PMC	Primary Medical Care
MH	Mental Health Services
OP SA	Outpatient Substance Abuse Services
Support	Support Services (including 1 Dental)

Question 13A: **DEPRESSION**

SCREENING TOOL	RWHAP-Funded Service Provided in FY 2018					
	PMC (Incl. MH & SA)	MH Only	OP SA Only	Support Service	Total	%
PHQ 9 (including PHQ 2)	5			1	6	22.2%
SAMISS	2				2	7.4%
GAINES	1				1	3.7%
Beck's	1				1	3.7%
Hospital approved Suicide Risk Assessment	1				1	3.7%
Internal Biopsychosocial w/ BDI	1				1	3.7%
Screening thru EMR -Epic, MCM	1				1	3.7%
How are you feeling?	1				1	3.7%
Mental health assessment	1				1	3.7%
Psychosocial assessment	1				1	3.7%
Screening questions created by staff.		1			1	3.7%
Biopsychosocial & mini-screens for behavioral health (MH & SA)			1		1	3.7%
Healthyplace.com online depression test			1		1	3.7%
Internal Intake Form/Packet				2	2	7.4%
Not Applicable for agency services). Referral if symptoms present.				4	4	14.8%
Observation. Talk to clients. Watch for isolation.				2	2	7.4%
TOTAL	**15**	**1**	**2**	**9**	**27**	**100.0%**

Standardized or Evidence-Based Tool*	**10**	**37%**
Agency-specific Tool	**11**	**41%**
Observation/Not Applicable	**6**	**22%**
* 1 agency used 3 tools.	**27**	**100%**

#2 BEHAVIORAL SCREENING TOOLS

Question 13B: ALCOHOL ABUSE

SCREENING TOOL	RWHAP-Funded Service Provided in FY 2018				Total	%
	PMC (Incl. MH & SA)	MH Only	OP SA Only	Support Service		
CAGE	5				5	18.5%
ASSIST V3.0	1				1	3.7%
AUDIT- Alcohol use Disorders Identification Test				1	1	3.7%
CRAFT	1				1	3.7%
GAINES	1				1	3.7%
MAST			1		1	3.7%
PHQ 9 (including PHQ 2)	1				1	3.7%
SAMISS	1				1	3.7%
Internal Biopsychosocial w/ CAGE in EMR	1				1	3.7%
Screening thru EMR -Epic, MCM	1				1	3.7%
MCM Assessment Tool	1				1	3.7%
Substance abuse assessment	1				1	3.7%
During initial screening and 6 month re-evaluation	1				1	3.7%
Screening questions created by staff.		1			1	3.7%
Biopsychosocial & mini-screens for behavioral health (MH & SA)			1		1	3.7%
La Casa's screening form				1	1	3.7%
Internal Intake Form/Packet				2	2	7.4%
Alcohol and drug screening. If negative, talk to clients to get them to go to rehab.				1	1	3.7%
Not Applicable for agency services). Referral if symptoms present.				4	4	14.8%
TOTAL	**15**	**1**	**2**	**9**	**27**	**100.0%**

Standardized or Evidence-Based Tool*	**13**	**48%**
Agency-specific Tool	**9**	**33%**
Observation/Not Applicable	**5**	**19%**
* 1 agency used 3 tools	**27**	**100%**

#2 BEHAVIORAL SCREENING TOOLS

Question 13C: ABUSE OF RECREATIONAL DRUGS (E.G., HEROIN, COCAINE, ETC.)

SCREENING TOOL	RWHAP-Funded Service Provided in FY 2018				Total	%
	PMC (Incl. MH & SA)	MH Only	OP SA Only	Support Service		
CAGE	3				3	11.1%
ASSIST V3.0	1				1	3.7%
CRAFT	2				2	7.4%
DAST- Drug Abuse Screening Test	2				2	7.4%
GAINES	1				1	3.7%
PHQ 9 (including PHQ 2)	1				1	3.7%
SAMISS	2				2	7.4%
Screening thru EMR -Epic, MCM	1				1	3.7%
Internal Biopsychosocial Assessment	1				1	3.7%
MCM Assessment Tool - UDS	1				1	3.7%
Substance abuse assessment	1				1	3.7%
During initial screening and 6 month re-evaluation	1				1	3.7%
Screening questions created by staff.		1			1	3.7%
Biopsychosocial & mini-screens for behavioral health (MH & SA)			1		1	3.7%
La Casa's screening form				1	1	3.7%
Internal Intake Form/Packet				2	2	7.4%
Alcohol and drug screening. If negative, talk to clients to get them to go to rehab.				1	1	3.7%
Not Applicable for agency services). Referral if symptoms present.				4	4	14.8%
TOTAL	**17**	**1**	**1**	**8**	**27**	**100.0%**

Standardized or Evidence-Based Tool*	**12**	**44%**
Agency-specific Tool	**10**	**37%**
Observation/Not Applicable	**5**	**19%**
* 1 agency used 3 tools	**27**	**100%**

#2 BEHAVIORAL SCREENING TOOLS

Question 13D: ABUSE OF PRESCRIPTION DRUGS (E.G., OPIOIDS)

SCREENING TOOL	RWHAP-Funded Service Provided in FY 2018				Total	%
	PMC (Incl. MH & SA)	MH Only	OP SA Only	Support Service		
ASSIST V3.0	1				1	3.7%
CRAFT	3				3	11.1%
DAST- Drug Abuse Screening Test	2				2	7.4%
GAINES	1				1	3.7%
PHQ 9 (including PHQ 2)	1				1	3.7%
SAMISS	2				2	7.4%
Screening thru EMR -Epic, MCM	1				1	3.7%
Internal Biopsychosocial Assessment	1				1	3.7%
Biopsychosocial & mini-screens for behavioral health (MH & SA)			1		1	3.7%
MCM Assessment Tool - UDS	1				1	3.7%
Substance abuse assessment	1				1	3.7%
During initial screening and 6 month re-evaluation	1				1	3.7%
Screening questions created by staff.		1			1	3.7%
Biopsychosocial & mini-screens for behavioral health (MH & SA)			1		1	3.7%
La Casa's screening form				1	1	3.7%
Internal Intake Form/Packet				2	2	7.4%
Not Applicable for agency services). Referral if symptoms present.				4	4	14.8%
Not Done	1				1	3.7%
No answer	1				1	3.7%
TOTAL	**17**	**1**	**2**	**7**	**27**	**100.0%**

Standardized or Evidence-Based Tool*	**10**	**37%**
Agency-specific Tool	**11**	**41%**
Not Applicable	**4**	**15%**
Not Done/No Answer	**2**	**7%**
* 1 agency used 3 tools	**27**	**100%**

#2 BEHAVIORAL SCREENING TOOLS

Question 13E: ABUSE OF OTHER SUBSTANCES

SCREENING TOOL	RWHAP-Funded Service Provided in FY 2018				Total	%
	PMC (Incl. MH & SA)	MH Only	OP SA Only	Support Service		
ASSIST V3.0	1				1	3.7%
CRAFT	3				3	11.1%
DAST- Drug Abuse Screening Test	2				2	7.4%
GAINES	1				1	3.7%
PHQ 9 (including PHQ 2)	1				1	3.7%
SAMISS	2				2	7.4%
Screening thru EMR -Epic, MCM	1				1	3.7%
Internal Biopsychosocial Assessment	1				1	3.7%
Biopsychosocial & mini-screens for behavioral health (MH & SA)			1		1	3.7%
MCM Assessment Tool - UDS	1				1	3.7%
Substance abuse assessment	1				1	3.7%
During initial screening and 6 month re-evaluation	1				1	3.7%
Direct questioning	1				1	3.7%
Screening questions created by staff.		1			1	3.7%
Biopsychosocial & mini-screens for behavioral health (MH & SA)			1		1	3.7%
La Casa's screening form				1	1	3.7%
Internal Intake Form/Packet				2	2	7.4%
Not Applicable for agency services). Referral if symptoms present.				4	4	14.8%
No answer	1				1	3.7%
TOTAL	**17**	**1**	**2**	**7**	**27**	**100.0%**

Standardized or Evidence-Based Tool*	**10**	**37%**
Agency-specific Tool	**12**	**44%**
Not Applicable	**4**	**15%**
No Answer	**1**	**4%**
* 1 agency used 3 tools	**27**	**100%**

#2 BEHAVIORAL SCREENING TOOLS

Question 13F: TOBACCO USE

SCREENING TOOL	RWHAP-Funded Service Provided in FY 2018				Total	%
	PMC (Incl. MH & SA)	MH Only	OP SA Only	Support Service		
ASSIST V3.0	1				1	3.3%
CRAFT	1				1	3.3%
CAGE	1				1	3.3%
DAST- Drug Abuse Screening Test			1		1	3.3%
GAINES	1				1	3.3%
PHQ 9 (including PHQ 2)	1				1	3.3%
Screening thru EMR -Epic, MCM	1				1	3.3%
Internal Biopsychosocial Assessment	1				1	3.3%
Biopsychosocial & mini-screens for behavioral health (MH & SA)			1		1	3.3%
MCM Assessment Tool - UDS	1				1	3.3%
Substance abuse assessment	1				1	3.3%
During initial screening and 6 month re-evaluation	1				1	3.3%
Direct questioning	1				1	3.3%
Screening questions created by staff.		1			1	3.3%
Biopsychosocial & mini-screens for behavioral health (MH & SA)			1		1	3.3%
La Casa's screening form				1	1	3.3%
Internal Intake Form/Packet				1	1	3.3%
Direct questioning by staff	**5**			**1**	**6**	20.0%
Direct questioning	1					
2 questions	1					
After vital signs are taken, the nurse will asked the patient if they smoke. This is called smoking cessation.	1					
Patients are asked about their tobacco habits and if their response is positive they are encouraged to quit and methods for quitting are				1		
Screening questions by staff.	1					
Screening questions: " Do you smoke tobacco? Are you interested in smoking cessation classes?	1					
Clients who smoke off premises. We educate them about harms of tobacco.				**1**	**1**	3.3%
Not Applicable for agency services). Referral if symptoms present.				5	5	16.7%
No answer	1				1	3.3%
TOTAL	**17**	**1**	**3**	**9**	**30**	**100.0%**

#2 BEHAVIORAL SCREENING TOOLS

Standardized or Evidence-Based Tool*	**6**	**20%**
Agency-specific Tool	**11**	**37%**
Direct Questioning by Staff	**7**	**23%**
Not Applicable	**5**	**17%**
No Answer	**1**	**3%**
* 1 agency used 3 tools	**30**	**100%**

Question 13G: INTERPERSONAL VIOLENCE

SCREENING TOOL	RWHAP-Funded Service Provided in FY 2018					
	PMC (Incl. MH & SA)	MH Only	OP SA Only	Support Service	Total	%
GAINES	1				1	3.8%
HITS	1				1	3.8%
Internal Biopsychosocial Assessment & EMR Tool	1				1	3.8%
IPV Screen & Assess by Physician	1				1	3.8%
If risk is presented question by provider	1				1	3.8%
Healthyplace.com online domestic violence test			1		1	3.8%
Bio/Psycho/Social questions regarding relationships	1				1	3.8%
MCM 6-month assessment tool	1				1	3.8%
Needs Assessment Form	1				1	3.8%
Personal safety assessment in EPIC	1				1	3.8%
Screening questions created by staff.	1				1	3.8%
La Casa's screening form				1	1	3.8%
Internal Intake Form/Packet/MCM	3			1	4	15.4%
2 questions asked by staff	1				1	3.8%
No formal tool adopted yet			1		1	3.8%
Not Applicable for agency services). Referral if issue is present.				5	5	19.2%
No answer	1			2	3	11.5%
TOTAL	**15**	**0**	**2**	**9**	**26**	**100%**

Standardized or Evidence-Based Tool*	**2**	**8%**
Agency-specific Tool	**14**	**54%**
Direct Questioning by Staff	**2**	**8%**
Not Applicable	**5**	**19%**
No Answer	**3**	**12%**
* 1 agency used 2 tools	**26**	**100%**

#2 BEHAVIORAL SCREENING TOOLS

Question 13H: HIV STIGMA

SCREENING TOOL	RWHAP-Funded Service Provided in FY 2018				Total	%
	PMC (Incl. MH & SA)	MH Only	OP SA Only	Support Service		
GAINES	1				1	4.0%
Internal Biopsychosocial Assessment & EMR Tool	1				1	4.0%
Initial screening	1				1	4.0%
Screening questions regarding who is aware of status and reasons.	1				1	4.0%
Patient encounter	1				1	4.0%
Screening questions created by staff.	1				1	4.0%
La Casa's screening form				1	1	4.0%
Internal Intake Form/Packet/MCM	1			1	2	8.0%
Discussion in support groups (MH, biweekly)	2	1			3	12.0%
Discussion with clients						
Clients usually share on her/his own	1				1	4.0%
Observe communication, educate	1				1	4.0%
1 questions asked by staff	1				1	4.0%
No formal tool adopted yet (just ask)			1	1	2	8.0%
Not Applicable for agency services). Referral if issue is present.	1		1	3	5	20.0%
No answer	2			1	3	12.0%
TOTAL	**15**	**1**	**2**	**7**	**25**	**100%**

Standardized or Evidence-Based Tool	**1**	**4%**
Agency-specific Tool	**8**	**32%**
Discussion with Clients	**8**	**32%**
Not Applicable	**5**	**20%**
No Answer	**3**	**12%**
	25	**100%**

#3 FURTHER BEHAVIORAL ASSESSMENT/FOLLOW UP

Question 14: **If a client has a positive screening for any of the following conditions, what is your procedure for providing further assessment/follow-up?**

Question 14A: **DEPRESSION**

Provide mental health/psychiatric services on site/Refer. **12**

Provider discusses with pt and LCSW follows to educate and provide referral/assist in linkage

For everything below all patients are referred to the MH or SA clinician the same day. A Psychosocial and MH, and SA screening is done and focused interview and referrals are made to appropriate service whether it is in house or outside agencies for detox or inpatient treatment or MAT.

Refer to the MCM for further assessment and referral to a Psychiatrist

Mental Health Services provided onsite with follow ups as needed.

PHQ9, referral to mental health clinician & or psych NP

Offer services of MH Clinician on-site.

Refer to MH clinician

Refer on-site to LCSW.

Mental Health Counselor

Outpatient behavioral health or integrated behavioral health as appropriate.

We provide written referrals to in-house and outside programs as well. And we follow up with patients.

Refer to on-site psychiatrist

Refer out for mental health services. **9**

Client is referred to an agency in which we have an agreement or to another agency that can offer the service provided. MCM will then check to make sure client met the referrals.

Refer client to agency within the Ryan White network.

Treatment plan+referral+case management+referrals

Referral to Mental Health counseling

MH referral

Referral

Client is referred to mental health specialist.

Linked to mental health services

Speak with client, refer out to groups or psychiatrist.

Not Applicable (Not within agency services) **4**

Provide Mental Health/Psychiatric Services On-Site/Refer	**12**	**48%**
Refer Out for Mental Health Services	**9**	**36%**
Not Applicable (Not Within Agency Services)	**4**	**16%**
	25	**100%**

#3 FURTHER BEHAVIORAL ASSESSMENT/FOLLOW UP

Question 14B: ALCOHOL ABUSE

Provide Substance Use Disorder services on site/Refer.	**10**
Provider discusses with pt and LCSW follows to educate and provide referral/assist in linkage	
For everything below all patients are referred to the MH or SA clinician the same day. A Psychosocial and MH, and SA screening is done and focused interview and referrals are made to appropriate service whether it is in house or outside agencies for detox or inpatient treatment or MAT.	
Refer to the MCM for further assessment and offer referral to a substance abuse facility.	
Referral to substance abuse specialist with continued mental health counseling provided onsite.	
Direct Questioning & referral to Substance Use Counselor	
Refer to SA Clinician	
Refer on-site to LCSW.	
Substance abuse referral or "in house" care	
We provide written referrals to in-house and outside programs as well. And we follow up with patients.	
Speak to client. Communicate. Educate. Group counseling.	

Refer Out for Substance Use Disorder services.	**10**
Client is referred to an agency in which we have an agreement or to another agency that can offer the service provided. MCM will then check to make sure client met the referrals.	
Refer client to agency within the Ryan White network.	
Treatment plan+referral+case management+referrals	
Referral to Substance Use counseling.	
Refer to outpatient SAS.	
Referral to appropriate agency	
Refer to appropriate treatment modality.	
Referral.	
Referred to an IOP program.	
Outside referral.	

Not Applicable (Not within agency services)	**4**
No Answer	**1**

Provide Substance Use Disorder Services On-Site/Refer	**10**	**40%**
Refer Out for Substance Use Disorder Services	**10**	**40%**
Not Applicable (Not Within Agency Services)	**4**	**16%**
No Answer	**1**	**4%**
	25	**100%**

#3 FURTHER BEHAVIORAL ASSESSMENT/FOLLOW UP

Question 14C: ABUSE OF RECREATIONAL DRUGS (E.G., HEROIN, COCAINE, ETC.)

