Disparities Elimination Committee Mental Health Focus Group Discussion

May 18, 2023

Panelists:

- Lauri Appelbaum, Psychotherapist/Clinical Social Worker, Positive Care Center
- Bianca Bodine-Haag, MPS, LADC, PLPCC, Mental Health therapist, The Aliveness Project
- Charlotte Detournay, Positive Care Coordinator, Positive Care Center
- Dr. Gari Jaleta, Medical Case Manager, Sub-Saharan African Youth and Family Services in Minnesota (SAYFSM)

Committee Members Present:	
Sarah Schiele (co-chair)	Jay Orne (co-chair)
Océane Lune	Calvin Hillary Hylton
Alejandro Aguilera	Tristan Sparks
Mohamedkader Mohamed	Gage Urvina
Nikki LeClaire	Charlotte Detournay
James Velek	
Committee Members Absent:	
Meg Thomas (Mueller)	
Guests and Community Members:	
Kevin Sitter, Council Member	Carissa Weisdorf, Hennepin County
Jonathan Hanft, Hennepin County	Aubrey Hagen, Hennepin County
Matt Toburen, Aliveness Project	Asneth Omare, DHS
Shea Grutemaro, Council Member	Quay Catalpa, Council Member
Thomas Blissett, DHS	Emily Reimer, DHS
Scott Bilodeau, Hennepin County	Ephraim Olani, SAYFSM
Darin Rowles, DHS	
Hennepin County (Part A) Representative:	**DHS (Part B) Representative:**
Eriika Etshokin	Amy Miller
MDH (Prevention) Representative:	**MDH (Surveillance) Representative:**
McKinzie Woelfel	Hannah Kass-Aten (MDH – Epi)
MCHACP Staff:	
Audra Gaikowski, coordinator	Jeremy Stadelman, admin specialist (minutes)

I. **QUESTION 1:** We know that people living with HIV have unique barriers and challenges to accessing mental health care, ranging from insurance, billing, cultural responsiveness of providers, and so on. What are some of the barriers and challenges that you see in providing mental health services to clients through the Ryan White system?

a. Lauri: barriers are a confluence of social, political, cultural, and economic issues. It forces folks into narrow paths to access care. Many Positive Care Center clients want to access mental health services at the clinic, but they have 2,700 clients and there is not the capacity to provide this.
    i. Most therapists do not promote themselves as having experience in providing care with people living with HIV. It is challenging to find a provider that has the background to provide care to those with HIV/AIDS.
        1. HIV stigma remains a barrier.
b. Dr. Jaleta: a barrier at SAYFSM is cultural differences about mental health in Sub-Saharan African countries.
    i. Members of the community are not seeking out mental health treatment. There is not a lot of talk about mental health issues in the community.
    ii. Lack of education is also an issue; illiteracy is common in the community.
c. Charlotte: a barrier is the Ryan White standards. They are not flexible enough to provide proper care.
    i. Certain requirements create barriers for individuals to engage in services.
d. Bianca: offering multiple services at one location helps. Shame and stigma remain issues; people coming into The Aliveness Project may feel ashamed or feel exposed coming into the building.
    i. Consistency of therapists; people are reluctant to open up when they believe they won't be seeing a therapist for a consistent amount of time.
e. Challenges around retaining people in care:
    i. Bianca: challenges include needing a diagnosis to bill accurately, stigma around diagnoses, and cultural differences. Other challenges are:
        1. Some therapists are not providing trauma-informed care.
        2. Some people feel badly about living with mental illness or HIV and they feel like therapists are judging them.
        3. Each therapist has a different style, and you don't always have chemistry with your therapist.
    ii. Charlotte: the Positive Care Center is an outpatient clinic and for those who are unhoused, this can be a challenge because the clinic turns into a walk-in clinic, but the center is not flexible to accommodate this. Other challenges include:
        1. Individuals missing their appointments.
        2. There is often a 3-4 week waitlist to see a therapist or psychiatrist.
        3. The high level of care that is needed by some individuals
        4. There is a lack of therapists and psychiatrists in the area.
        5. Ryan White funding is low and cannot sustain psychiatrists.
    iii. Dr. Jaleta: a challenge is that it is difficult keeping clients in care.
        1. Labeling things as social support groups rather than mental health therapy has helped reduce stigma.
f. Challenges outside of Ryan White limitations:
    i. Providers need more flexibility about how positions are funded, or how services are funded for clients.

ii. Not retaining people in care who don't have access to transportation or a phone.
iii. Program HH does not cover therapy, even though it looks like that it does.
1. The traditional care model has a lot of barriers in establishing a therapeutic relationship with clients.

