Co-occurring Disorders: Supporting Clients Living with HIV, SMI, and/or SUD

Carolyn Chu, MD, MSc, AAHIVS, FAAFP
Erin Lutes, MS, RN, PHN, CNS
James Gasper, PharmD, BCPP
Clinician Consultation Center, AIDS Education Training Center Program (AETC)
The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).
Presenter(s):

Dr. Carolyn Chu, MD, MSc
Erin Lutes, MS, RN, PHN
Dr. James Gasper, PharmD, BCPP
Learning Objectives

• Identify best clinical practices to evaluate for HIV-specific neurologic complications (i.e. HIV-associated neurocognitive disorder) among PLWH with co-occurring SMI and/or SUD

• Discuss how co-occurring SMI and/or SUD can impact antiretroviral therapy (ART) or other treatment/care

• Discuss strategies to address challenges to maintenance and in care collaborations including practice/system-level changes

• Identify how effective SMI and/or SUD treatment can positively affect HIV care outcomes
Who We Are

Our mission is to improve patient health outcomes by building the capacity of healthcare providers through expert clinical consultation and education

• As a part of the AIDS Education Training Centers program, FREE clinical decision support to U.S.-affiliated clinicians for 25+ years, with funding through HRSA, as well as CDC, IHS and the federal Bureau of Prisons

• Multidisciplinary, inter-professional teams -> 500+ collective years of direct clinical experience in HIV, HCV, and substance use

• Wrap-around/”one-stop” resource for expert consultation

• Practical, point-of-care assistance!
What We Do – Clinical Consultation Center (CCC)
How We Work

Just call us!
Mon-Fri, 6am-5pm PT

Web-based portal for electronic HIV, HCV, and substance use consultation requests

No patient identifiers collected.
All calls are completely confidential.

After-hours voicemail available; Perinatal Hotline is 24/7
Case from the CCC Substance Use Warmline: Ms. B

The CCC Substance Use Warmline received a call from a healthcare provider regarding a female, age 56, living with HIV (CD4 < 50 cells/mm³, VL 43,000 copies/mL).

Ms. B has been diagnosed with bipolar disorder, is experiencing homelessness, and also has an extensive history of chronic polysubstance use: heroin, cocaine, methamphetamine, and K2 (“spice”).
The patient has had difficulty taking medications on time, as well as attending appointments, and has developed multi-class antiretroviral (ARV) medication resistance, which can occur as the result of frequently missed ARV doses.

The patient’s only contact with the healthcare system over the last few years has involved several hospitalizations for skin infections. During the most recent hospitalization, the care-team noted she appeared slightly unsteady on her feet, and also could not remember what had occurred from day to day.
What Would You Prioritize At This Time?

A. Substance use: heroin use puts the client at risk for overdose

B. Bipolar disorder: untreated/undertreated bipolar disorder increases the risk of recurrent mood episodes, challenges in daily functioning, and cognitive impairment

C. HIV: the CD4 is so low, the client may develop a major opportunistic infection due to the low immune system

D. Housing and safety

E. Other: something else is going on...
No Wrong Answer

• What else could be going on?
  • Gather further information
  • HIV-Associated Neurocognitive Disorder (HAND)

• Prioritize client safety

• Complex situations can translate to multifaceted approaches

• No “one-size fits all”
HIV-Associated Neurocognitive Disorder (HAND)

Changes across 3 subcortical domains: (a) cognitive; (b) behavioral; (c) motor

**Cognitive:** deficits in memory, concentration, comprehension, judgment/impulse control

**Behavioral/affective:** changes may include apathy, depression, agitation

**Motor symptoms:** changes may include gait unsteadiness, decreased coordination, tremor

Asymptomatic neurocognitive impairment (ANI)

Mild neurocognitive disorder (MND)

HIV-associated dementia (HAD)

ANI = 2 domains 1 S.D. below norm; *no* significant impact on daily function
MND = 2 domains 1 S.D. below norm, but *minor* impact on daily function
HAD = 2 domains 2 S.D below norm, *major* impact on daily function
HAND – As a Continuum