Provide Substance Use Disorder services on site/Refer.	**10**
Provider discusses with pt and LCSW follows to educate and provide referral/assist in linkage	
For everything below all patients are referred to the MH or SA clinician the same day. A Psychosocial and MH, and SA screening is done and focused interview and referrals are made to appropriate service whether it is in house or outside agencies for detox or inpatient treatment or MAT.	
Refer to the MCM for further assessment and offer referral to a substance abuse facility.	
Referral to substance abuse specialist with continued mental health counseling provided onsite.	
Direct Questioning & referral to Substance Use Counselor	
Refer to SA Clinician	
Refer on-site to LCSW.	
Substance abuse referral or "in house" care	
Communicate. Educate. Work out of reconciliation.	
We provide written referrals to in-house and outside programs as well. And we follow up with patients.	

Refer Out for Substance Use Disorder services.	**10**
Client is referred to an agency in which we have an agreement or to another agency that can offer the service provided. MCM will then check to make sure client met the referrals.	
Refer client to agency within the Ryan White network.	
Treatment plan+referral+case management+referrals	
Referral to Substance Use counseling	
Refer to outpatient SAS.	
Referral to appropriate agency.	
Refer to appropriate treatment modality.	
Referral	
Referred to an IOP program.	
Outside referral	

Not Applicable (Not within agency services)	**4**
No Answer	**1**

Provide Substance Use Disorder Services On-Site/Refer	**10**	**40%**
Refer Out for Substance Use Disorder Services	**10**	**40%**
Not Applicable (Not Within Agency Services)	**4**	**16%**
No Answer	**1**	**4%**
	25	**100%**

#3 FURTHER BEHAVIORAL ASSESSMENT/FOLLOW UP

Question 14D: ABUSE OF PRESCRIPTION DRUGS

Provide Substance Use Disorder services on site/Refer.	**10**
Provider discusses with pt and LCSW follows to educate and provide referral/assist in linkage	
For everything below all patients are referred to the MH or SA clinician the same day. A Psychosocial and MH, and SA screening is done and focused interview and referrals are made to appropriate service whether it is in house or outside agencies for detox or inpatient treatment or MAT.	
Counseling and referral to Pain Management Provider.	
Referral to substance abuse specialist with continued mental health counseling provided onsite.	
Direct Questioning & referral to Substance Use Counselor	
Refer to SA Clinician	
Refer on-site to LCSW.	
Substance abuse referral or "in house" care	
Communicate. Educate. Refer out.	
We provide written referrals to in-house and outside programs as well. And we follow up with patients.	

Refer Out for Substance Use Disorder services.	**10**
Client is referred to an agency in which we have an agreement or to another agency that can offer the service provided. MCM will then check to make sure client met the referrals.	
Refer client to agency within the Ryan White network.	
Treatment plan+referral+case management+referrals	
Referral to Substance Use counseling	
Refer to outpatient SAS.	
Referral to appropriate agency.	
Refer to appropriate treatment modality.	
Referral	
Referred to an IOP program.	
Outside referral	

Not Applicable (Not within agency services)	**4**
No answer.	**1**

Provide Substance Use Disorder Services On-Site/Refer	**10**	**40%**
Refer Out for Substance Use Disorder Services	**10**	**40%**
Not Applicable (Not Within Agency Services)	**4**	**16%**
No Answer	**1**	**4%**
	25	**100%**

#3 FURTHER BEHAVIORAL ASSESSMENT/FOLLOW UP

Question 14E: ABUSE OF OTHER DRUGS

Provide Substance Use Disorder services on site/Refer.	**10**
Provider discusses with pt and LCSW follows to educate and provide referral/assist in linkage	
For everything below all patients are referred to the MH or SA clinician the same day. A Psychosocial and MH, and SA screening is done and focused interview and referrals are made to appropriate service whether it is in house or outside agencies for detox or inpatient treatment or MAT.	
Counseling and referral to Pain Management Provider and/or offer referral to substance abuse facility.	
Referral to substance abuse specialist with continued mental health counseling provided onsite.	
Direct Questioning & referral to Substance Use Counselor	
Refer to SA Clinician	
Refer on-site to LCSW.	
Substance abuse referral or "in house" care	
Communicate. Educate. Refer out.	
We provide written referrals to in-house and outside programs as well. And we follow up with patients.	

Refer Out for Substance Use Disorder services.	**10**
Client is referred to an agency in which we have an agreement or to another agency that can offer the service provided. MCM will then check to make sure client met the referrals.	
Refer client to agency within the Ryan White network.	
Treatment plan+referral+case management+referrals	
Referral to Substance Use counseling	
Refer to outpatient SAS.	
Referral to appropriate agency.	
Refer to appropriate treatment modality.	
Referral	
Referred to an IOP program.	
Outside referral	

Not Applicable (Not within agency services)	**4**
No answer.	**1**

Provide Substance Use Disorder Services On-Site/Refer	**10**	**40%**
Refer Out for Substance Use Disorder Services	**10**	**40%**
Not Applicable (Not Within Agency Services)	**4**	**16%**
No Answer	**1**	**4%**
	25	**100%**

#3 FURTHER BEHAVIORAL ASSESSMENT/FOLLOW UP

Question 14F: TOBACCO USE

Provide Tobacco Use services on site.	**11**
Provider discusses with pt and provides referral to state tobacco quit help line	
For everything below all patients are referred to the MH or SA clinician the same day. A Psychosocial and MH, and SA screening is done and focused interview and referrals are made to appropriate service whether it is in house or outside agencies.	
Counseling, assist in smoking cessation, or offer referral to smoking cessation program.	
Provide smoking cessation counseling, refer to medical provider for tobacco cessation plan and continue mental health counseling.	
Direct Questioning, harm reduction, and prescribing patch/pill	
Refer to physician	
Talk about the importance of not smoking and the doctor will prescribe the patient nicotine patch if permitted.	
Patients tobacco use is monitored yearly.	
MD discusses use of smoking cessation products.	
Communicate. Educate. Refer out.	
Patient encounter.	

Refer Out for Tobacco Use services.	**9**
Client is referred to an agency in which we have an agreement or to another agency that can offer the service provided. MCM will then check to make sure client met the referrals.	
This is done only to transitional house clients at intake	
Treatment plan+referral+case management+referrals	
Referral tobacco cessation classes	
NJ QUITS	
Referral to appropriate agency.	
Provide smoking cessation counseling, referred to Quit line.	
Referral	
No formal procedure in place	

Not Applicable (Not within agency services)	**3**
No answer.	**2**

Provide Tobacco Use Services On-Site/Refer	**11**	**44%**
Refer Out for Tobacco Use Services	**9**	**36%**
Not Applicable (Not Within Agency Services)	**3**	**12%**
No Answer	**2**	**8%**
	25	**100%**

#3 FURTHER BEHAVIORAL ASSESSMENT/FOLLOW UP

Question 14G: INTERPERSONAL VIOLENCE

Provide Appropriate Services On Site/Refer	**10**
Provider discusses with pt and LCSW and provide referral/assist in linkage	
For everything below all patients are referred to the MH or SA clinician the same day. A Psychosocial and MH, and SA screening is done and focused interview and referrals are made to appropriate service whether it is in house or outside agencies.	
Refer to MA Clinician on site for further evaluation.	
Refer to social worker	
Counseling and refer to a counselor who deals with the issue of violence.	
Refer on-site to LCSW.	
Provide appropriate intervention to ensure safety of client.	
Client is given information regarding domestic violence and they are offered assistance in getting out of the situation, and they are referred to a specialist.	
Communicate. Educate. Refer out.	
Screening by medical staff and assessment completed by physician and mental health clinician. Referral to available resources when needed.	

Refer Out for Appropriate Services.	**8**
Client is referred to an agency in which we have an agreement or to another agency that can offer the service provided. MCM will then check to make sure client met the referrals.	
Treatment plan+referral+case management+referrals	
Referral to Mental Health/ trauma counseling	
Referral to Mental Health Counselor LCSW	
Referral to appropriate agency.	
Referral to DV organizations or internal counseling.	
Referral	
Outside referral	

Not Applicable (Not within agency services)	**4**
No Answer.	**3**

Provide Appropriate Services On Site/Refer	**10**	**40%**
Refer Out for Appropriate Services.	**8**	**32%**
Not Applicable (Not Within Agency Services)	**4**	**16%**
No Answer	**3**	**12%**
	25	**100%**

#3 FURTHER BEHAVIORAL ASSESSMENT/FOLLOW UP

Question 14H: HIV-RELATED STIGMA

Provide Appropriate Services On Site/Refer	**13**
HIV staff (MCM, linkage to care) for support, Program Director to intervene if related to clinic staff	
For everything below all patients are referred to the MH or SA clinician the same day. A Psychosocial and MH, and SA screening is done and focused interview and referrals are made to appropriate service whether it is in house or outside agencies.	
This is a discussion during group settings among peers and on a one on one basis with MCM if need be.	
Explore and discuss the issue with the patient and find resolution to the problem with stigma.	
Mental health counseling to address challenges and provide coping skills needed.	
Discussion with client and MCM.	
Provide counseling by MCM and/or refer to MH Clinician. Or refer to Community Health Law Project.	
Non-medical case management	
Mental health counselor.	
Provide counseling, offer support group, peer mentoring, CLEAR.	
Stigma is dealt with at support groups.	
Coaching	
Counseling.	

Refer Out for Appropriate Services.	**6**
Client is referred to an agency in which we have an agreement or to another agency that can offer the service provided. MCM will then check to make sure client met the referrals.	
Treatment plan+referral+case management+referrals	
Referral to Mental Health Counselor LCSW	
Referral to Mental Health and in-house HIV support groups	
Client is given literature and referred to a specialist.	
Communicate. Educate. Refer out.	

Not Applicable (Not within agency services)	**4**
No Answer.	**2**

Provide Appropriate Services On Site/Refer	**13**	**52%**
Refer Out for Appropriate Services.	**6**	**24%**
Not Applicable (Not Within Agency Services)	**4**	**16%**
No Answer	**2**	**8%**
	25	**100%**

#4 ABILITY TO MEET BEHAVIORAL NEEDS ONSITE/BY REFERRAL

Question 15: **For each of the following services, please indicate whether you are able to adequately meet the needs of your clients onsite/within your organization or whether (1) you have to refer clients out for those services or (2) you feel there is an unmet need for the service within the EMA. For services for which you provide referrals, please indicate whether you have a written referral agreement in place with an outside agency.**
(n = 25)

Service Category	Able to Provide Adequately Onsite/Within My Organization	Requires Referral to an Outside Agency*	In Agency + Outside Referral	Not Applicable/No Answer	MET NEED	UNMET NEED for Service within the EMA**	Written Referral Agreement in Place*
Crisis intervention	44%	28%	16%	8%	**96%**	**4%**	27%
Individual counseling	68%	12%	4%	12%	**96%**	**4%**	0%
Group counseling	52%	28%	4%	12%	**96%**	**4%**	38%
Psychiatric services	28%	52%	4%	12%	**96%**	**4%**	7%
Drug detoxification	0%	64%	4%	12%	**80%**	**20%**	41%
Inpatient drug treatment	0%	67%	4%	12%	**84%**	**16%**	44%
Outpatient drug treatment	20%	52%	8%	12%	**92%**	**8%**	40%
Relapse prevention	20%	52%	8%	12%	**92%**	**8%**	27%
Shelter for victims of interpersonal violence	4%	72%	4%	12%	**92%**	**8%**	21%

*** Providers who referred to outside agency were asked to indicate if they had a written referral agreement. The percent of "Written Referral Agreement" is a percent of the agencies that referred out to other agencies.**
**** Unmet Need includes BOTH computed unmet need of the providers who were UNABLE to provide the service EITHER directly or by Referral Agreement AND agencies that specifically indicated that this service was an "Unmet Need" (Column 3). If an agency reported BOTH that they were able to provide the service [by referral] AND that it was an unmet need, the response was recorded as "unmet need".**

#5 SUBSTANCE USE ISSUES, NEEDS, CHALLENGES, GAPS

Question 16: What are the most commonly abused substances among your clients?

22 of the 25 agencies responded.
Heroin, cocaine and marijuana are used/abused most.

Substances	# Times Mentioned		%	
Heroin	13		22%	
Cocaine	10		17%	
Marijuana	9	**32**	16%	**55%**
Alcohol	7		12%	
Opiates	5		9%	
Crack cocaine	3		5%	
Meth/crystal meth	3		5%	
Prescription narcotics	3		5%	
Benzodiazepines	1		2%	
Oxycodone	1		2%	
Cigarettes	1		2%	
Cannabinoids	1		2%	
Xanax	1		2%	
	58		**100%**	

Question 16A: How have trends in substance abuse changed among your clients over the past five years?

Increasing Trends **1**
Yes. Increased dramatically.

Increase by Specific Substances **10**

We have seen a transition from opioid pain killers to heroin by injection and we have seen a lot of drug seeking behaviors for benzodiazepines.
There has been an increase with the consumption of crystal meth.
Opioid pain meds have become an epidemic and has caused clients to become addicted after never having substance abuse issues.
Increased Heroin & Crystal Meth usage. More common in younger MSM.
Increase in Crystal Meth use. Decrease of injecting opiates, more have reported snorting heroin over shooting.
The trends have been in prescription drugs. Increase in age 50+ males have been successful with opioid treatment.
Decline in abuse of benzos noted. Cannabinoids use is VERY common.
Less IV use. Increased use of multiple substances.
Increase in illegal use of prescription drugs.
I've noticed that there are more people addicted to pain medications or over-the-counter medications.

Not Much Change **5**
Not much. (3)
Steady. It has not changed among our clients.
They have remained the same.

Decreasing Trends **1**
Not Applicable **4**
No Answer **4**

#5 SUBSTANCE USE ISSUES, NEEDS, CHALLENGES, GAPS

Increasing Trends	**1**	**4%**
Increase by Specific Substances	**10**	**40%**
Not Much Change	**5**	**20%**
Decreasing Trends	**1**	**4%**
Not Applicable	**4**	**16%**
No Answer	**4**	**16%**
	25	**100%**

Question 16B: **What challenges have you faced in addressing the needs for substance abuse services as patterns of abuse have changed?**

Respondents cited lack of substance abuse resources, patient barriers (denial of substance use disorder), and specific issues in the health system.

Access to Treatment	**9**
Having treatment provided while incarcerated.	
Access to facilities to provide services (location, schedules and insurance/no insurance).	
Access to inpatient treatment for withdrawal management and access to quality medication assisted treatment i.e. Suboxone.	
It has become more difficult to receive long term treatment.	
Not readily available.	
Some providers have abstinence based- thinking and policy. The substance is the symptom and not the problem. Detox unavailability and lack for adequate & legitimate services for suboxone treatment.	
Specific groups for Crystal Meth use.	
Difficulty in finding inpatient detox/services when patient is ready. By the time a bed is available, patient has changed their mind.	
Timely entry into SA facilities. Root cause of issues are trauma-related and require a MH approach.	

Patient Challenges	**1**
It is hard for the client to quit.	

Patient Barriers	**8**
Patient not being honest about the extent of their recreational drug use, and missing the opportunity to refer patients to these places. Lack of availability of places to refer patients and limited access to these places. Patients	
The most prominent challenge is the lack of motivation for clients to follow through with referrals/appointments once substance abuse services have been identified as a need.	
Lack of client readiness for change, and when ready treatment resources are not always immediately available.	
Most of the time the challenge is that consumers do not want to go for treatment. And if they go for treatment, they drop out.	
Continued usage over the years.	
Challenges faced include clients trying to self detox on illegally obtained a Suboxone.	
Some clients are in denial about their substance abuse issues.	
Clients don't feel they have a problem. Clients are getting younger and harder to deal with. Because of being given to clients by doctors they feel it is okay.	

#5 SUBSTANCE USE ISSUES, NEEDS, CHALLENGES, GAPS

Systems Issues	**2**
Consistency in addressing diversion of prescribed medications across disciplines.	
Usually by the time the client has reached our office he has already addressed any substance use problem, so we have insufficient knowledge to address this.	

No Challenges	**1**
Not Applicable	**3**
No Answer	**1**

Access to Treatment	**9**	**36%**
Patient Challenges	**1**	**4%**
Patient Barriers	**8**	**32%**
Systems Issues	**2**	**8%**
No Challenges	**1**	**4%**
Not Applicable	**3**	**12%**
No Answer	**1**	**4%**
	25	**100%**

Question 16C: **What are the most significant gaps in services for substance abuse problems within the Newark EMA?**

The gaps are lack of drug treatment, and specifically the lack of inpatient treatment beds.