II. **QUESTION 2:** One topic that DEC is particularly interested in, is the topic of billing. We have heard that this is a major challenge for organizations and would like to get more information from providers and administrators on the panel, how do billing challenges effect access to Ryan White mental health services?

a. Charlotte: Ryan White funding covers a full time equivalent (FTE), not unit cost and there is not a lot of funding available in this capacity. How are you going to cover the salary of a clinical therapist?
i. The Positive Care Center sees around 25% recoupment of charges from patients. This makes it difficult to cover salaries.
ii. 97% of individuals are low income and don't have commercial insurance, so there is a low reimbursement rate.
iii. Retainment of staff is an issue because salaries are too low.
b. Dr. Jaleta: most of his clients have government covered insurance.
c. Bianca: non-profits with third-party billing is a battle. Her organization does not want to turn anyone away, but this can lead to burnout. Bianca also noted that:
i. The sense of community in HIV community is not lacking.
ii. Licensed Professional Clinical Counselors (LPCC) can't take Medicare insurance, but this may change in 2024.
iii. There are logistical issues around getting credentials and dealing with insurance.
iv. Providers should have awareness around being non-judgmental.
d. Lauri: one challenge is that reimbursement rates are different based on levels of certification (i.e. family therapists vs. PhDs).
i. Confusion around what insurance covers can be a barrier for clients. How are we helping people understand complexities of bureaucracy?
1. If people think they will end up with a bill, they won't engage.
ii. Individual psychotherapy is the focus, but it keeps people in isolation with their problems. How can we create revenue that honors social meetings and creates community?
iii. The documentation and administrative burden are a barrier. At the state level, mental health services require a lot of documentation, and it is onerous.
1. Treatment plans work for the system, but not the individual.
2. Administrative burden limits client interactions because providers are spending time with providing necessary documentation.
3. How to make the administrative requirements less burdensome:
a. Streamlining the process so it is patient centered.

b. Diagnostic questions are very invasive, it's best to be able to develop a relationship with the client before getting into certain topics. Even a couple of sessions to see if a therapist is a good fit is helpful.

III. **QUESTION 3:** DEC's work prioritizes communities that have historically been underserved by health care institutions. Referring to the most recent Needs Assessment data, 21-22% of people living with HIV reported that problems with their emotions, nerves or mental health caused them to miss HIV medical opportunities, and/or to not take their HIV medication as prescribed. However, these rates are much higher for communities of color, particularly for people who identify as multi-racial and Non-Hispanic American Indian, where 50.0% of people who identify as multiracial and 35.4% of people who identify as Non-Hispanic American Indian reported that emotions, nerves, or mental health led to missed HIV medical appointments or not taking HIV medication as prescribed. What is your organization doing to promote cultural responsiveness in mental health care, and what successes has your organization seen in doing so?

a. Dr. Jaleta: SAYFSM provides culturally and linguistically appropriate care. All workers are African immigrants and speak multiple languages. They know the language, where they came from, and how to assess for mental health issues.
    i. Dr. Jaleta has two mental health professionals on staff.
b. Charlotte: there is a systems gap in catering to diverse communities in regards to mental health services.
    i. This could be addressed by creating better relationships with other community organizations, like Healthcare for the Homeless to figure out how to bring services to individuals. Funding is a major barrier to this, however.
c. Bianca: there should be efforts to encourage more people that aren't a part of culturally dominant communities to get involved in mental health care. Diverse options are really important for clients.
    i. Having people with lived experience who can be providers would be helpful.
        1. 70% of people living with HIV are gay men, and religion can be a barrier for the LGBT community.
d. Lauri: there is a lack of people of color (POC) providers. This might be addressed by:
    i. Developing training programs for POC providers, which are also gender affirming.
    ii. Creating training programs in schools to grow our own providers.
        1. Most grad schools are not focusing on providing care to those with HIV/AIDS.

IV. **QUESTION 4:** Following in-line with communities who are disproportionately impacted by mental health, our needs assessment data shows that 34.3% of transgender or anyone who identified with a different gender identity other than male or female responded that mental health caused them to miss HIV medical

appointments, and 45.7% of transgender or anyone who identified with a gender identity other than male or female responded that mental health caused them to not take HIV medication as prescribed, compared to 21-23% of males and 18-19% for females. What are some success stories that your organization has of providing mental health services to people with HIV within the trans-community and people who are non-binary, and retaining this community in care?

a. Lauri: The Positive Care Center retains people in care by providing competent providers who understand gender affirming care. The clinic does not put-up extra barriers and is as accessible as possible for the trans community.
    i. The Positive Care Center can communicate better about services available to trans community.
b. Bianca: she is honored to hear people's stories and the focus is on adherence using motivational interviewing.
    i. Shame is also something that should be acknowledged, and gender affirming care should be provided without judgement.
c. Lauri: how many trans ppl have experienced medical trauma? Not knowing if your provider is non-judgmental can be a barrier in accessing and being retained in care.
    i. Offering video and phone sessions has helped ease this.
    ii. Having consistent policies and procedures for all clients is essential.
d. Charlotte: the Positive Care Center has provided a lot of training around trans care. This is not the reality of the hospital as a whole, however. There are efforts to provide training more widely, but some departments are not as affirming as the Positive Care Center.
    i. The hospital seems stuck working in systems that are preferential to the white community, or the dominant culture.