Mood | Motor | Mentation

Asymptomatic neurocognitive impairment (ANI) | Mild neurocognitive disorder (MND) | HIV-associated dementia (HAD)
Many Things Can Look Like HAND

- Sleep disorders
- Metabolic disorders (e.g. hypothyroidism)
- Cerebrovascular disease (stroke)
- Psychiatric conditions, including mood disorders
- Substance use, including chronic heavy alcohol use
- Neurotoxicity related to some ART medications
- Medication side effects (e.g. psychotropic agents)
- Previous/current CNS opportunistic infections
- Neurosyphilis, other non-OI CNS infections
- B12 deficiency, other vitamin/nutritional deficiencies
- CNS tumors, other space-occupying lesions
- Alzheimer’s disease, other dementias
• “Rule out” other etiologies

• Various in-office screening tools available, none proven as superior; diagnostic “gold standard” = comprehensive neuro-cognitive-psychologic testing
  • History provided by family, friends, other informants can be helpful
  • Other testing (brain imaging, etc.) typically done to rule out other processes/conditions

**Early and sustained ART, with virologic suppression, is mainstay of treatment!!**
# Modified HIV Dementia Scale (MHDS)*

<table>
<thead>
<tr>
<th>Max Score</th>
<th>Score</th>
<th>Test Item</th>
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</thead>
<tbody>
<tr>
<td>n/a</td>
<td>n/a</td>
<td><strong>Memory-Registration:</strong> Give four words to recall (dog, hat, green, peach); give 1 second to say each. Then ask the patient all 4 after you have said them (<strong>No score for this item</strong>)</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Psychomotor Speed (PS): Ask the patient to write the alphabet in upper case letters horizontally across a sheet of paper and record time in seconds. (&lt;21 sec = 6; 21.1-24 sec = 5; 24.1-27 sec = 4; 27.1-30 sec = 3; 30.1-36 sec = 2; 33.1-36 sec = 1; &gt;36 sec = 0) (Alternative – <strong>Coin Rotation Test – CRT</strong>)**</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td><strong>Memory – Recall:</strong> Ask for the four words from Registration above. Give one point for each correct. For words not recalled, prompt with a “semantic” clue, as follows: animal (dog), piece of clothing (hat), color (green), fruit (peach). (Give ½ point for each correct after prompting.)</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td><strong>Construction:</strong> Ask the patient to copy a cube; record time in seconds. (&lt;25 sec = 2; 25-35 = 1; &gt;35 sec = 0)</td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td>/ 12</td>
<td><strong>8 or above</strong> = normal; <strong>7 or below</strong> = impaired</td>
</tr>
</tbody>
</table>

* Skolasky et al. J Neurovirol 1998
** Minor KS et al. J Acquir Immune Defic Syndr, 2010
Montreal Cognitive Assessment (MOCA)

Early and sustained treatment with combination ART, with virologic suppression, is mainstay of treatment for patients with a neurocognitive impact of HIV!
ART Maintenance and Viral Suppression Are Critical

Virologic suppression: “undetectable” HIV viral load

↓ Reduced forward transmission (“U = U”), including perinatal transmission

Improved mortality and other key clinical outcomes

“Direct benefits”

Improved quality of life

↓ Reduced risk of malignancy, neurocognitive d/o, cardiovascular and pulmonary disease, kidney disease, liver disease

Immune system recovery (ideally CD4 > 500 cells/mm³)

↓ Reduced opportunistic infections

↓ Reduced other AIDS-defining conditions

“Indirect benefits”
What Happens When Someone Misses ARV Doses?

Multi-drug HIV resistance can be a HUGE clinical challenge!!
How Can Behavioral Health Care Support Client Engagement and Maintenance to HIV Care?

- Case management and patient navigation services (particularly peer-based models)
  - Home visits, or visits in the community

- Provision of evidence based treatment for mental and substance use disorders

- Access to safer housing, food security, income

- Primary care: active lines of communication

- Patient communication: assess language preferences, health literacy

- Transportation: how does someone get to, and organize, appointments?