Insufficient Drug Treatment	**9**
Unavailability of Drug Rehab Centers to which to refer patients.	
The most significant gaps are lack of available treatment facilities.	
(28 days) inpatient rehab, Long term inpatient (more than 90 days) in Morris County.	
Not enough treatment available - our long-term users need intensive treatment.	
Availability of Medicaid-eligible inpatient detox & rehab services. Memoranda or agency agreements about communication for continuity of care once patient has been referred to outside agency.	
Access to mental health/behavioral services. Access to safe housing.	
Long-term support. Detox alone is just the initial part of an extensive process.	
Too few drug rehabilitations. No education on drugs. Few places to send for mental health and drug adherence.	
Not readily available	

Lack of Inpatient Treatment/Beds	**4**
Inpatient treatment	
Access to inpatient and detox services.	
Inpatient beds.	
Lack of inpatient treatment facilities.	

Funding	**2**
Funding	
Ryan White funding addressing the epidemic.	

Access	**1**
Access (particularly for the western part of NJ where transportation and facilities are limited).	

#5 SUBSTANCE USE ISSUES, NEEDS, CHALLENGES, GAPS

Systems Issues **1**

Challenged collaboration & communication among some outside agencies. Lack of respect for disciplines or specialties. Lack of adequate suboxone providers.

Not Applicable **5**

No Answer **3**

Insufficient Drug Treatment	**9**	**36%**
Lack of Inpatient Treatment/Beds	**4**	**16%**
Funding	**2**	**8%**
Systems Issues	**1**	**4%**
Access	**1**	**4%**
Not Applicable	**5**	**20%**
No Answer	**3**	**12%**
	25	**100%**

#6 MENTAL HEALTH ISSUES, NEEDS, CHALLENGES, GAPS

Question 17: What are the most common mental health problems among your clients?

22 of the 25 agencies responded.
Depression, anxiety and bipolar disorder are experienced most.

Mental Health Issue	# Times Mentioned		%	
Depression	20		39%	
Anxiety	9		18%	
Bipolar Disorder	9	**38**	18%	**75%**
Medication Compliance	3		6%	
Schizophrenia	2		4%	
PTSD-Trauma	2		4%	
Behavioral Disorders (Children, adol.)	2		4%	
Stigma	2		4%	
Substance Use Disorder	1		2%	
Personality Disorder	1		2%	
	51		**100%**	

Question 17A: How have trends in mental health needs changed among your clients over the past five years?

Changed As Follows	**11**
Scheduling dates. Some clients have to wait for months when they need services ASAP. (2)	
Limited psychiatric services.	
The trend for Mental Health needs has increased as patients are getting older, and the effects of changes in Health Insurance and Government rules and regulations.	
There have been significant changes in mental health needs as clients with HIV have comorbid mental health challenges and substance abuse issues. This has continued to be a persistent pressing concern that has only increased with the lack of mental health	
There is a greater need for community based mental health care.	
Not sure if the need has changed or is it that we now have put a label on it. More screenings done now and we have identified more patients with disorders. Still difficult to engage patients in treatment and therapy.	
Increase in patients seeking treatment. Having psychiatrist onsite has helped with linkage to care and retention in Mental Health care. High risk case management has provided additional support to individuals suffering with MH & substance abuse disorders.	
It is more difficult for clients to obtain SSI/SSD benefits based on anxiety/depression.	
More self-medicating with pills.	
People seem to becoming more aware of mental health and how it affects recovery & HIV. (Because of lack of mental health agencies.)	

No Change/Remained Same	**6**
Not really changed.	
No changes. Remains a problem.	
Not much.	
They have remained the same.	
Trends in need have not changed among our clients the needs continue to: housing, nutrition, medical care, oral health care.	
Unchanged if not a more prevalent.	

#6 MENTAL HEALTH ISSUES, NEEDS, CHALLENGES, GAPS

None	**1**
Not Applicable	**4**
No Answer	**3**

Changed As Follows	**11**	**44%**
No Change/Remained Same	**6**	**24%**
None	**1**	**4%**
Not Applicable	**4**	**16%**
No Answer	**3**	**12%**
	25	**100%**

Question 17B: **What challenges have you faced in addressing the needs for mental health services as patterns have changed?**

Respondents cited lack of MH resources particularly psychiatrists, patient behavior, access to care, and specific issues in the health system.

Inadequate MH Providers/Psychiatrists	**7**
Funding for more mental health professionals	
Not enough providers (psychiatrists or APNs with mental health) for our area.	
Funding for psychiatric services, Medicaid only covers a fraction of the cost of the visits and medications, long waiting lists to see a provider.	
There has been challenges in the lack of available psychiatrists available once psychiatric services have been identified as a need.	
Severe lack of bilingual MH providers. Lack of trauma sensitivity training among some RW and non-RW providers. Poor access to MH clinicians given most agencies/clinics close at 4-5 pm.	
Access to prescriber for psychiatric care without being part of a “bundled services” requirement. Clients cannot access this care unless they leave trusted medical providers and enroll in clinic care.	
The psychiatrist availability has to be increased. The wait for new patients is 3 months. Increase need for Departmental de-escalation training.	

Access to Services	**4**
Our Medical Case Managers vigorously assess the state of patients’ mental health and if their finding is positive, they refer the patient to either the Mental Health provider (psychiatrist) on site or refer patient to a Counselor outside.	
We have on site services.	
Access to care.	
Linking to appropriate services.	

Special Service Needs	**2**
With regard to assisting clients to get SSI/SSD, it is very important to get all pertinent records & get physician reports to fully document their disability.	
Challenge identifying treatment for dual diagnosis.	

Patient Behavior/Issues	**7**
Patients are not comfortable talking in groups. Getting them to engage in RX programs is our biggest challenge. Services are available-patients don't want to go.	
Retention.	

#6 MENTAL HEALTH ISSUES, NEEDS, CHALLENGES, GAPS

Most of the time the challenge is that consumers do not want to go for treatment or they drop out.
Clients not taking their prescribed meds and taking illegal narcotics.
It is very challenging trying to get clients medications. Once they have been out of treatment for a while it is very hard to get clients reengaged.
Patients are reluctant to seek help.
Decompensation.

None/No Challenges	**2**
Not Applicable	**3**

Inadequate MH Providers/Psychiatrists	**7**	**28%**
Access to Services	**4**	**16%**
Special Service Needs	**2**	**8%**
Patient Behavior/Issues	**7**	**28%**
None/No Challenges	**2**	**8%**
Not Applicable	**3**	**12%**
	25	**100%**

Question 17C: What are the most significant gaps in services for mental health needs within the Newark EMA?

The gaps continue to be lack of MH providers particularly psychiatrists and bilingual MH professionals, access to MH services, systems and communication issues, and client behavior.

Inadequate MH Providers/Psychiatrists	**5**
Funding for more mental health professionals.	
Funding for psychiatric services, Medicaid only covers a fraction of the cost of the visits and medications, long waiting lists to see a provider.	
Availability of a Bilingual Psychiatrist, Psychiatric Nurse Practitioner and Counselors	
The most significant gaps continue to be lack of additional mental health services which affect other areas such as medication adherence, maintaining or obtaining employment, and housing. Lack of stable housing and resources for such continues to be a sig	
Access to psychiatrists. UBHC has small catchment area.	

Access	**4**
Access (particularly for the western part of NJ where transportation and facilities/providers are limited)	
Access to prescriber for psychiatric care without being part of a “bundled services” requirement. Clients cannot access this care unless they leave trusted medical providers and enroll in clinic care.	
Lack of sites for individual counseling. This may get more patients involved. Lack of sites for uninsured (undocumented) population.	
Linkage to care - follow-up	

Systems and Communication	**3**
Collaboration & Communication gaps in and outside agency. Again, severe lack of bilingual MH providers in Spanish, Creole and Portuguese.	
Poor communication between agencies that promote continuity of care. Lack of availability of services with at least a 6 week wait for most agencies.	
Integration of mental health services with addiction therapy.	

#6 MENTAL HEALTH ISSUES, NEEDS, CHALLENGES, GAPS

Support Services	**1**

Housing and lack thereof is a critical need as it affects clients' mental health.

Client Behavior	**2**

Managing clients adherence to psych medications.

What I notice is that if I have a client who is been out of care for a while and I try to get medications, I have to call crisis.

None	**1**
Not Applicable	**4**
No Answer	**5**

Inadequate MH Providers/Psychiatrists	**5**	**20%**
Access	**4**	**16%**
Systems and Communication	**3**	**12%**
Support Services	**1**	**4%**
Client Behavior	**2**	**8%**
None	**1**	**4%**
Not Applicable	**4**	**16%**
No Answer	**5**	**20%**
	25	**100%**

#7 EMERGING SUBSTANCE USE AND MENTAL HEALTH NEEDS

Question 18: What do you see as the emerging substance abuse and/or mental health needs among your clients?

No Change - Continuing Need **5**

Not emerging…still the same. 1) Access when they are ready, 2) Clients slow to accept and be willing to seek services

Treatment that addresses both issues and use of multiple substances.

Proper treatment.

Follow-up Care.

I see we need more mental health agencies and substance abuse agencies. That will help with helping the clients to start battling some essential needs.

Access to MH Care **4**

Because of the limited availability of these Mental Health providers, Substance Abuse Centers, there is a lag time available in referring patients. By the time the services are available, patients are already deep into the habit and

An emerging and continued substance /mental health need continues to be the difficulty in linkage to care to address identified needs such as psychiatric care.

Not enough support for Crystal meth use, lack of transportation to resource that do exist, and lack of access to psychiatric prescribers.

Access to psychiatry services.

Specialized Services & Care **5**

Meeting these needs while client is incarcerated.

Medication assisted treatment with diversion programs

Increased understanding and treatment of trauma. Increased Depression in MSM. Increased dementia & depression in the elderly HIV+ population.

Continued use of opioids and cannabinoids especially among clients who do not wish to stop or do not view cannabinoids use as an issue.

Trauma-informed staff at ALL levels including clinical providers.

Support Services **3**

The ability to provide supportive services to individuals with HIV/AIDS.

When we have consumers with substance abuse and mental health problems the need as with other individuals is housing

Housing.

Not Applicable (Not Within Agency Services) **4**

No Answer **4**

No Change - Continuing Need	**5**	**20%**
Access to MH Care	**4**	**16%**
Specialized Services & Care	**5**	**20%**
Support Services	**3**	**12%**
Not Applicable (Not Within Agency Services)	**4**	**16%**
No Answer	**4**	**16%**
	25	**100%**

#8 BEHAVIORAL HEALTH RESOURCE NEEDS

Question 19: What resources are needed within the Newark EMA to address the emerging needs you identified in question 18?

These are responses from 25 agencies. Some responses span several categories.

More Funding (In General)	**3**
More funding to hire more professionals.	
More funding to provide said service	
Funding for psychiatry services.	
Specific Staff & Staff Resources	**7**
Need more Psychiatrists, Psychiatric Nurse Practitioners, Counselors, especially bilingual providers. The only way to entice the professionals to the job s to pay them adequately.	
Behavioral Health Clinicians (MH & SA) need to be allowed more funds and time off to pursue additional trainings focused on educating clinicians about new methods of treatment as well as a deeper understanding of the connection among MH issues, substance use and trauma. Again, we need more bilingual providers, more home-based caregivers (HHA) and clinical providers who make home visits.	
Psychiatrist to write prescriptions for clients who do not wish to receive "bundled services". For example, clients who are in private medical care are faced with having to leave a trusted provider in order to receive mental health prescriptions.	
Access to providers who can see people in the evenings/weekends, more agencies providing needed services, ability to take clients who do not have insurance or willing to work with a Ryan White provider who can pay for the services directly on behalf of patient.	
More training. More referral sources.	
Provide more help with getting clients meds for mental health issues. Or getting clients diagnosed without having to go through crisis. Also more information on drug treatment and rehabilitation.	
Patient Navigator.	
Housing & Related Services	**4**
To address these needs, additional housing resources are needed as it is difficult to address any need if there is a lack of residential stability. The needs to be additional mental health resources such as psychiatry readily available for our clients.	
Housing.	
More affordable housing.	
More funding for long term and short term rental assistance.	
Specific Services	**5**
Possibly to link up with county jails to see that this need is being met with our clients.	
Medication assisted treatment with diversion programs	
Increased availability of inpatient detox and inpatient substance abuse rehab. For our long term users a MINIMUM of 28 days is needed.	
Drug treatment, stable housing, treatment for co-occurring mental illness and substance abuse	
Revisit opening allocations to provide services for individuals &/or families who are **affected** by HIV/AIDS. Having vocational resources to help address or increase skills for independence.	
Not Applicable	**2**
No Answer	**4**

More Funding (In General)	**3**	**12%**
Specific Staff & Staff Resources	**7**	**28%**
Housing & Related Services	**4**	**16%**
Specific Services	**5**	**20%**
Not Applicable	**2**	**8%**
No Answer	**4**	**16%**
	25	**100%**

1.3.3 Agency Survey Conclusions and Recommendations

AGENCY SURVEY OF BEHAVIORAL ISSUES
CONCLUSIONS AND RECOMMENDATIONS

#1 BEHAVIORAL SCREENING FREQUENCY

Conclusion:

- It appears that agencies are completing behavioral screenings at times and intervals in accordance with the Newark EMA Service Standards.

Recommendation:

- ✚ The EMA should review the results and determine if the screening frequencies are sufficient to detect behavioral issues timely, enabling referral of RWHAP Clients for further follow up. Service standards should be adjusted based on these findings and best practices within the behavioral care field.

#2 BEHAVIORAL SCREENING TOOLS

Conclusions:

- A portion of agencies are using evidence-based tools for behavioral screening. Others are using tools required by their health or hospital system employer. Others use agency-based tools which may be appropriate for specific patient needs.
- One question is: **Is it necessary to use evidence-based tools to identify behavioral issues or are agency-based tools sufficient? Specifically, those BH issues which are minor and treatable versus those that interfere with HIV health and taking medications.**
- Second question is: **Is it necessary to use evidence-based tools to diagnose and treat behavioral issues or are agency-based tools sufficient? Specifically, those BH issues which are minor and treatable versus those that interfere with HIV health and taking medications.**

Comments from Research and Evaluation Committee (REC)

- Some of the tools being used are clearly insufficient for the purposes of screening. For example, "How are you feeling?" is inadequate to assess for depression. Similarly, use of a hospital-approved suicide risk assessment may be appropriate to identify clients with suicidal ideation but will miss patients with more mild cases of depression.
- Based on the questions that were asked, it is unclear how agencies use behavioral health screens on a day-to-day basis. Who conducts the screening and how is a positive screen handled? A better understanding of agency-specific practices is necessary to determine whether the use of evidence-based tools is necessary or whether agency-specific tools are sufficient.

Recommendations:

- ✚ The EMA should review the results and determine whether the screening tools are sufficient to detect BH issues.
  If so, the tools can continue to be used.
  If not, the Planning Council should consider updating Mental Health and/or Outpatient Substance Abuse Service Standards to include use of evidence-based Behavioral Health screening tools.
- ✚ The EMA should also review the results and determine whether the only evidence-based tools are sufficient to treat BH issues.

Recommendations from Research and Evaluation Committee (REC)

- ✚ The Planning Council should consider updating Mental Health and/or Outpatient Substance Abuse Service Standards to include use of evidence-based Behavioral Health screening tools.
- ✚ The EMA should also review processes used by individual agencies to assess for behavioral health issues to determine the adequacy of the screening process and consider including training on screening for behavioral health issues among case workers..

1.3.3 Agency Survey Conclusions and Recommendations

AGENCY SURVEY OF BEHAVIORAL ISSUES
CONCLUSIONS AND RECOMMENDATIONS

#3 FURTHER BEHAVIORAL ASSESSMENT/FOLLOW UP

Conclusion:

- The agencies seem to have specific policies and procedures in place for treatment and/or referral of patients who appear to have behavioral health issues, and have specific referral agencies depending on the extent and/or degree of the mental health, substance use disorder, social issues asked on the questionnaire.

Recommendations:

- ✚ The EMA should review the results and determine whether the responses and referral protocols are sufficient to address patient needs.
- ✚ The Planning Council's Continuum of Care (COC) Committee may want to identify if there are any gaps in referrals and treatment, and recommend ways to reduce or eliminate these gaps.
- ✚ Also, the PC is responsible for developing an inventory of resources available to serve needs of PLWH. This inventory should be reviewed and updated to include non-RWHAP funded BH resources.

Recommendations from Research and Evaluation Committee (REC)

- ✚ This inventory should be reviewed and updated to include non-RWHAP funded BH resources.

#4 ABILITY TO MEET BEHAVIORAL NEEDS ONSITE/BY REFERRAL

Conclusion:

- An equal percentage of agencies have to refer out for behavioral health needs as can provide services on site (40% in both cases).

Recommendation:

- ✚ Agencies should consider the use of telehealth services as a way of enhancing access to behavioral health services on the premises. For example, telepsychiatry could be provided to clients onsite through contractual arrangements with a licensed psychiatrist.