V. **QUESTION 5:** We know that mental health and substance use can be two different issues, but they can also impact each other. What is your organization's policy and how do you promote equity amongst people who need mental health services and also use substances?

a. Lauri: at the Positive Care Center they have foundational belief in harm reduction practices.
    i. They want people to come to their appointments, so they will meet with you if you are high. The goal is to get a client to a place where they are "safe enough" to treat.
        1. The clinic focuses on what are the client's needs are rather than getting them to stop using substances.
    ii. Charlotte: the hospital system is starting to move in the right direction in regards to harm reduction practices, but it's not there yet.
        1. A big challenge is providing a comprehensive community center in a hospital setting.
    iii. Charlotte: the clinic does everything it can to see patients, even if they are hours late, because they have so many medical providers. This is not the case for mental health providers, however.

b. Dr. Jaleta: SAYFSM uses a screening tool, but they have limited experience with clients using substances.
c. Alejandro asked if any of the providers have experience advocating for clients who end up in the judicial system (i.e. Rule 20)?
    i. Bianca: in that case, we would advocate for that person.
    ii. Lauri: they could find ways to support the individual without providing medical records to courts. For example, is there an alternative, like writing a letter?
d. The providers agreed that reducing shame and guilt around substance use is important. It is also critical to acknowledge that substance use is a coping skill.

VI. **QUESTION 6:** We've talked a lot about different challenges and successes today. Of the issue and strategies that we've raised so far, which do you consider to be the most important for DEC to address?
a. Bianca: being able to access a therapist that a client wants to continue to see, while providing low cost or free services.
b. Charlotte: reduce the rigidity of systems.
c. Dr. Jaleta: how to provide culturally specific health education so that the stigma around mental health care is reduced.
d. Lauri: responsiveness; does the system respond to the needs people are seeking? Are the services being provided flexible, culturally based, meeting people where they are at, and addressing cost and billing issues?

VII. Questions from the audience:
a. How has your program successfully reduced mental health stigma so they can engage in the services?
    i. Dr. Jaleta: by helping clients get linked to appropriate care.
    ii. Charlotte: a needs assessment revealed that the mental health services provided are not what clients wanted. Care was provided rapidly, but not consistently. Positive Care hired two mental health professionals so that more acute needs can be responded to. Charlotte suggested changing services to mirror what clients are asking for.
    iii. Lauri: creating, building, and strengthening relationships. Warm handoffs help with this.
        1. Educating people about what therapy looks like (a brochure was created) and what can it do to help clients.
        2. One value the Positive Care Center has is engaging with people; just saying hello to clients with no shaming around missed appointments
    iv. Bianca: The Aliveness Project is responsive in keeping the space as safe as possible. Meeting people where they are at and being welcoming and accepting to develop a sense of community.
        1. Hosting Mental health Mondays- Bianca noted that there is still a bit of stigma around mental health issues.
b. What are MA rates for therapy and how do they compare to private insurance?
    i. Not sure, but it is quite different.

    ii. Can't charge a late fee for MA, for example.
c. Childhood sexual abuse- what social media messages would be beneficial?
    i. Shock value to start conversations ("let's talk about sex").
    ii. Using the right type of language ("living with" rather than being defined by a diagnoses)
    iii. Provide education and a sense of community- it's a validation of experience.
        1. Don't silo mental health care from other medical care.
        2. Focus on resilience and being a survivor- not just focus on traumatic history. How do people survive and thrive?
d. Many long-term survivors are in institutionalized poverty- how does this affect mental health care?
    i. Bianca: Medicare not reimbursing for mental health is a big barrier for older communities.
    ii. Lauri: the Positive Care Clinic has a Golden Compass program, which helps help build community for aging populations.
    iii. Poverty is isolating and there is a stigma around aging in the LGBT community.
    iv. The HIV community will continue to age, and we are not ready for it, so we need more focus on this.
e. In regard to the status-neutral approach, how easy would it be to provide mental health services to those not living with HIV?
    i. There are capacity and funding issues to consider.
        1. AIDS service organizations have to prioritize those living with HIV/AIDS because resources are so limited.
f. Wrap-up
    i. Charlotte: how the system has been set-up (allocations and prioritizations) is a barrier in providing mental health care. Mental health services are not being utilized for various reasons, which leads funding cuts. However, we are not meeting the needs of the community.
    ii. Bianca: maintaining confidentiality in the small HIV community is a challenge and should be a priority for providers. This can be a barrier in accessing care.
    iii. Lauri: break out of the idea that the only mental health service worth billing for is a 50-minute one-on-one session. Social support groups, mutual aid, and other methods are valid too.