- Concurrently provide evidence based, co-occurring mental and substance use disorder treatment; include medication assisted treatment, or syringe services program linkage

Patient-centered = co-located, integrated, coordinated service delivery

Patient-centered =
Assess and address patient priorities
Medications

Medications: challenges

- Concerns about side effects and safety—some ARVs can affect sleep, mood
- Co-pays/other costs?
- Size of pills, total number of daily pills, dosing requirements
- Difficulty swallowing medications? Need for refrigeration? Take with food?
- Confidentiality/inadvertent disclosure of HIV status
- Health literacy
- Lost medications

Medications: opportunities

- Reduce drug-drug interaction risk, mitigate side effects
- “Bubble packs”/pill organizers (“Medi-Sets”), direct delivery to home address or other secure location
- Nursing: medication reconciliation, patient education
- Directly observed therapy (DOT)—coordination between primary care and behavioral health/substance use treatment programs
- Patient incentives/reward systems?
- Future: long-acting (injectable) ARV options
Practical - But Important Issues

• Confirm reliable contact information/plan for communicating with client
  • Personal phone with voicemail? Text capability? Friend/family’s phone? Phone at SRO (single room occupancy)? Case manager/other professional you have ROI (release of information) with?
    • If no phone, can you help get one?
    • Secure mailing address? If none, can correspondence be mailed general delivery?
  • Keeping track of time/calendar
    • How does client keep track of dates and appointments?
    • Can you print out a calendar, or obtain donated calendars/planners?
Potential Issues

- Phone/medications lost/stolen
- Missed appointment
- Poor sleep/energy
- Stress
- Discrimination
- HIV Social Marginalization
- Message to you from family/friend
- Increasing HIV viral load
- Mistrust of healthcare system
- Trauma history
Take Home Point #2

Start with the BASICS; keep patient goals at the center of every interaction. Supporting ongoing medication maintenance and engagement in care takes creative, interdisciplinary collaboration!!

Picker’s Eight Principles of Patient-centered Care

- Respect for patients’ preferences
- Coordination and integration of care
- Information and education
- Physical comfort
- Emotional support
- Involvement of family and friends
- Continuity and transition
- Access to care

HIV, SMI, and Substance Use: Why Are the Connections so Important?

• Both SMI and SUD have both been linked to increased risk for HIV acquisition and transmission
• Co-morbidity of HIV and SMI/SUD highly prevalent, can affect both morbidity and mortality
• 50-70% of PLWH experienced a mood/anxiety disorder, 10%+ PTSD
• Up to half showed a concurrent substance use disorder
• HIV-related Stigma can be significant determinant of healthcare-related behaviors (2.)
• Undiagnosed/undertreated SMI and SUD can affect quality of life, maintenance in treatment and care, ART provision, and viral suppression

Mental Healthcare Improves HIV Outcomes

Frequent follow-up with behavioral health providers has many benefits:

- Decreases depression from PHQ 14.4 down to 1.6
- Increases ART adherence by 10%
- Increases virologic suppression, with 18% newly suppressed
- Increases CD4 count
- Decreases substance use, with 25% increased abstinence from alcohol

SUD Treatment also Improves HIV Outcomes...

- Opioid agonist therapies have been associated with:
  - Almost 70% increase in recruitment onto ART
  - 2-fold increase in ART adherence
  - Almost 25% decrease in odds of ART attrition
  - Almost 50% increase in odds of viral suppression

Effective Treatments for Opioid Addiction

NEW SAMHSA Medication Assisted Treatment Resource as of May, 2018:

- http://pcssnow.org/
- https://store.samhsa.gov/shin/content//SMA18-5063FULLDOC/SMA18-5063FULLDOC.pdf
- SAMHSA published TIP 63, focusing on medications for Opioid Use Disorder https://onlinelibrary.wiley.com/doi/pdf/10.1002/adaw.31884

Neurocognitive Disorders and HIV

- MAI CoC Webinar, with audio/video slides, 2016: By Marshall Forstein, MD, Assistant Professor of Psychiatry, Harvard Medical School, Cambridge, MA
- “Managing Multiple Diagnoses: Hepatitis C, HIV, Mental and Substance Use Disorders”
- American Psychiatric Association, Office on HIV Psychiatry https://apafdn.org/psychiatrists/clinical-training/hiv-psychiatry
Screening and treatment of PLWH for SUD and mental illness is critical for improving HIV-related outcomes. Behavioral health care providers are uniquely positioned to provide this care.
# Contact Info, Hotlines, Warmlines