#5 SUBSTANCE USE ISSUES, NEEDS, CHALLENGES, GAPS

Conclusions:

- The agencies are well aware of the substance abuse problems experienced by their clients.
- They have also identified patient barriers to care - lack of treatment options and resources, strength of addiction, do not want to seek or remain in treatment, do not view substance use as a problem.
- 30% of clients report using tobacco products on a daily basis, but tobacco use is not seen as a problem within communities, whereas marijuana is listed by both clients and agencies as one of the most commonly abused substances.

Recommendations:

- ✚ It is recommended that the Planning Council do a thorough study of substance abuse treatment resources in the EMA, including payment sources, to identify sources that RWHAP funded agencies may not be accessing for PLWH. Include a gaps analysis of resources not available to PLWH based on income, insurance, other demographics.

  This is consistent with the federal RWHAP requirement to assess resources available to meet needs of PLWH, as discussed in the mental health section below.
- ✚ For FY 2020, the COC and Newark EMA PC should identify which RWHAP and non-RWHAP resources are being used by RWHAP agencies for referral to care, the reasons not being used, barriers, and actions to improve access.

1.3.3 Agency Survey Conclusions and Recommendations

AGENCY SURVEY OF BEHAVIORAL ISSUES
CONCLUSIONS AND RECOMMENDATIONS

- ✚ Given its detrimental health effects, the EMA should consider new approaches to addressing tobacco use within the community and examine how changing perceptions of the use of nicotine (e.g., vaping) and marijuana (e.g., medical uses) may affect patterns of substance abuse going forward.

#6 MENTAL HEALTH ISSUES, NEEDS, CHALLENGES, GAPS

Conclusions:

- The agencies are well aware of the mental health problems experienced by their clients.
- The agencies have articulated challenges relating access to MH care and lack of specific MH resources (e.g., psychiatrists, bilingual MH providers, and lack of resource in the suburban/rural region.
- The agencies have identified funding limitations of Medicaid and other health insurance programs.
- They have also identified patient barriers to care - they do not want to seek or remain in care, do not view MH as a problem, use substances.

Recommendations:

- ✚ It is the federal statutory responsibility of the Planning Council to assess resources available to meet the needs of PLWH - as part of the annual Needs Assessment process.
- ✚ The EMA should review available RWHAP-funded BH (MH & SA) resources and identify the capacity, barriers, and opportunities for increasing services.
- ✚ It is recommended that the **Continuum Of Care (COC) Committee** be the designated entity to oversee an assessment of resource availability. Specifically, for behavioral resources - mental health and substance use - both funded by RWHAP and funded by other non-RWHAP sources.
- ✚ For FY 2020, the COC and Newark EMA PC should identify which RWHAP and non-RWHAP resources are being used by RWHAP agencies for referral to care, the reasons not being used, barriers, and actions to improve access.

#7 EMERGING SUBSTANCE USE AND MENTAL HEALTH NEEDS

Conclusion:

- Agencies report need for more detox and inpatient substance abuse services.

Recommendation:

Recommendations from Research and Evaluation Committee (REC)

- ✚ Research shows that detox programs are generally not effective in the long term at reducing substance abuse. New Jersey is investing resources on expanding access to medication-assisted treatment (MAT) with Buprenorphine. NEMA should encourage more eligible providers to receive training in MAT and seek the Drug Addiction Treatment Act (DATA 2000) waiver to prescribe Buprenorphine to patients.

#8 BEHAVIORAL HEALTH RESOURCE NEEDS

Conclusions:

- The agencies are well aware of the behavioral health resources needed to treat their clients.
- Many agencies in the Newark EMA are funded by non-RWHAP sources to provide BH services and these Lists of Agencies are available at the State of New Jersey website - NJ Department of Human Services, Division of Mental Health and Addiction Services (NJDHS, DMHAS).
- New Jersey Medicaid funds many agencies to provide MH/SA services. A list of these agencies should be available from NJDHS, DMAHS.
- Psychiatric services are needed and many do not accept Medicaid reimbursement levels. However, RWHAP has flexibility in reimbursing for needed cost of care for PLWH.

1.3.3 Agency Survey Conclusions and Recommendations

AGENCY SURVEY OF BEHAVIORAL ISSUES
CONCLUSIONS AND RECOMMENDATIONS

Recommendations:

- As discussed in above recommendations, the Planning Council should identify all BH resources in the Newark EMA which could be utilized for PLWH. These resources do NOT have to be funded by RWHAP.
- The Planning Council should assess whether ALL agencies funded by Newark EMA Part A RWHAP are utilizing these resources, gaps and barriers to access. This could increase the availability of BH services for PLWH.
- Psychiatric services are not usually ongoing treatment but more often one-time or several times. RWHAP-funded agencies in the EMA should consider contractual or subcontractual arrangements with psychiatrists to provide short-term, time-limited services for PLWH. Since the providers cannot be forced to take Medicaid, RWHAP can be used to fund psychiatric services since the PLWH would be considered "underinsured." Some agencies in the EMA are successfully using this model. It could be helpful in locating bilingual psychiatrists as well.

PART 2: BEHAVIORAL HEALTH OUTCOMES OF BHIP vs. NON-BHIP AGENCIES

2.1 Introduction

Research Question #2 to be answered is:

How do behavioral health outcomes compare for consumers being served by NEMA-funded agencies participating in the State's Behavioral Health Integration Project (B-HIP) versus those agencies not participating in B-HIP? (NOTE: Analyses will be limited to agencies providing primary medical care services.)

Sub-questions: (a) How does housing status compare across these two groups of agencies? (b) What is the association between housing and viral load across the two groups of agencies? and (c) Are behavioral health outcomes better for those with more stable housing?

Methodological approach: Analysis of CHAMP data from primary medical care sites to compare behavioral health status and viral load by housing status in B-HIP-participating agencies versus those not participating in B-HIP.

2.2 Findings Regarding Behavioral Health Outcomes

2.2.1 BHIP and Non-BHIP Agencies

The analysis presents data for the total Newark EMA, the seven (7) agencies receiving RWHAP primary medical care funding who are participating in BHIP, and the remaining seven (7) agencies receiving RWHAP Part A primary medical care funding who are not participating in BHIP. They are listed below.

Table 1: Newark EMA RWHAP Part A Provider Agencies' Participation in BHIP

	BHIP Participant		Not BHIP Participant
1	Hyacinth Foundation	**8**	Morristown Medical Center – Family Health
2	NJCRI	**9**	Neighborhood Health Center
3	Rutgers – Infectious Disease Practice	**10**	Newark Beth Israel Medical Center
4	Rutgers – DAYAM	**11**	Newark Community Heath Centers
5	St. Michael's Medical Center	**12**	Newark Dept. Health & Comm. Wellness
6	Trinitas Regional Medical Center	**13**	Rutgers – FXB
7	Zufall Health Center	**14**	Smith Center

2.2.2 Findings of BHIP Indicators #1 through #6

Performance was measured for the four available measurement years ending in 12/31/18 (baseline), 2/28/19, 4/30/19, and 6/30/19. Three groups were measured – Total EMA, BHIP agencies, and non-BHIP agencies. The percentages, original data and figures/graphs showing trends are shown below.

BHIP #1 Depression Screening

BHIP1 - PLWH Screened for Depression (Based on NQF 418). EMA-wide, nearly 90% of PLWH were screened for depression as of 12/31/18 which increased to 92% as of 6/30/19. The ending rates for BHIP agencies at 91% was slightly lower than for non-BHIP agencies at 94%.

BHIP #2 Substance Use Screening

BHIP2 - PLWH Screened for Substance Abuse (Based on NQF 418). Substance use screening was slightly higher than depression screening. EMA-wide, 90% of PLWH were screened for substance use as of 12/31/18 which increased to 93% as of 6/30/19. The ending rates for BHIP agencies at 92% was slightly lower than for non-BHIP agencies at 95%.

BHIP #3 Behavioral Care Plan

BHIP3 - PLWH with Positive Screens who have Follow-up Plans (Based on NQF 418). The percent of PLWH with positive behavioral screens (mental health, substance use or both) as indicated by Follow UP Care Plan drops significantly from those screened. However, the trends are positive. EMA-wide, the percent of PLWH with Follow Up Care Plans increased from 25% as of 12/31/18 to 39% as of 6/30/19 – an increase of over 50%. Here, BHIP agencies performed better than non-BHIP agencies. BHIP agencies with Follow Up Care Plans increased from 27% as of 12/31/18 to 41% as of 6/30/19. In contrast, non-BHIP agencies began with only 22% as of 12/31/18 and rose to 37% as of 6/30/19.

BHIP #4 Retention in Behavioral Care

BHIP4 - PLWH with Behavioral Health (BH) Disorders Retained in BH Care (Not a NQF measure). This measure captures clients who have a follow up BH visit. EMA-wide, retention in BH care increased from 26% to 29%. However, percentages were slightly higher for non-BHIP agencies than BHIP agencies. For BHIP agencies, retention rose from 24% as of 12/31/18 to 27% as of 6/30/19. In contrast, for non-BHIP agencies retention increased from 29% as of 12/31/18 to 31% as of 6/30/19.

Note: This measure will be changing in CHAMP from those with a positive BH screen to those with a positive BH <u>diagnosis</u>.

BHIP #5 Viral Load Suppression of BH Diagnosis Clients

BHIP5 - PLWH with BH Disorders Viral Suppression. This measures viral load suppression among PLWH diagnosed with a BH disorder. The purpose is to see if there is a [significant] difference compared to total PLWH. EMA-wide, VLS for PLWH with BH disorders was an arc – starting at 84% as of 12/31/18

increasing to 85% as of 2/28/19 and 4/30/19 and returning to 84% as of 6/30/19. BHIP agencies had better performance – starting at 85% as of 12/31/18 and increasing to 86% in 2019. Non-BHIP agencies had lower VLS performance among BH clients – at 83% as of 12/31/18, increasing to 84% in 2/28/19 and 4/30/19, and decreasing to 82% as of 6/30/19.

Note: This measure will be changing in CHAMP from those with a positive BH screen to those with a positive BH diagnosis.

BHIP #6 Viral Load Suppression of PLWH

BHIP6 - PLWH with Viral Suppression (NQF 2082)(collected through NJ CPC). This captures viral load suppression (VLS) among all PLWH age 18 and older. EMA-wide, VLS for total PLWH showed an increase – starting at 84% as of 12/31/18 increasing to 85% as of 2/28/19, 4/30/19 and 6/30/19. BHIP agencies had better performance – remaining a steady 85% as of 12/31/18 through 6/30/19. Non-BHIP agencies had lower VLS performance showing an arc – at 82% as of 12/31/18, increasing to 85% in 2/28/19 and 4/30/19, and decreasing to 84% as of 6/30/19.

2.3 Findings Regarding Housing Status and Behavioral Health Outcomes

This section answers three Sub-questions: (a) How does housing status compare across these two groups of agencies? (b) What is the association between housing and viral load across the two groups of agencies? and (c) Are behavioral health outcomes better for those with more stable housing?

2.3.1 Housing Definitions

The federal government – USDHHS HRSA and US Department of Housing and Urban Development HUD) - have established definitions for housing which are applied to RWHAP. These include three (3) broad housing categories of “Stable Permanent”, “Temporary” and “Unstable.” These definitions and categories are set forth in the HRSA HAB annual Ryan White Services Report (RSR) Manual. The CHAMP client level data base captures these federal categories and definitions. The crosswalk between USDHHS/HUD categories and CHAMP “Living Arrangement” categories is shown below.

The definition of ”unstable” housing is very narrow and includes those who are homeless, living in emergency shelters, living in a hotel or motel with a subsidy or voucher, or in jail/prison. Individuals who are “doubling up” – living with family or friends – are considered to be in “temporary” housing. Doubling up is not an unstable housing situation according to the federal government, although many case managers and RWHAP agencies consider this situation to be reflective of personal and housing instability which interferes with medication/treatment adherence and adversely affects overall physical and behavioral health.

2.3.2 BHIP Outcomes by Housing Status

The tables below show outcomes for BHIP indicators by housing status of RWHAP clients – stable permanent, temporary and unstable.

BHIP1 - PLWH Screened for Depression (Based on NQF 418).
BHIP2 - PLWH Screened for Substance Abuse (Based on NQF 418).
EMA-wide, screening for mental health and substance abuse (percent of clients screened) was slightly lower for those in unstable housing compared to stable housing as of 12/31/18. By 6/30/19, the percent of unstably housed clients screened for behavioral care had increased and was equal to those in stable and temporary housing. The overall percentages were slightly higher for non-BHIP agencies (94%-95%) than BHIP agencies (91%), but both followed the same trend.

Conclusion: All RWHAP clients are screened for screening for depression and substance abuse regardless of housing situation - There is no difference in behavioral health screening by housing status.

BHIP3 - PLWH with Positive Screens who have Follow-up Plans (Based on NQF 418).
The percent of PLWH with positive behavioral screens (mental health, substance use or both) as indicated by Follow Up Care Plan drops significantly from those screened. However, the **percent of RWHAP clients in unstable housing with Follow Up Care Plans is nearly double that of clients in stable and temporary housing.** Percentages are higher for BHIP agencies vs non-BHIP agencies.

- As of 12/31/18, 47% of EMA clients in unstable housing had care plans, including 50% in BHIP agencies and 42% in non-BHIP agencies. As of 6/30/19, these percentages rose to 63%, 65%, and 60%, respectively.
- Percentages increased by over 50% as well for those in stable and temporary housing from 12/31/18 to 6/30/19. For those in stable housing, BHIP agencies went from 25% to 39% and non-BHIP agencies rose from 25% to 40%. For clients in temporary housing, BHIP agency percentages increased from 30% to 42% and non-BHIP agencies from 15% to 29%.

BHIP4 - PLWH with Behavioral Health (BH) Disorders Retained in BH Care (Not a NQF measure). This measure captures clients who have a follow up BH visit. EMA-wide, retention in BH care increased from 26% to 29%. As with BHIP3, the percent of RWHAP clients in unstable housing Retained in BH care is higher than clients in stable and temporary housing – nearly double the rate. But the percentage declined from 12/31/18 to 6/30/19.

- As of 12/31/18, 58% of EMA clients in unstable housing were retained in BH care, including 55% in BHIP agencies and 63% in non-BHIP agencies. As of 6/30/19, these percentages declined to 49%, 46%, and 54%, respectively.
- Percentages increased slightly for those in stable and temporary housing from 12/31/18 to 6/30/19. For those in stable housing, BHIP agencies went from 22% to 25% and non-BHIP agencies rose from 28% to 32%. For clients in temporary housing, BHIP agency percentages increased from 28% to 32% and non-BHIP agencies from 26% to 28%.

Note: This measure will be changing in CHAMP from those with a positive BH screen to those with a positive BH diagnosis.

BHIP5 - PLWH with BH Disorders Viral Suppression. There were differences in Viral Load Suppression (VLS) among RWHAP clients with behavioral screening (behavioral disorders) by housing status for the EMA, BHIP agencies, and non-BHIP agencies. Housing status is always a factor in VLS such that VLS is lower overall for PLWH in unstable housing. **EMA-wide VLS percentages for PLWH with BH disorders remained unchanged or showed slight improvements as of 12/31/18 and 6/30/19 for stable and temporary housing (86% and 82%), but declined from 67% to 62% for those unstably housed.**

- BHIP agencies showed the following VLS trends as of 12/31/18 and 6/30/19: Stable housing 87% to 88%, temporary housing 83% (unchanged), unstable housing 62% to 68%.
- Non-BHIP agencies showed the following VLS trends as of 12/31/18 and 6/30/19: Stable housing 85% to 84%, temporary housing 82% to 80%, unstable housing 73% to 56%.

Note: This measure will be changing in CHAMP from those with a positive BH screen to those with a positive BH diagnosis.

BHIP6 - PLWH with Viral Suppression (NQF 2082)(collected through NJ CPC). There were also differences in Viral Load Suppression (VLS) among all RWHAP clients age 18 and older (regardless of behavioral disorders) by housing status for the EMA, BHIP agencies, and non-BHIP agencies. Housing status is always a factor in VLS such that VLS is lower overall for PLWH in unstable housing. **EMA-wide VLS percentages for PLWH age 18+ increased slightly as of 12/31/18 and 6/30/19 for stable and temporary housing (85% to 87%), but remained the same at 71% for those unstably housed.**

- BHIP agencies showed the following VLS trends for all PLWH as of 12/31/18 and 6/30/19: Stable housing 87% (unchanged), temporary housing 83% (unchanged), unstable housing 70% to 68%.
- Non-BHIP agencies showed the following VLS trends for all PLWH as of 12/31/18 and 6/30/19: Stable housing 83% to 86%, temporary housing 82% (unchanged), unstable housing 72% to 75%.

