Supplementary. Table 2: Additional Illustrative Quotes from In-depth Interviews with Medical Case Managers (MCM: n=9) and Supervisors (SUP: n=6), Chicagoland Ryan White Medical Case Management System

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| **Theme** | **Select Quotations** |
| **High BH Needs and Low Availability of Services** | MCM: “Right now….is this sort of pandemic and situation related or...it's just like, ‘well, things are really bad right now,’ and sometimes...things have been really bad and... continue to be bad.”  MCM: “...you do encounter [substance use treatment] waitlists where ... the person you're talking to for intake can't tell you where they are on the waitlist, so you've no idea how much longer it'll be between now and then being able to receive the treatment they deserve.”  SUP: “We’ll be referring people to our case managers and right now, if I'm not mistaken, every single therapist that we work with is full...everybody has waitlists.”  MCM: “...so if I'm asking you these questions, to be like, ‘Well, that sucks. I have nothing, nothing to show for it.’...I just need to know you're depressed, check that box... and then...I can't find a psychiatrist that’ll see ‘em for six months. I can't find, you know, a therapist that will take their insurance, because their insurance is terrible. You know, like, then, I feel like if I'm asking these questions, then it has to be to provide something.”  MCM: “...we do the normal referral part. It's just getting them and getting a call back. That's the part that, it's like, they're calling me, ‘hey, you know, I haven't got a call back,’ or, you know, ‘I don't have my appointment for the next two months and I need, I’m running out of medication,’...I feel bad because I can’t do anything at that point....I could just say ‘I’m sorry, try, you could try calling other places to see if you get in sooner, and I’m here if you need me to talk to you.’ But I think that's hard, and especially it's harder for our Latino population because there's not a lot of people out there that speak Spanish, so it's harder on that side.” |
| **Client Barriers to Accessing ORCHID** | MCM: “And for some people, their mental wellness is important but it’s at the back when compared to food insecurity or housing insecurity and stabilization.”  MCM: “The barriers with language, will it be in Spanish and English and Russian and Aramaic or whatever. How will that be solved?”   MCM: “Sometimes it's difficult to reach the clients, a lot of my clients, they have a phone, they don't have a phone, they have service, they don't have service. Some of my clients are currently jobless, because of the pandemic or houseless because of the pandemic or even other reasons outside of their control, so sometimes in terms of reaching the clients and making sure they're going they're following up with services that I refer them to outside of ORCHID that can be difficult. Sometimes clients have a difficulty with follow through which I definitely think can be tied to their mental health so it's kind of like a vicious cycle... I think those are probably some of the external barriers I’d be worried about…”  MCM: “So it's never good when somebody's trying to tell you that you need this or offer you this when you're not asking. Some people might take it as an offense. It can be really offensive. ‘Why do you offer this to me? I've never asked you. Did I tell you that I need the service? Do I look like I'm crazy?’ That's what they say. This is their language. ‘Do I look crazy? Do I look like I need a therapist?’”  MCM: “I also feel like sometimes people just don't like to seek help when they have a hard time noticing when they need assistance. So, that could be a factor, as a person doesn't know when they need help, or how to ask for help even when it is offered to them. So that can exacerbate the mental health outcomes they're experiencing and then also, I think that, yes, the stigma definitely plays a role...sometimes it's hard to even get them to come here and see their providers because of mistrust and then just community things.”  SUP: “I think our clients have mental health and substance use needs that are beyond the care of a self-guided program that is really about experiencing moments of joy…I think it's a nice extra tool, but I don't know that a lot of our clients who are going to screen positive. And then I think our clients who don't screen positive, it might be a really great referral for them because this is something that probably anyone would benefit from.”  MCM: “The biggest concern for me is technology. With my caseload, I can see it's a lot of barriers for my clients because they just simply don't know what to do. Then they're calling me and I'm doing everything on their behalf. Normally, you don't need to do it all for clients... We need to teach them how to be independent. But sometimes it's just simple, like scheduling your medication delivery...What can be easier? No, for some of my clients, that's the barrier. So, if you think, ‘Oh, what can be easier than just to log in and enter your credentials.’ For some people, it's impossible. That was my biggest concern.” |
| **Team Culture** | MCM: “We've gotten hit with so many new things within this past year alone that we can just handle it no problem. We try to be as resourceful as we can be. That's a really big value to us…being resourceful, empathetic…”  MCM: “We're a really tight team…if we find a problem, we'll talk about it, and then we always reach out to each other, we reach out to our supervisor. I don't think we've seen anything that we’re like ‘Oh no, we can't do that’…”  MCM: “I think we have a healthy skepticism, but we are open to trying. I think we have an idea of, well, it can't hurt to give it a shot. I think that's how we look at things, for the most part. I know that even when it came to doing the Wellness Questionnaire [BHS pilot], some people on my team just weren't open to it, because they didn't think that participants won't be honest and they'll know what we're doing. We are going to do it anyway and if they need the referral, then we're going to refer them. Also, just remind them that they can be honest with us, they can be vulnerable with us and that's fine. Yeah, we have a healthy skepticism, but we're always open to giving anything a shot, because anything might work.”  SUP: “…there are members on my team who are really passionate about mental health and mental health care. And I think that might be part of the reason why some of these more in detail conversations are already happening.”  SUP: “Honestly, I think I have a great team. Anytime I kind of present something new to them that we need to do or going to add more work to them, I really don't get a lot of pushback. Comments are more so, like questions for clarity. They are really, really great at once they try it bringing me feedback on what's working well, what's not working or tweaks to make the workflow or the assignment or task better.” |