To learn more, please visit: [nccc.ucsf.edu](http://nccc.ucsf.edu)
Questions/materials? E-mail: [Carolyn.Chu@ucsf.edu](mailto:Carolyn.Chu@ucsf.edu)

<table>
<thead>
<tr>
<th>Warmline</th>
<th>Phone Number</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Substance Use Warmline</strong></td>
<td>855-300-3595</td>
<td>Substance use evaluation and management</td>
</tr>
<tr>
<td><strong>HIV/AIDS Warmline</strong></td>
<td>800-933-3413</td>
<td>HIV testing, ARV decisions, complications, and co-morbidities</td>
</tr>
<tr>
<td><strong>Hepatitis C Warmline</strong></td>
<td>844-HEP-INFO</td>
<td>HCV testing, staging, monitoring, treatment</td>
</tr>
<tr>
<td><strong>Perinatal HIV Hotline</strong></td>
<td>888-448-8765</td>
<td>Pregnant women with HIV or at-risk for HIV &amp; their infants</td>
</tr>
<tr>
<td><strong>PrEPline</strong></td>
<td>855-HIV-PrEP (855-448-7737)</td>
<td>Pre-exposure prophylaxis for persons at risk for HIV</td>
</tr>
<tr>
<td><strong>PEPline</strong></td>
<td>888-448-4911</td>
<td>Occupational &amp; non-occupational exposure management</td>
</tr>
</tbody>
</table>
Meet Some of Our Substance Use Care Team Consultants

Jackie Tulsky, MD is an internist and HIV specialist. She is part of ZSFG’s Positive Health Program, and researches care delivery during incarceration.

Ben Smith, MD, MPH is a family physician and addiction expert at ZSFG/UCSF. He is an Assistant Professor of Family and Community Medicine.

Rebecca Sedillo, FNP, also provides HIV/hepatitis prevention consultation. She practices in primary care and weight management.

Erin Lutes, MS, RN, PHN, CNS also provides HIV/hepatitis prevention consultation. She is a Clinical Instructor at Samuel Merritt University and nurse for the San Francisco Department of Public Health.

James Gasper, PharmD, BCPP is a psychiatric and substance use disorder pharmacist. His work includes expanding treatment access, increasing naloxone availability, and improving opioid safety.
More CCC Team Members

Jason Tokumoto, MD is an Infectious Diseases specialist who has provided care at the Native American Health Center and the Asian/Pacific Islander Wellness Center in San Francisco.

Betty Dong, PharmD is a clinical pharmacist who provides HIV and hepatitis C consultation. She sees patients at ZSFG’s Family Health Center as well as the UCSF Liver Clinic.

Michele Tana, MD, MHS is a hepatology specialist who provides consultation on viral hepatitis and other liver/GI disorders.

Cristina Gruta, PharmD is a clinical pharmacist who specializes in HIV and HCV. She sees patients at UCSF’s Men of Color Program.

Jose Eguia, MD, MPH is an Infectious Disease specialist who provides HIV and HCV consultations. He is Associate Clinical Professor of Medicine at UCSF and also teaches at St. Mary’s Medical Center.


June Webinar

Tuesday, June 19, 2018
1:00 – 2:00 PM ET

Title:
Sustainability Beyond Finance: Infrastructure Considerations

Registration Link:
https://attendee.gotowebinar.com/register/1617460055873844225
The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) is a national training and technical assistance center dedicated to the planning and development of integration of primary and behavioral health care for those with mental illness and/or substance use disorders and physical health conditions, whether seen in specialty mental health or primary care safety-net provider settings across the country.

CIHS is jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources Services Administration (HRSA), and is run by the National Council for Behavioral Health, the unifying voice of America’s healthcare organizations that deliver mental health and addictions treatment and services.
Visit www.integration.samhsa.gov or e-mail integration@thenationalcouncil.org

Free consultation on any integration-related topic!
SAMHSA’s Mission and Links

SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities.

The mission of HRSA is to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs.

www.hrsa.gov
www.samhsa.gov
integration.samhsa.gov