2.4 Conclusions and Recommendations Regarding Behavioral Health Outcomes and Housing

Behavioral health issues – depression and other mental health issues and substance use – are comorbid factors among persons living with HIV (PLWH) disease both nationwide and especially in the Newark EMA. These comorbidities adversely affect health of PLWH, treatment/medication adherence, viral suppression, and hence lead to the continued spread of HIV. The EMA must continue efforts to screen, diagnose and treat these illnesses.

Conclusions

- The Newark EMA RWHAP is screening nearly all clients (93%) for behavioral health regardless of housing status.
- There is a need to focus on the need for BH services – by identifying persons diagnosed with BH disorder, developing Follow Up Care Plans, and monitoring retention in BH care.

- There should be better tracking of the behavioral care continuum, care engagement and outcomes, through CHAMP and other agency electronic medical records (EMR) systems.

Recommendations

- The Newark EMA RWHAP should review clients who have not been screened for BH, reasons, and institute a policy for 100% BH screening.
- The EMA should further assess the BH treatment continuum of care among agencies screening for BH, identify gaps and needs, and develop strategies to fill those gaps and ensure follow up for clients receiving BH services. This is part of the NJ BHIP, and the BHIP agencies in the EMA should take the lead in this initiative.
- CHAMP data tracking and performance reporting should be updated to reflect BHIP definitions, and client retention in BH care. Agencies should ensure that their EMR systems track BH services, treatment and BH care plans.

Research Question #2

How do behavioral health outcomes compare for consumers being served by NEMA-funded agencies participating in the State's Behavioral Health Integration Project (B-HIP) versus those agencies not participating in B-HIP? (NOTE: Analyses will be limited to agencies providing primary medical care services.)

Sub-questions: (a) How does housing status compare across these two groups of agencies? (b) What is the association between housing and viral load across the two groups of agencies? and (c) Are behavioral health outcomes better for those with more stable housing?

NEWARK EMA TOTAL		Measurement Year Ending: 12/31/18	2/28/19	4/30/19	6/30/19
7. BHIP					
BHIP1 - PLWH Screened for Depression (Based on NQF 418)		89.79%	92.74%	92.86%	91.72%
BHIP2 - PLWH Screened for Substance Abuse (Based on NQF 418)		90.13%	93.08%	93.16%	92.89%
BHIP3 - PLWH with Positive Screens who have Follow-up Plans (Based on NQF 418)		25.17%	30.01%	33.85%	39.05%
BHIP4 - PLWH with BH Disorders Retained in BH Care (Not a NQF measure)		25.95%	26.02%	27.36%	28.87%
BHIP5 - PLWH with BH Disorders Viral Suppression		84.37%	85.53%	85.53%	84.05%
BHIP6 - PLWH with Viral Suppression (NQF 2082)(collected through NJ CPC)		84.06%	85.36%	85.30%	84.97%

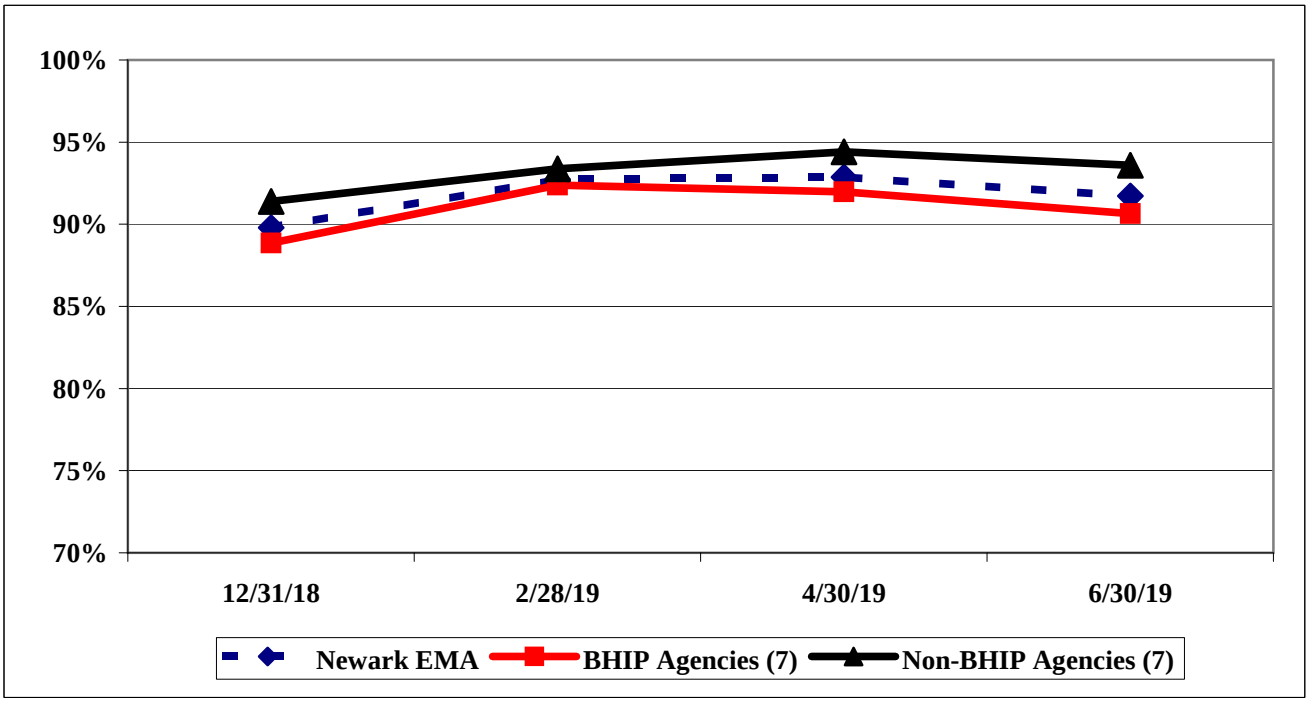
NEWARK EMA TOTAL - BHIP AGENCIES (7 Medical Providers Excluding ARFC)					
7. BHIP					
BHIP1 - PLWH Screened for Depression (Based on NQF 418)		88.86%	92.38%	91.97%	90.65%
BHIP2 - PLWH Screened for Substance Abuse (Based on NQF 418)		88.86%	92.32%	91.97%	91.62%
BHIP3 - PLWH with Positive Screens who have Follow-up Plans (Based on NQF 418)		27.07%	31.88%	35.24%	40.71%
BHIP4 - PLWH with BH Disorders Retained in BH Care (Not a NQF measure)		24.17%	24.45%	25.60%	27.22%
BHIP5 - PLWH with BH Disorders Viral Suppression		85.08%	86.10%	86.23%	85.79%
BHIP6 - PLWH with Viral Suppression (NQF 2082)(collected through NJ CPC)		85.38%	85.35%	85.53%	85.52%

NEWARK EMA TOTAL - NON-BHIP AGENCIES (7 Medical Provider Agencies)					
7. BHIP					
BHIP1 - PLWH Screened for Depression (Based on NQF 418)		91.39%	93.38%	94.41%	93.59%
BHIP2 - PLWH Screened for Substance Abuse (Based on NQF 418)		92.31%	94.44%	95.23%	95.12%
BHIP3 - PLWH with Positive Screens who have Follow-up Plans (Based on NQF 418)		22.24%	27.09%	31.77%	36.69%
BHIP4 - PLWH with BH Disorders Retained in BH Care (Not a NQF measure)		28.69%	28.46%	29.99%	31.23%
BHIP5 - PLWH with BH Disorders Viral Suppression		83.26%	84.64%	84.48%	81.57%
BHIP6 - PLWH with Viral Suppression (NQF 2082)(collected through NJ CPC)		81.85%	85.39%	84.91%	84.00%

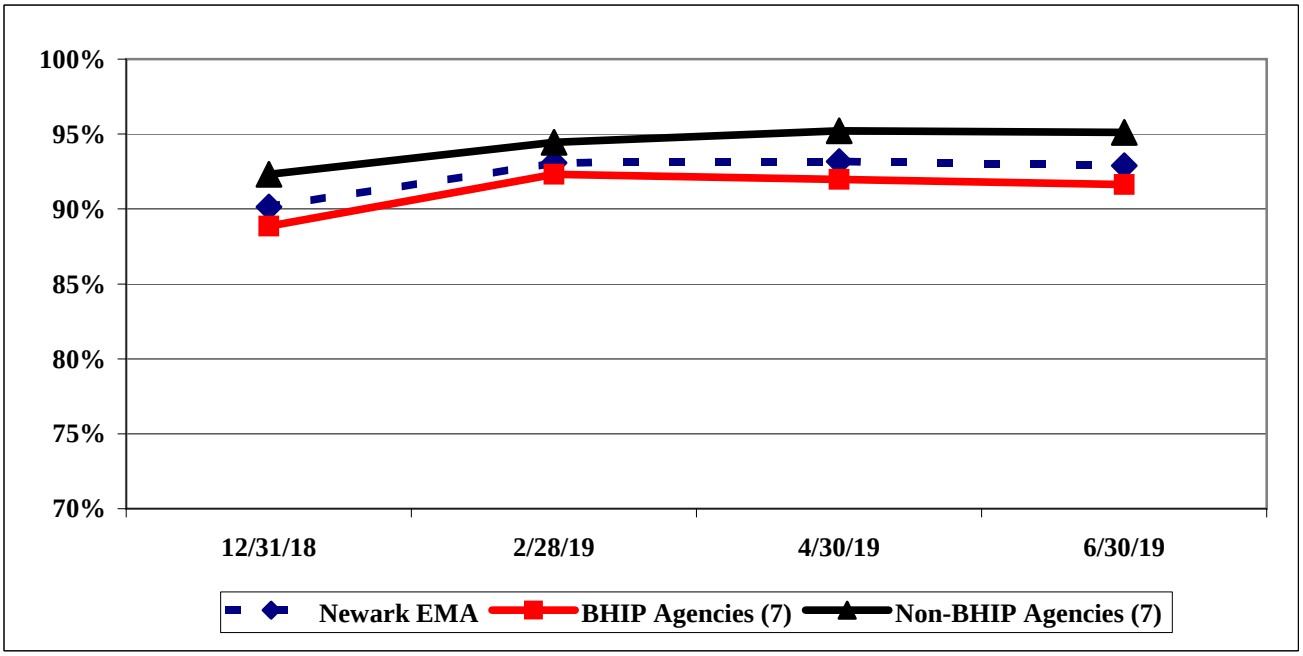
Source Data for BHIP Outcomes
CHAMP Performance Reports - Numerator and Denominator

	Measurement Year Ending							
	12/31/18		2/28/19		4/30/19		6/30/19	
	Num	Denom	Num	Denom	Num	Denom	Num	Denom
NEWARK EMA TOTAL								
BHIP 1	4,232	4,713	4,358	4,699	4,358	4,693	4,307	4,696
BHIP 2	4,248	4,713	4,374	4,699	4,372	4,693	4,362	4,696
BHIP 3	1,003	3,985	1,120	3,732	1,137	3,359	1,109	2,840
BHIP 4	1,034	3,985	971	3,732	919	3,359	820	2,840
BHIP 5	3,362	3,985	3,192	3,732	2,873	3,359	2,387	2,840
BHIP 6	3,988	4,744	4,036	4,728	4,027	4,721	4,013	4,723
NEWARK EMA TOTAL - BHIP AGENCIES (7 Medical Providers Excluding ARFC)								
BHIP 1	2,640	2,971	2,778	3,007	2,736	2,975	2,716	2,996
BHIP 2	2,640	2,971	2,776	3,007	2,736	2,975	2,745	2,996
BHIP 3	655	2,420	725	2,274	709	2,012	679	1,668
BHIP 4	585	2,420	556	2,274	515	2,012	454	1,668
BHIP 5	2,059	2,420	1,958	2,274	1,735	2,012	1,431	1,668
BHIP 6	2,540	2,975	2,569	3,010	2,547	2,978	2,564	2,998
NEWARK EMA TOTAL - NON-BHIP AGENCIES (7 Medical Provider Agencies)								
BHIP 1	1,592	1,742	1,580	1,692	1,622	1,718	1,591	1,700
BHIP 2	1,608	1,742	1,598	1,692	1,636	1,718	1,617	1,700
BHIP 3	348	1,565	395	1,458	428	1,347	430	1,172
BHIP 4	449	1,565	415	1,458	404	1,347	366	1,172
BHIP 5	1,303	1,565	1,234	1,458	1,138	1,347	956	1,172
BHIP 6	1,448	1,769	1,467	1,718	1,480	1,743	1,449	1,725

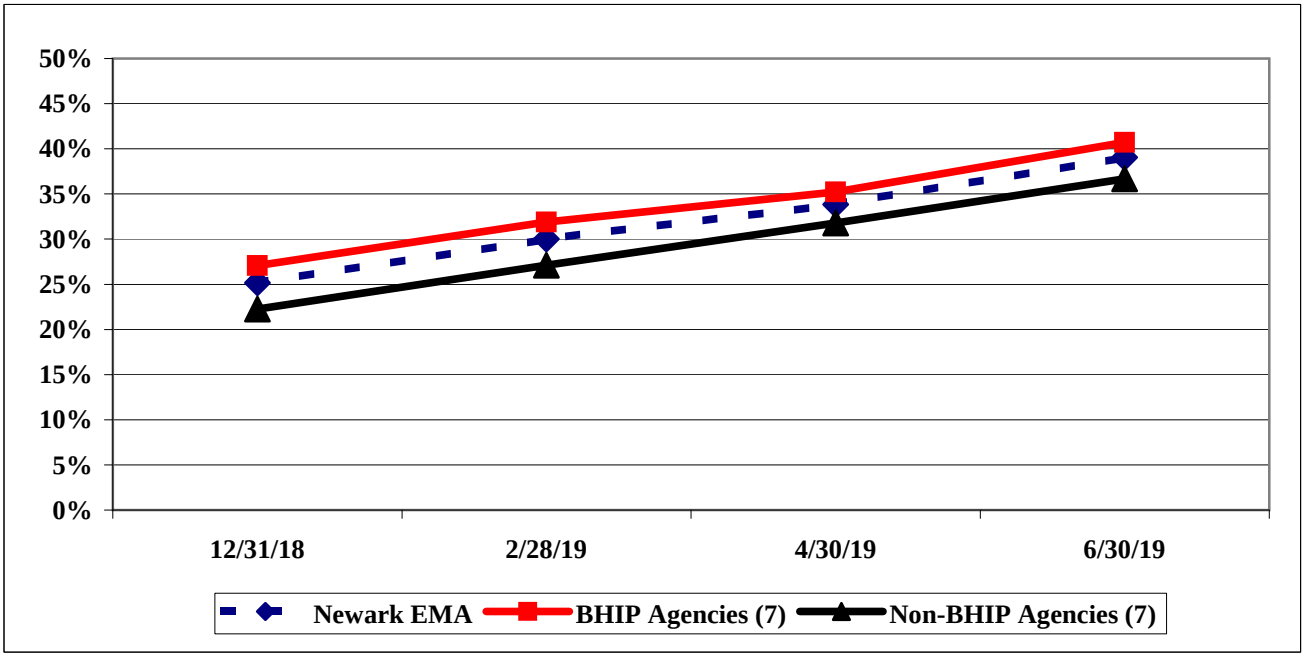
BHIP1 - PLWH Screened for Depression (Based on NQF 418)



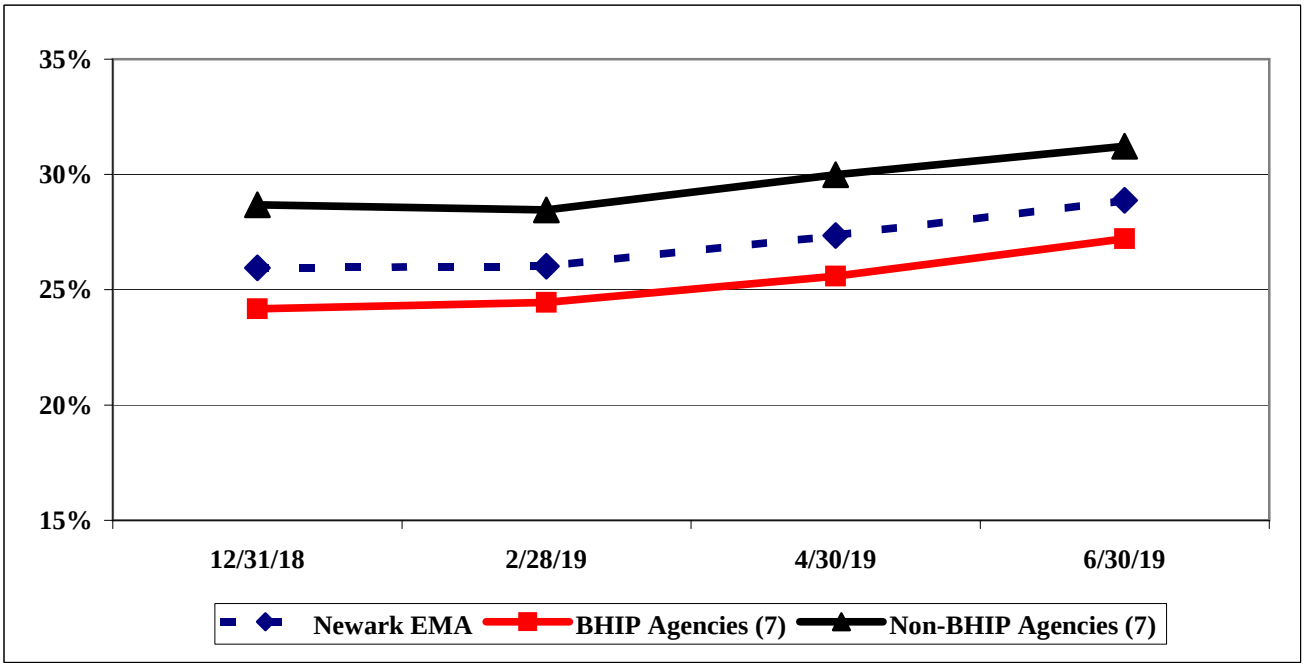
BHIP2 - PLWH Screened for Substance Abuse (Based on NQF 418)



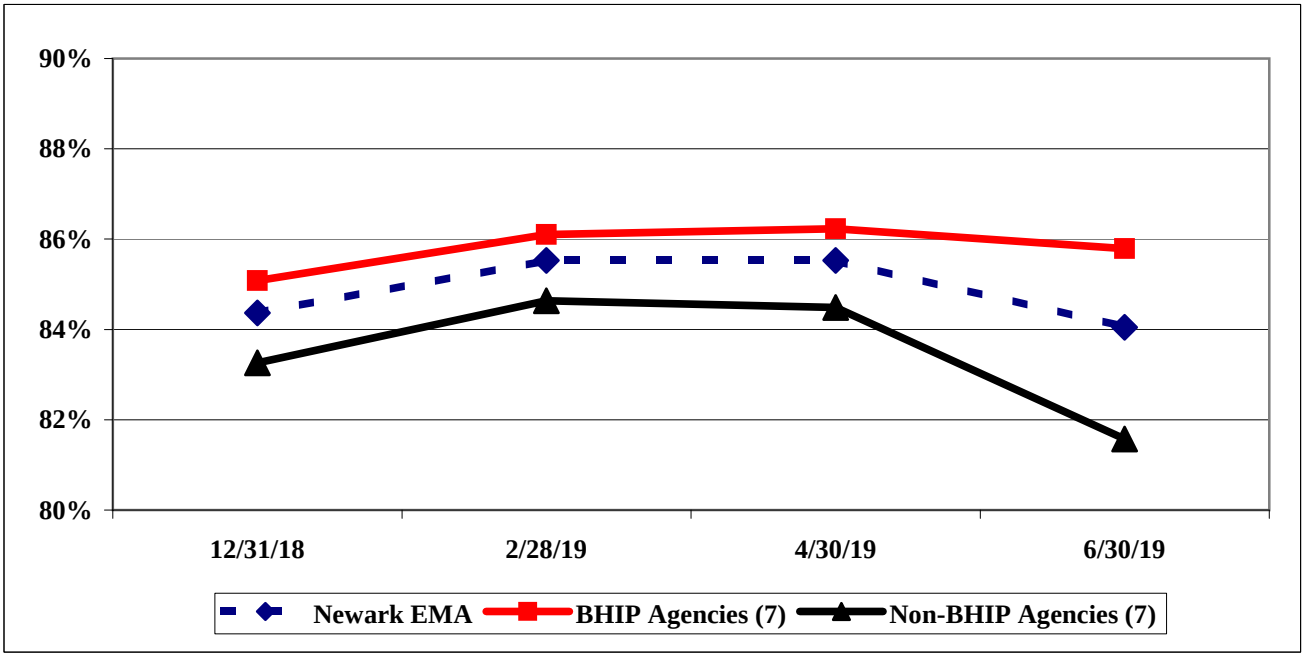
BHIP3 - PLWH with Positive Screens who have Follow-up Plans (Based on NQF 418)



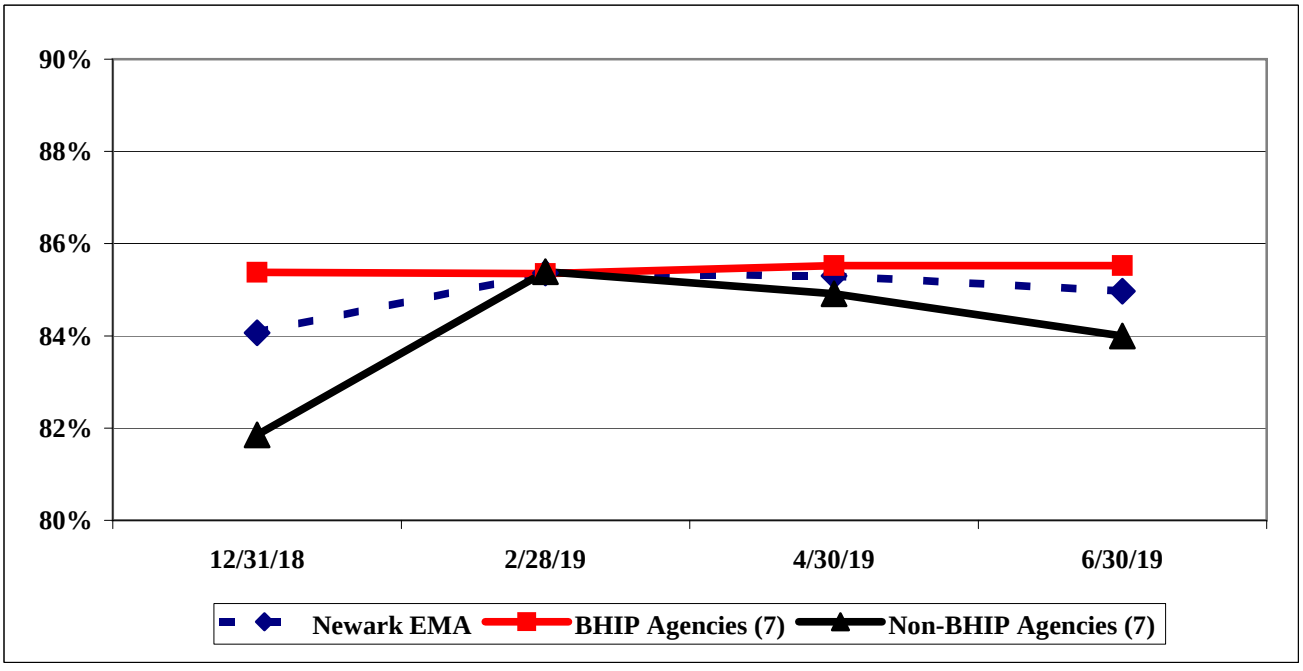
BHIP4 - PLWH with BH Disorders Retained in BH Care (Not a NQF measure)



BHIP5 - PLWH with BH Disorders Viral Suppression



BHIP6 - PLWH with Viral Suppression (NQF 2082)(collected through NJ CPC)



HOUSING STATUS AND BEHAVIORAL HEALTH OUTCOMES

This section answers two Sub-questions: (a) How does housing status compare across these two groups of agencies? (b) What is the association between housing and viral load across the two groups of agencies? and (c) Are behavioral health outcomes better for those with more stable housing?

The definitions of **Housing Status** from US DHHS and HUD and CHAMP housing status ("live in" variable) are shown below.

USDHHS	CHAMP/US HUD
Stable Permanent Housing	HOPWA - Long Term House/Apartment - Rent or Own Unsubsidized House/Apartment - Subsidized Non HOPWA Nursing Home/Hospice SRO or Group Housing
Temporary Housing	Hotel or motel no subsidy-voucher House/Apartment - Doubling up, staying with family/friends Institution (Hospital, Psych.) Residential Treatment Program Ryan White Housing Transitional Housing - Not Ryan White Transitional Housing - Ryan White
Unstable Housing	Emergency Shelter Homeless Hotel or motel with subsidy-voucher Jail/Prison

HOUSING STATUS AND BEHAVIORAL HEALTH OUTCOMES

BHIP1 - PLWH Screened for Depression (Based on NQF 418)

	Year Ending 12/31/18			Year Ending 2/28/19			Year Ending 4/30/19			Year Ending 6/30/19		
Housing Status	**With MH Screen**			**With MH Screen**			**With MH Screen**			**With MH Screen**		
Total EMA	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	2972	89.5%	3,320	3013	92.2%	3268	2974	92.6%	3212	2931	91.7%	3195
Temporary Housing	1126	90.8%	1,240	1209	93.9%	1287	1242	93.4%	1330	1238	91.6%	1352
Unstable Housing	134	87.6%	153	136	94.4%	144	142	94.0%	151	138	92.6%	149
Total	**4,232**	**89.8%**	**4,713**	**4,358**	**92.7%**	**4,699**	**4,358**	**92.9%**	**4,693**	**4,307**	**91.7%**	**4,696**
BHIP Agencies	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	2019	89.1%	2,265	3037	92.9%	3268	2062	92.0%	2241	2019	90.7%	2226
Temporary Housing	547	87.9%	622	1199	93.2%	1287	597	91.7%	651	618	90.5%	683
Unstable Housing	74	88.1%	84	138	95.8%	144	77	92.8%	83	79	90.8%	87
Total	**2,640**	**88.9%**	**2,971**	**4,374**	**93.1%**	**4,699**	**2,736**	**92.0%**	**2,975**	**2,716**	**90.7%**	**2,996**
Non-BHIP Agencies	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	953	90.3%	1,055	769	30.0%	2560	912	93.9%	971	912	94.1%	969
Temporary Housing	579	93.7%	618	279	26.6%	1050	645	95.0%	679	620	92.7%	669
Unstable Housing	60	87.0%	69	72	59.0%	122	65	95.6%	68	59	95.2%	62
Total	**1,592**	**91.4%**	**1,742**	**1,120**	**30.0%**	**3,732**	**1,622**	**94.4%**	**1,718**	**1,591**	**93.6%**	**1,700**

HOUSING STATUS AND BEHAVIORAL HEALTH OUTCOMES

BHIP2 - PLWH Screened for Substance Abuse (Based on NQF 418)

	Year Ending 12/31/18			Year Ending 2/28/19			Year Ending 4/30/19			Year Ending 6/30/19		
Housing Status	**With SA Screen**			**With SA Screen**			**With SA Screen**			**With SA Screen**		
Total EMA	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	2994	90.2%	3320	3037	92.9%	3268	2987	93.0%	3212	2962	92.7%	3195
Temporary Housing	1120	90.3%	1240	1199	93.2%	1287	1240	93.2%	1330	1259	93.1%	1352
Unstable Housing	134	87.6%	153	138	95.8%	144	145	96.0%	151	141	94.6%	149
Total	**4,248**	**90.1%**	**4,713**	**4,374**	**93.1%**	**4,699**	**4,372**	**93.2%**	**4,693**	**4,362**	**92.9%**	**4,696**
BHIP Agencies	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	2018	89.1%	2265	2102	92.4%	2276	2064	92.1%	2241	2036	91.5%	2226
Temporary Housing	548	88.1%	622	597	91.8%	650	595	91.4%	651	629	92.1%	683
Unstable Housing	74	88.1%	84	77	95.1%	81	77	92.8%	83	80	92.0%	87
Total	**2,640**	**88.9%**	**2,971**	**2,776**	**92.3%**	**3,007**	**2,736**	**92.0%**	**2,975**	**2,745**	**91.6%**	**2,996**
Non-BHIP Agencies	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	976	92.5%	1,055	935	94.3%	992	923	95.1%	971	926	95.6%	969
Temporary Housing	572	92.6%	618	602	94.5%	637	645	95.0%	679	630	94.2%	669
Unstable Housing	60	87.0%	69	61	96.8%	63	68	100.0%	68	61	98.4%	62
Total	**1,608**	**92.3%**	**1,742**	**1,598**	**94.4%**	**1,692**	**1,636**	**95.2%**	**1,718**	**1,617**	**95.1%**	**1,700**

HOUSING STATUS AND BEHAVIORAL HEALTH OUTCOMES

BHIP3 - PLWH with Positive Screens who have Follow-up Plans (Based on NQF 418)

	Year Ending 12/31/18			Year Ending 2/28/19			Year Ending 4/30/19			Year Ending 6/30/19		
Housing Status	**With BH Plan**			**With BH Plan**			**With BH Plan**			**With BH Plan**		
Total EMA	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	695	25.2%	2,760	769	23.7%	2560	762	33.7%	2259	739	39.4%	1878
Temporary Housing	246	22.5%	1,093	279	16.4%	1050	299	30.5%	981	303	35.4%	855
Unstable Housing	62	47.0%	132	72	32.8%	122	76	63.9%	119	67	62.6%	107
Total	**1,003**	**25.2%**	**3,985**	**1,120**	**30.0%**	**3,732**	**1,137**	**33.8%**	**3,359**	**1,109**	**39.0%**	**2,840**
BHIP Agencies	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	458	25.2%	1,816	513	30.2%	1700	499	33.5%	1491	471	39.1%	1206
Temporary Housing	160	30.1%	531	172	33.9%	507	170	37.0%	460	171	42.2%	405
Unstable Housing	37	50.7%	73	40	59.7%	67	40	65.6%	61	37	64.9%	57
Total	**655**	**27.1%**	**2,420**	**725**	**31.9%**	**2,274**	**709**	**35.2%**	**2,012**	**679**	**40.7%**	**1,668**
Non-BHIP Agencies	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	237	25.1%	944	256	29.8%	860	263	34.2%	768	268	39.9%	672
Temporary Housing	86	15.3%	562	107	19.7%	543	129	24.8%	521	132	29.3%	450
Unstable Housing	25	42.4%	59	32	58.2%	55	36	62.1%	58	30	60.0%	50
Total	**348**	**22.2%**	**1,565**	**395**	**27.1%**	**1,458**	**428**	**31.8%**	**1,347**	**430**	**36.7%**	**1,172**

HOUSING STATUS AND BEHAVIORAL HEALTH OUTCOMES

BHIP4 - PLWH with BH Disorders Retained in BH Care (Not a NQF measure)

	Year Ending 12/31/18			Year Ending 2/28/19			Year Ending 4/30/19			Year Ending 6/30/19		
Housing Status	**Retained in BH Care**			**Retained in BH Care**			**Retained in BH Care**			**Retained in BH Care**		
Total EMA	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	659	23.9%	2760	616	24.1%	2560	576	25.5%	2259	513	27.3%	1878
Temporary Housing	298	27.3%	1093	283	27.0%	1050	278	28.3%	981	254	29.7%	855
Unstable Housing	77	58.3%	132	72	59.0%	122	65	54.6%	119	53	49.5%	107
Total	**1,034**	**25.9%**	**3,985**	**971**	**26.0%**	**3,732**	**919**	**27.4%**	**3,359**	**820**	**28.9%**	**2,840**
BHIP Agencies	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	394	21.7%	1816	376	22.1%	1700	348	23.3%	1491	300	24.9%	1206
Temporary Housing	151	28.4%	531	145	28.6%	507	136	29.6%	460	128	31.6%	405
Unstable Housing	40	54.8%	73	35	52.2%	67	31	50.8%	61	26	45.6%	57
Total	**585**	**24.2%**	**2,420**	**556**	**24.5%**	**2,274**	**515**	**25.6%**	**2,012**	**454**	**27.2%**	**1,668**
Non-BHIP Agencies	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	265	28.1%	944	240	27.9%	860	228	29.7%	768	213	31.7%	672
Temporary Housing	147	26.2%	562	138	25.4%	543	142	27.3%	521	126	28.0%	450
Unstable Housing	37	62.7%	59	37	67.3%	55	34	58.6%	58	27	54.0%	50
Total	**449**	**28.7%**	**1,565**	**415**	**28.5%**	**1,458**	**404**	**30.0%**	**1,347**	**366**	**31.2%**	**1,172**

HOUSING STATUS AND BEHAVIORAL HEALTH OUTCOMES

BHIP5 - PLWH with BH Disorders Viral Suppression

	Year Ending 12/31/18			Year Ending 2/28/19			Year Ending 4/30/19			Year Ending 6/30/19		
Housing Status	**With BH Diagnosis**			**With BH Diagnosis**			**With BH Diagnosis**			**With BH Diagnosis**		
Total EMA	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	2375	86.1%	2760	2240	87.5%	2560	1972	87.3%	2259	1623	86.4%	1878
Temporary Housing	899	82.3%	1093	876	83.4%	1050	818	83.4%	981	698	81.6%	855
Unstable Housing	88	66.7%	132	76	62.3%	122	83	69.7%	119	66	61.7%	107
Total	**3,362**	**84.4%**	**3,985**	**3,192**	**85.5%**	**3,732**	**2,873**	**85.5%**	**3,359**	**2,387**	**84.0%**	**2,840**
BHIP Agencies	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	1574	86.7%	1816	1499	88.2%	1700	1314	88.1%	1491	1057	87.6%	1206
Temporary Housing	440	82.9%	531	418	82.4%	507	377	82.0%	460	336	83.0%	405
Unstable Housing	45	61.6%	73	41	61.2%	67	44	72.1%	61	38	66.7%	57
Total	**2,059**	**85.1%**	**2,420**	**1,958**	**86.1%**	**2,274**	**1,735**	**86.2%**	**2,012**	**1,431**	**85.8%**	**1,668**
Non-BHIP Agencies	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	801	84.9%	944	741	86.2%	860	658	85.7%	768	566	84.2%	672
Temporary Housing	459	81.7%	562	458	84.3%	543	441	84.6%	521	362	80.4%	450
Unstable Housing	43	72.9%	59	35	63.6%	55	39	67.2%	58	28	56.0%	50
Total	**1,303**	**83.3%**	**1,565**	**1,234**	**84.6%**	**1,458**	**1,138**	**84.5%**	**1,347**	**956**	**81.6%**	**1,172**

HOUSING STATUS AND BEHAVIORAL HEALTH OUTCOMES

BHIP6 - PLWH with Viral Suppression (NQF 2082)(collected through NJ CPC)

	Year Ending 12/31/18			Year Ending 2/28/19			Year Ending 4/30/19			Year Ending 6/30/19		
Housing Status	**PLWH Age 18+**			**PLWH Age 18+**			**PLWH Age 18+**			**PLWH Age 18+**		
Total EMA	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	2,858	85.4%	3,348	2868	87.0%	3295	2804	86.6%	3237	2791	86.7%	3218
Temporary Housing	1,020	82.2%	1,241	1066	82.8%	1288	1108	83.2%	1332	1116	82.4%	1355
Unstable Housing	110	71.0%	155	102	70.3%	145	115	75.7%	152	106	70.7%	150
Total	**3,988**	**84.1%**	**4,744**	**4,036**	**85.4%**	**4,728**	**4,027**	**85.3%**	**4,721**	**4,013**	**85.0%**	**4,723**
BHIP Agencies	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	1,965	86.6%	2,268	1987	87.2%	2279	1954	87.1%	2243	1939	87.1%	2227
Temporary Housing	516	82.8%	623	528	81.2%	650	530	81.3%	652	566	82.7%	684
Unstable Housing	59	70.2%	84	54	66.7%	81	63	75.9%	83	59	67.8%	87
Total	**2,540**	**85.4%**	**2,975**	**2,569**	**85.3%**	**3,010**	**2,547**	**85.5%**	**2,978**	**2,564**	**85.5%**	**2,998**
Non-BHIP Agencies	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**	**Total**
Stable Permanent Housing	893	82.7%	1,080	881	86.7%	1,016	850	85.5%	994	852	86.0%	991
Temporary Housing	504	81.6%	618	538	84.3%	638	578	85.0%	680	550	82.0%	671
Unstable Housing	51	71.8%	71	48	75.0%	64	52	75.4%	69	47	74.6%	63
Total	**1,448**	**81.9%**	**1,769**	**1,467**	**85.4%**	**1,718**	**1,480**	**84.9%**	**1,743**	**1,449**	**84.0%**	**1,725**

PART 3: BEHAVIORAL HEALTH TREATMENT CASCADE

3.1 Introduction

Research Question #3 to be answered is:

What are the numbers along the behavioral health (BH) cascade among clients served by the Ryan White Program? How does viral load compare across clients by stage in the BH cascade? Components of the BH cascade include the following:

- Number of clients screened for behavioral health needs
- Number of clients who screen positive for behavioral health needs
- Number of clients who screen positive for behavioral health needs for whom there is a referral documented
- Number of clients for whom a referral is documented with documentation verifying at least one visit to a behavioral health provider (where the provide could be within the same agency, to another Ryan White-funded agency, or an agency outside the Ryan White system

Methodological approach: Analysis of CHAMP data for all funded agencies.

3.2 Behavioral Health Treatment Cascade

CHAMP data for the Behavioral Health (BH) Treatment Cascade are from the measurement year July 1, 2018 – June 30, 2019.

The Behavioral Health Treatment Cascade is based on measures defined by and used in the New Jersey Behavioral Health Integration Project (BHIP). The six measures of the BHIP BH Treatment Cascade are below.

Table 10: Behavioral Health Treatment Cascade - NJ BHIP Measures

BEHAVIORAL HEALTH MEASURES	
NOTE: Measurement Period is 12 Months for all measures.	
BEHAVIORAL HEALTH SCREENING MEASURES (BHIP 1 and BHIP 2)	
BHIP 1: PLWH Screened for Depression (Based on NQF 418)	
Description:	**Percentage of patients aged 18 years and older with a diagnosis of HIV screened for clinical depression in the measurement period using the PHQ9* standardized depression screening tool. (*Modified to any evidence-based tool.)**
Numerator:	Patients screened for clinical depression during the measurement period using the PHQ9 tool. (Modified to any evidence-based tool.)
Denominator:	All HIV patients aged 18 years and older before the beginning of the measurement period with at least one primary care visit with a provider who has prescribing privileges[1] during the measurement period. **This will match the denominator for measures 2 and 6.**
Data Element:	1. Does the patient have a diagnosis of HIV and is the patient 18 years or older before the start of the measurement period? (Y/N) a. If yes, did the patient have primary care visit with a provider with prescribing privileges during the measurement period? (Y/N) i. If yes, did the patient have a depression screening using PHQ9* during measurement period? (Y/N)
BHIP 2: PLWH Screened for Substance Use Disorders (Based on NQF 418)	
Description:	**Percentage of patients aged 18 years and older with a diagnosis of HIV who have been screened for substance use (alcohol & drugs) in the measurement period using [an evidence-based] tool.**
Numerator:	**Patients screened for substance use during the measurement period using an evidence-based tool.**
Denominator:	All HIV patients aged 18 years and older before the beginning of the measurement period with at least one primary care visit with a provider who has prescribing privileges during the measurement period. **This will match the denominator for measures 1 and 6.**
Data Element:	1. Does the patient have a diagnosis of HIV and is the patient 18 years or older before the start of the measurement period? (Y/N) a. If yes, did the patient have primary care visit with a provider with prescribing privileges during the measurement period? (Y/N) i. If yes, was the patient screened for substance use using TAPS[1] during the measurement year? (Y/N)
BEHAVIORAL HEALTH REFERRAL MEASURES (BHIP 3 and BHIP 4)	
BHIP 3: PLWH with Positive Screens who have Follow-up Plans (Based on NQF 418)	
Description:	**Percentage of patients aged 18 years or older with a diagnosis of HIV who screened positive for depression using the PHQ9* and/or a substance use disorder using an evidence-based tool and have a follow-up/treatment plan documented.**
Numerator:	Patients who have a treatment follow-up plan documented in their patient records on the day of the positive screening.
Denominator:	All HIV patients aged 18 years and older before the beginning of the measurement period with at least one primary care visit with a provider who has prescribing privileges who screen positive for depression or substance use during the measurement period.
Data Element:	1. Does the patient have a diagnosis of HIV and is the patient 18 years or older before the start of the measurement period? (Y/N)

BEHAVIORAL HEALTH MEASURES	
NOTE: Measurement Period is 12 Months for all measures.	
	a. If yes, did the patient have primary care visit with a provider with prescribing privileges during the measurement period? (Y/N) i. If yes, was the patient screened for depression using the PHQ9 and/or TAPS during the measurement year? (Y/N) 1. If yes, was the result positive? (Y/N) a. If yes, was there a treatment follow-up plan documented in the patient records? (Y/N)
BHIP 4: PLWH with BH Disorders Retained in BH Care (not an NQF measure)	
Description:	**Percentage of patients aged 18 years or older with a diagnosis of HIV and with a <u>diagnosed behavioral health disorder</u> who are retained in behavioral healthcare. This measure is based on <u>diagnosed illness</u> at the end of the measurement period as opposed to positive screening during the measurement period.**
Numerator:	Patients who are engaged in behavioral health services as demonstrated by a behavioral health treatment plan that has at least one follow-up noted in the referring providers' notes in the measurement period.
Denominator:	All HIV patients aged 18 years and older before the beginning of the measurement period who have behavioral health disorder diagnosis at the end of the measurement period at least one primary care visit with a provider who has prescribing privileges[3]. This will match the denominator for measure 5.
Patient Exclusions:	Patients who have achieved remission and who are no longer indicated for behavioral health care should not be included in the denominator.
Data Element:	1. Does the patient have a diagnosis of HIV and is the patient 18 years or older before the start of the measurement period? (Y/N) a. If yes, did the patient have primary care visit with a provider with prescribing privileges during the measurement period? (Y/N) i. If yes, did the patient have a behavioral health diagnosis at the end of the measurement period? (Y/N) 1. If yes, was the patient indicated for behavioral treatment? (not in remission for the behavioral disorder) (Y/N) a. If yes, was there evidence of follow-up noted in the referring providers' notes in the measurement period? (Y/N)
TREATMENT MEASURES (BHIP 5 and BHIP 6)	
BHIP 5: PLWH with BH Disorders Viral Suppression (based on NQF 2082)	
Description:	**Percentage of patients aged 18 years or older with a diagnosis of HIV and a <u>behavioral health diagnosis</u> with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year**
Numerator:	Patients with a viral load test less than 200 copies/mL at last HIV viral load test during the measurement year.
Denominator:	All HIV patients aged 18 years and older before the beginning of the measurement period who have **<u>behavioral health disorder diagnosis</u>** at the end of the measurement period at least one primary care visit with a provider who has prescribing privileges. This will **match the denominator for measure 4.**
Patient Exclusions:	Patients who have achieved remission and who are no longer indicated for behavioral health care should not be included in the denominator.
Data Element:	1. Does the patient have a diagnosis of HIV and is the patient 18 years or older before the start of the measurement period? (Y/N)

BEHAVIORAL HEALTH MEASURES	
NOTE: Measurement Period is 12 Months for all measures.	
	a. If yes, did the patient have a behavioral health diagnosis at the end of the measurement period? (Y/N) i. If yes, did the patient have at least one primary care visit with a provider who has prescribing privileges during the measurement year? (Y/N) 1. If yes, was the patient indicated for behavioral treatment? (not in remission for the behavioral disorder) (Y/N) a. If yes, did the patient have a HIV viral load test with a result <200 copies/mL at last viral load test? (Y/N)
BHIP 6: PLWH with Viral Suppression (NQF 2082) (*collected through NJ CPC)*	
Description:	**Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.**
Numerator:	Patients with a viral load test less than 200 copies/mL at last HIV viral load test during the measurement year.
Denominator:	All HIV patients, regardless of age, with a diagnosis of HIV with at least one primary care visit with a provider who has prescribing privileges in the measurement year. This will **match the denominator for measures 1 and 2.**
Data Element:	1. Does the patient, regardless of age, have a diagnosis of HIV? (Y/N) a. If yes, did the patient have at least one primary care visit with a provider who has prescribing privileges during the measurement year? (Y/N) i. If yes, did the patient have a HIV viral load test with a result <200 copies/mL at last viral load test? (Y/N)

3.3 Behavioral Health Treatment Cascade Performance

CHAMP data for the 12-month measurement period July 1, 2018 through June 30, 2019 show the following:

Table 11: Behavioral Health Treatment Cascade – EMA Performance Year Ending June 30, 2019

MEASURE	Numera-tor	Denomin-ator	%	% VLS
BEHAVIORAL HEALTH SCREENING MEASURES (BHIP 1 and BHIP 2)				
BHIP 1: PLWH Screened for Depression (Based on NQF 418)	4,307	4,696	**91.7%**	**85.4%**
BHIP 2: PLWH Screened for Substance Use Disorders (Based on NQF 418)	4,362	4,696	**92.9%**	**85.5%**
BEHAVIORAL HEALTH REFERRAL MEASURES (BHIP 3 and BHIP 4)				
BHIP 3: PLWH with Positive Screens who have Follow-up Plans (Based on NQF 418)	1,109	2,840	**39.0%**	**82.6%**
BHIP 4: PLWH with BH Disorders Retained in BH Care (not an NQF measure)	820	2,840	**28.9%**	**84.5%**
TREATMENT MEASURES (BHIP 5 and BHIP 6)				
BHIP 5: PLWH with BH Disorders Viral Suppression (based on NQF 2082)	2,387	2,840	**84.0%**	
BHIP 6: PLWH with Viral Suppression (NQF 2082) (*collected through NJ CPC)*	4,013	4,723	**85.0%**	

Observations regarding the Treatment Cascade measurements. At the statewide NJ BHIP Learning Session #5 meeting on October 3, 2019, it was clarified that two different populations are being measured in the BHIP cascade. For BHIP #3 the population is PLWH **screened** for behavioral health issues. For BHIP #4 and BHIP #5, the population is PLWH **diagnosed with a behavioral disorder.** As of the date of this measurement period, CHAMP does not currently capture behavioral diagnosis and such diagnosis cannot be inferred or deduced from any current service sub type.

However, as a result of this clarification, CHAMP is being modified to capture data on mental health and substance abuse diagnosis. Agencies will have to enter this "diagnosis" result based on reports from a behavioral professional. This revision is in process and will go into production around December 2019. Revised CHAMP Performance Reports will be available after that date. However, it will take time for the data fields and hence measurements BHIP #4 and BHIP #5 to be populated fully.

APPENDIX A:

2018 NEWARK EMA NEEDS ASSESSMENT

CONSUMER SURVEY TOOL

2018 Newark EMA Needs Assessment Questionnaire: Consumer Survey

Purpose
The Newark Eligible Metropolitan Area (NEMA) is conducting a Needs Assessment to better identify and understand the needs of people living with HIV in Essex, Morris, Sussex, Union, and Warren counties. We need your help to make sure we understand the needs of people receiving services.

The first set of questions are about your background. The second set of questions ask about your need for and access to HIV-related care and services. and your need for and access to substance abuse and mental health services. The survey should take 15 minutes to complete. A staff member will be available to help you if you need it.

Your participation is completely voluntary. You do not have to complete the survey. If you decide not to participate, it will not affect your care or access to services. Your answers to the questions that follow are completely anonymous.

Part 1: About You

1.What is your current age? _____ years

2. In what county do you live?
_____ Essex
_____ Union
_____ Morris
_____ Warren
_____ Sussex
_____ Other (please write in the county's name) _____

3. What is the ZIP Code where you currently live? _____

4. Which race or races do you identify with (select all that apply)?
_____ American Indian/Alaska Native
_____ Asian
_____ Black or African American
_____ Native Hawaiian/Pacific Islander
_____ White
_____ Other (please describe): _____

5. Do you identify as Hispanic or Latino?
_____ No
_____ Yes – (please write in which country or countries you identify with):

_____

6.What is the highest level of education that you completed?
_____ Some high school or less
_____ High school diploma or GED
_____ Some college
_____ Associate's degree
_____ Bachelor's degree
_____ Graduate degree

7. What type of insurance do you have (select all that apply)?
_____ None
_____ Private insurance (self-pay or through an employer)
_____ Obamacare plan/plan through the ACA Marketplace
_____ Medicare
_____ Medicaid
_____ Other (please describe):_____

8.What is your gender identity?
_____ Male
_____ Female
_____ Transgender: Male-to-Female
_____ Transgender: Female-to-Male
_____ Other:(please describe): _____

9. What is your sexual orientation?
_____ Heterosexual
_____ Gay/Lesbian
_____ Bisexual
_____ Other (please describe): _____

10.In what year were you infected with HIV? _____

11.Have you ever been diagnosed with AIDS?
_____ Yes
_____ No

12. How do you believe you were infected with HIV?
_____ Born with HIV
_____ Sex with an infected partner
_____ Sharing injection drug equipment
_____ Unknown/other

13.When was your most recent visit to your doctor for HIV care?
_____ Within the past three months
_____ Between 3 and 6 months ago
_____ 6 months to one year ago
_____ More than one year ago
_____ I have never received HIV medical care

14. Do you currently take HIV medications?
_____ Yes
_____ No
_____ Don't know

15.Is your viral load currently undetectable?
_____ Yes
_____ No
_____ Don't know

16. What is your current viral load? _____ copies/mL

17. Have you ever heard of U=U (undetectable = untransmittable)?
_____ Yes
_____ No
_____ Don't know

18.Have you ever heard of PrEP (pre-exposure prophylaxis)?
_____ Yes
_____ No
_____ Don't know

19.Have you ever heard of PEP (post-exposure prophylaxis)?
_____ Yes
_____ No
_____ Don't know

Part 2. Access to HIV-related Services

20. For each of the services mentioned in Table 1 (see the following two pages), please put an **"X"** in column…

(1) if you have **never** personally needed the service but would know where to tell someone to go to receive the service.

(2) if you have ever personally needed the service and **were** able to receive it.

(3) if you have ever personally needed the service but **were not** able to receive it.

(4) if you have never heard of the service.

Table 1: Ryan White-funded Service Categories and Prevention Services

Ryan White-funded Service Categories and Prevention Services **Service Category**	**(1)** **I have never needed this service but would know where to tell someone to go to receive it**	**(2)** **I needed the service and was able to receive it**	**(3)** **I needed the service but was not able to receive it**	**(4)** **I have never heard of this service**
1 Medical care for HIV				
2 Medical care for non-HIV health needs (e.g., diabetes, heart disease, etc.)				
3 Access to medications to manage HIV infection				
4 Access to medications to manage non-HIV health issues				
5 Access to medications for people with limited or no insurance				
6 Assistance in paying health insurance premiums				
7 Assistance in paying for insurance co-payments or deductibles				
8 Dental care				
9 Mental health services provided by a psychiatrist, psychologist, or social worker, including medications				
10 Nutritional therapy provided by a registered dietician				
11 Medical case management services (including adherence support)				
12 Legal services				
13 Transportation to health care services				
14 Substance abuse treatment – Inpatient detox (hospital setting)				
15 Substance abuse treatment – Residential setting (short or long term)				
16 Substance abuse treatment – Outpatient (outside of a hospital or residential facility - intensive outpatient, partial care, day programs, etc.)				
17 Housing – Payment for Emergency short term (1-2 months, security deposit)				
18 Housing – Payment for Transitional (up to 1 year)				
19 Housing – HOPWA (Housing for Persons With AIDS)				
20 Housing – Section 8 or other public support				

Ryan White-funded Service Categories and Prevention Services **Service Category**	**(1)** **I have never needed this service but would know where to tell someone to go to receive it**	**(2)** **I needed the service and was able to receive it**	**(3)** **I needed the service but was not able to receive it**	**(4)** **I have never heard of this service**
21 Housing – Other rental assistance				
22 Housing - Assistance in finding emergency or short-term housing				
23 Support groups - Support and counseling services provided by other health care workers				
24 Home health care provided by nurses				
25 Home health services provided by other health professionals				
26 Hospice services (for people with terminal illnesses)				
27 Outreach services to identify people who are living with HIV but have not been tested or have never been in medical care.				
28 Retention in Care Services – locating people who have missed appointments or dropped out of care and returning them to care.				
29 Permanency Planning - for the care of children when their parents die or are not able to take care of them				
30 Referrals to health care or other supportive services outside of case management.				
31 Interpretation or translation services				
32 Advice or assistance in locating social, community, legal, or other services				
33 Child care to allow people living with HIV to attend medical appointments or support groups				
34 Emergency financial assistance – Emergency housing, food, utilities. Vouchers or payment for emergency expenses				
35 Education about HIV transmission and how to prevent it				
36 Physical, occupation, or speech therapy or low-vision training				
37 Respite Care - Services to support someone with primary responsibility for taking care of someone living with HIV				
38 Adherence support - counseling to help people take their				

Ryan White-funded Service Categories and Prevention Services **Service Category**	**(1)** **I have never needed this service but would know where to tell someone to go to receive it**	**(2)** **I needed the service and was able to receive it**	**(3)** **I needed the service but was not able to receive it**	**(4)** **I have never heard of this service**
medications regularly (outside of the medical setting)				
39 Needle exchange for injection drug use				
40 Needle exchange for-hormone replacement, other medical issues, etc.				
41 Testing for sexually transmitted diseases				
42 Pre-exposure prophylaxis (PrEP) – drugs that people who are risk for HIV can take to avoid infection				
43 Post-exposure prophylaxis (PEP) – drugs that people who have been exposed to HIV can take to avoid infection				
44 Behavioral interventions (e.g., CLEAR, Healthy Relationships, etc.)				
45 Access to medications pregnant women can take to prevent giving HIV to their babies				
46 Free condoms				
47 Services to reduce HIV-related stigma				

21. Please indicate with an "X" how much you agree that the following are reasons that people might not receive the services mentioned in Table 1:

Reason…	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
1 Lack of health insurance				
2 Homeless/housing issues				
3 Can't find a provider that they like				
4 Transportation problems				
5 Lack of child care				
6 Work during times that services are available				
7 Language barriers				
8 Don't know that the services are available				
9 Services are not culturally appropriate				
10 Don't know where to receive the services				
11 Agencies don't provide people with the referrals they need				
12 Trouble paying for the services				
13 Don't understand how the system works				
14 Don't seek services because of cultural beliefs				
15 Drug use				
16 Mental health problems				
17 Don't feel sick				
18 Don't trust the system				
19 HIV-related stigma (people are made to feel bad because they have HIV)				

22. Please describe any other reasons you think people have for not receiving any of the services mentioned in Table 1:

_____

_____

_____

23. How often do you…

	Never	Once or Twice a Month	On Weekends Only	Three to Five Days Per Week	Daily
1 Use tobacco products?					
2 Have more than 3 (for women) or 4 (for men) alcoholic drinks in a day?					
3 Use marijuana?					
4 Use cocaine?					
5 Use heroin?					
6 Use other illegal drugs?					
7 Use pain killers (oxycontin/oxycodone) that were not prescribed to you **or** for the feeling it caused?					

24. In the last 12 months, how often did you feel you wanted or needed to cut down on your drinking or drug use but were not able to?

_____ Never
_____ Once
_____ Twice or more

25. In the last 12 months, how often did you continue to drink even though it was causing problems with your family/friends or school/work?

_____ Never
_____ Once
_____ Twice or more

26. In the last 12 months did you ever experienced any of the following:

	Yes	No
1 When not high or intoxicated, felt extremely energetic or irritable and more talkative than usual?		
2 Experienced a time where you felt sad, blue, or depressed for more than 2 weeks in a row?		
3 Lost interest in most things (like hobbies, work, or activities that usually give you pleasure) for more than 2 weeks in a row?		
4 Had a period lasting more than one month when most of the time you felt worried or anxious?		
5 Had a spell or attack when all of a sudden you felt frightened, anxious or very uneasy when most people would not be afraid or anxious?		
6 Had a spell or attack when, for no reason, your heart suddenly started to race, you felt faint, or you couldn't catch your breath?		

27. During your lifetime, as a child or adult, have you experienced or witnessed traumatic events that involved harm to yourself or to others?

_____ No
_____ Yes ➔ 28 In the past year, have you been troubled by flashbacks, nightmares, or thoughts of the trauma?
_____ No
_____ Yes

28. In the last 12 months…

Has your case manager asked you…	**Yes**	**No**	**Don't Know/ Don't Remember**
1 If you were feeling sad, lonely or depressed?			
2 If you were having trouble focusing?			
3 How frequently you were using alcohol?			
4 If you were using recreational drugs (cocaine, heroin, etc.)?			
5 If you were misusing prescription drugs (pain medications)?			
6 If you were misusing any other substances (sniffing glue)			
7 If you use tobacco/smoke?			
8 If you have felt unsafe in your home?			
9 If you felt stigmatized (made to feel bad about your HIV status)?			

29. In the last 12 months, did you ever need any of the following services?

Services	**No**	**If "Yes" – Where did you receive services?**		
		From my Primary Site of Care	**Through Referral to an Outside Agency**	**I Did Not Receive the Service**
1 Crisis intervention				
2 Individual counseling				
3 Group counseling				
4 Psychiatric services (prescription drugs)				
5 Methadone treatment				
6 Suboxone treatment				
7 Drug detoxification (inpatient)				
8 Inpatient drug treatment				
9 Outpatient drug treatment				
10 Relapse prevention				
11 Shelter for victims of interpersonal violence				

30. Are you currently prescribed any narcotic medications (that is, pain killers, opioids – oxycodone or oxycontin)?

_____ Yes

_____ No

31. What are the most commonly abused substances within your community?

31a) How have trends in substance abuse changed within your community over the past five years?

31b) What types of services or resources are most needed to better address the substance abuse problems faced by members of your community?

APPENDIX B:

2018 NEWARK EMA NEEDS ASSESSMENT

AGENCY SURVEY TOOL

2018 Newark EMA Needs Assessment Questionnaire: Provider Survey

Thank you for taking the time to complete this survey. It was developed to address the following research questions: (1) What are the needs of people living with HIV (PLHIV) regarding current and potential Ryan White-funded Part A service categories? and (2) What are the current gaps and barriers to achieving better integration between prevention and care services for PLHIV in the Newark EMA?; Your responses to the following questions are invaluable to improving healthcare for the clients we serve.

NOTE: For all the following questions, the time-period referred to is the past fiscal year (March 1, 2017 to February 28, 2018).

Contact information (Confidential, in case follow-up is needed)

Agency Name: _____

Person Answering Survey: _____

Phone Number: _____

Email: _____

Part A. Funding and Services

1) Please indicate the percentage of your agency's funding derived from the following sources (total percentage should sum to 100%):

    a. Ryan White HIV/AIDS program _____%

    b. Centers for Disease Control and Prevention _____%

    c. New Jersey HIV/AIDS State Funds _____%

    d. Other _____%

2) Please provide an estimate of the number of clients your agency served during the past fiscal year. _____ clients

    a. What percentage of those clients were HIV positive? _____%

    b. What percentage of those clients were high-risk HIV-negative individuals? _____%

3) For each of the service categories listed in Table 1 below, please indicate…

    a. Whether you are able to adequately meet the needs of your clients onsite/within your organization or whether (1) you have to refer clients out for those services and/or (2) you feel there is an unmet need for the service within the Newark EMA.

b. For services for which you provide referrals, please indicate whether you have a written referral agreement in place with an outside agency.

Table 1. Ryan White-funded Service Categories and Prevention Services

Service Category	Able to Provide Adequately Onsite/Within My Organization (X)	Requires Referral to an Outside Agency (X)	Unmet Need for Service within the EMA (X)	Written Referral Agreement in Place Yes/No
1 Outpatient/ambulatory medical care				
2 AIDS Drug Distribution Program (ADDP) treatments				
3 Local AIDS pharmacy assistance				
4 Oral health care				
5 Early Intervention Services (EIS)				
6 Health insurance premium/cost sharing assistance				
7 Home health care				
8 Home and community-based health services				
9 Hospice services				
10 Mental health services				
11 Medical nutrition therapy				
12 Medical case management (MCM)				
13 Housing services				
14 Legal services				
15 Linguistic services				
16 Medical transportation services				
17 Outreach services				
18 Permanency planning				
19 Psychosocial support services				
20 Referral for health care/supportive services				
21 Substance abuse services (outpatient)				
22 Non-medical case management				
23 Child care services				
24 Emergency financial assistance				
25 Food bank/home-delivered meals				
26 Health education/risk reduction (outside of medical or MCM setting)				
27 Rehabilitation services				
28 Respite care				
29 Residential substance abuse services				
30 Treatment adherence counseling (outside of medical or MCM setting)				
31 Needle exchange				
32 STD/STI testing				
33 Stigma reduction				
34 Pre-exposure prophylaxis (PrEP) for high-risk negatives				
35 Post-exposure prophylaxis (PEP)				
36 Non-occupational post-exposure prophylaxis (nPEP)				
37 Behavioral interventions (e.g., CLEAR, Healthy Relationships, etc.)				

4) Of all of the services listed above for which there is an unmet need or service gaps, which are the three most significant for your clients?

   a. _____

   b. _____

   c. _____

Part B. Barriers and Facilitators to Service Provision

5) Please indicate to what extent the following are barriers to ensuring that clients have access to the services mentioned in Table 1.

Barriers to Services	Strongly Disagree **(X)**	Disagree **(X)**	Agree **(X)**	Strongly Agree **(X)**
1 We have limited funding to serve all who need the service				
2 We have inadequate capacity to serve all who need the service				
3 We don't have enough community partnerships/linkages to provide our clients with the referrals they need				
4 We have trouble identifying resources whereby our clients can pay for services				
5 There is inadequate coordination between prevention and care service providers				
6 There is inadequate coordination between our agency and other agencies that serve our clients				
7 Our clients are reluctant to seek services due to financial barriers (e.g., co-pays, spend down, uncovered services)				
8 Our clients have difficulty accessing services because they are unsure how to navigate the system				
9 Our clients are reluctant to seek services due to stigma				
10 Possible referral sites do not have appropriate services for subgroups (e.g., LGTBQ clients, clients with limited English proficiency)				
11 Possible referral sites do not have the capacity to meet clients' needs (e.g., due to location or hours)				

6) Please describe any other challenges you are facing in ensuring your clients have access to any of the specific services mentioned in Table 1.

7) Please describe any factors (e.g., resources) that are particularly helpful in facilitating clients' access to the services mentioned in Table 1.

8) Please describe your agency's approach to re-engaging clients who have been lost to care.

9a) How effective are each of the following entities in providing linkages to services where there are unmet needs?

	Ineffective	**Neutral**	**Effective**	**I have not used this service for this purpose**	**I was not aware of this service/ agency**
	(X)	**(X)**	**(X)**	**(X)**	**(X)**
1 Early Intervention and Retention in Collaboratives (EIRCs)					
2 State-funded Linkage to Care Coordinators					
3 State-funded Navigators					
4 State-funded Community Health Workers					

9b) How effective are each of the following entities in re-engaging clients lost to care?

	Ineffective	**Neutral**	**Effective**	**I have not used this service for this purpose**	**I was not aware of this service/ agency**
1 Early Intervention and Retention in Collaboratives (EIRCs)					
2 State-funded Linkage to Care Coordinators					
3 State-funded Navigators					
4 State-funded Community Health Workers					

10) What additional resources are needed within your agency to ensure that clients have access to services for which there is currently an unmet need?

11) What additional resources are needed within your agency to re-engage clients who have been lost to care?

12) How often do you screen your clients for each of the following:

Problem	At Every Visit **(X)**	Every 6 Months **(X)**	Annually **(X)**	If Signs or Symptoms are Present **(X)**	Only at Intake **(X)**	Other (please specify) **(X)**	We Do Not Do This Assessment **(X)**
1 Depression							
2 Alcohol abuse							
3 Abuse of recreational drugs (e.g., heroin, cocaine, etc.)							
4 Abuse of prescription drugs (e.g., opioids)							
5 Abuse of other substances							
6 Tobacco use							
7 Interpersonal violence							
8 HIV-related stigma							

13) For each of the following problems, please indicate what tool you use to screen clients (e.g., and evidence-based tool like the CAGE for alcohol abuse or a screening question created by staff – if the latter, please provide the wording of the screening question you use). If you do not know which screening tool you use, please indicate as such:

1 Depression	
2 Alcohol abuse	
3 Abuse of recreational drugs	
4 Abuse of prescription drugs	
5 Abuse of other substances	
6 Tobacco use	

7 Interpersonal violence	
8 HIV-related stigma	

14) If a client has a positive screening for any of the following conditions, what is your procedure for providing further assessment/follow-up?

1 Depression	
2 Alcohol abuse	
3 Abuse of recreational drugs	
4 Abuse of prescription drugs	
5 Abuse of other substances	
6 Tobacco use	
7 Interpersonal violence	
8 HIV-related stigma	

15) For each of the following services, please indicate whether you are able to adequately meet the needs of your clients onsite/within your organization or whether (1) you have to refer clients out for those services or (2) you feel there is an unmet need for the service within the EMA. For services for which you provide referrals, please indicate whether you have a written referral agreement in place with an outside agency.

Service Category	**Able to Provide Adequately Onsite/Within My Organization**	**Requires Referral to an Outside Agency**	**Unmet Need for Service within the EMA**	**Written Referral Agreement in Place**
	(X)	**(X)**	**(X)**	**Yes/No**
1 Crisis intervention				
2 Individual counseling				
3 Group counseling				
4 Psychiatric services				
5 Drug detoxification				
6 Inpatient drug treatment				
7 Outpatient drug treatment				

Service Category	Able to Provide Adequately Onsite/Within My Organization (X)	Requires Referral to an Outside Agency (X)	Unmet Need for Service within the EMA (X)	Written Referral Agreement in Place Yes/No
8 Relapse prevention				
9 Shelter for victims of interpersonal violence				

16) What are the most commonly abused substances among your clients?

16a) How have trends in substance abuse changed among your clients over the past five years?

16b) What challenges have you faced in addressing the needs for substance abuse services as patterns of abuse have changed?

16c) What are the most significant gaps in services for substance abuse problems within the Newark EMA?

17) What are the most common mental health problems among your clients?

17a) How have trends in mental health needs changed among your clients over the past five years?

17b) What challenges have you faced in addressing the needs for mental health services as patterns have changed?

17c) What are the most significant gaps in services for mental health needs within the Newark EMA?

18) What do you see as the emerging substance abuse and/or mental health needs among your clients?

19) What resources are needed within the Newark EMA to address the emerging needs you identified in question 18?