| **Variability in BH screening across clinics** | MCM: “We don't have a set screening right now, so it's really just in conversation. If I hear, oh, I'm really tired, I'm not interested in doing anything, anything that pings for me.”  MCM: “I offer those resources to them in house here at my clinic. We have a mental health specialist. She and I have been working together. Oftentimes, with client permission, we may do our assessments together initially…”  MCM: “When we talk about mental health needs, I usually have a series of questions that probably mimics a PHQ-9 about, like... ‘have you gained or lost interest in doing activities that bring you joy?’ I ask how's their appetite? I ask how their sleep is...and if it sounds like those questions open a door to, like, ‘No, I haven't been sleeping. No, I haven't been eating.’” |
| **Relative Advantage of BHS** | MCM: “...it seems like it'll give me a wider scope to talk about the different types of assessments, …I think that, even though I’m not a mental health specialist, this might help me really refine my referrals.”  MCM: “Their assessments for mental health haven't been as thorough or ... which I think is kind of a problem already...Like I said, for our assessment, we have the PHQ-9. ...there could be so much more.... I just feel like it's just a very brief screening, and I don't necessarily think it delves into more the complex trauma or the complexity of their mental health in general.”  MCM: “I think it would just formalize the process. Right now, it's very informal. It's very much just based on conversation and it's also based on my own knowledge of depression symptoms. If there was something more formalized, then people who might have a less severe case or people who are describing the symptoms that I'm aware of, it would be able to catch those people. I think it would have a more formalized referral process which would help too.”  SUP: “I think having it split in those five categories would be more informative to the case manager to know exactly what that person is dealing with….”  SUP: “From an agency standpoint, leadership may say, “Well, why do we need to do that if we already have a screener in place?” |
| **Flexible and Adaptable Implementation** | MCM:“They're [clients] going to react differently to this. Some people don't care and some people might get kind of insulted that we're still asking these questions...if people have taken it three times, maybe we can go to once a year.”  MCM: “…depending on where the client is and their needs, is probably going to shift, where I would implement this but ideally I would want to do it in the first session or the first month of working with that client.”  MCM: “The other problem is if I'm seeing them for the first time in clinic and we’re also at the first clinic appointment, then it's more difficult because they're already asking a thousand questions too, and then I'm asking a thousand questions. So, I don't know. We might have to schedule a different time.”  MCM: “Everyone's really struggling and I think yeah finding different ways to be flexible. I think one of [my organization’s] things they were talking about doing is renting a large space, so that people could do group in, like, an auditorium or something socially distant. So, yeah I think finding a way to do it on tablets or something in an agency might be really helpful and might get it rolling.”  MCM: “With my team, we work really closely together with mental health. So, being able to have the communication between mental health and case management, I think that would be a big help for that to make sure that clients are getting referred or clients are getting just that communication between the two I think is really helpful.” |
| **Relative Advantage of ORCHID** | MCM: I can't think of anybody on our team that would be resistant to this, to ORCHID. I think we've all done it long enough that we know that one approach is not good enough. You have to have different approaches, and so I think we would all be very receptive to this, into trying to refer clients, engage clients into the ORCHID program because I think it would be very effective.  MCM: I think the advantages would be like I said we could help them get in for help right when it's needed. When we are seeing it, when we're starting to see their symptoms, we're starting to see the depression, we're starting to see or they're coming up to us and telling us, "hey, I don't feel well. I need to talk to someone." Getting it started sooner than later. I think that would be a big advantage for them.  MCM: “It's not going to be like, ‘Oh, you're interested. Okay, let me refer you,’ and then they're waiting for two days then maybe five days. So by that time, probably they will say, ‘Oh, I'm good now. I don't need this,’ but the problem does not disappear. It's still there. It's just they overcame that crisis moment, but still they have that issue. What I like about this process, if we’re going to do the screening process, is that right away you grab your client and they're asking you about this. You're just like, ‘Okay, let me do this. Wham bam bam! Questions? Referred, got it!’”  MCM: “So first, it's good that it's going to be online. Some clients might benefit from this because I have an issue with clients not willing to leave their house, their commute or problem with mobility and that's going to be solved by just that fact that it's online based.”  MCM: “...I think the brevity of it is also really good. I like that it's, you know, you said it's, like, one or two modules a week for five weeks, like a brief intervention as opposed to something long winded and then it opens the door for somebody who may find positives in this approach...” |
| **MCM Role Compatibility** | MCM: “A lot of times we hear a lot of positive feedbacks from our clients saying, ‘Oh wow, even my therapist is not doing this job this good.’"  MCM: “We have doctors who are there for years and they know patients for years so of course, they know more about them… they know better than us.”   MCM: “You are talking with me with a person who was engaged in this field for years, like 10 years or something. Can you imagine what it will be like for another person who is not familiar with this, who is not familiar with basic definitions of PTSD or depression, or even how to feel it, how to screen it. I don't know. I feel like it will be just an additional, unnecessary step in this long, long wait for clients. So, that's why I would prefer them to be screened, to be referred to the right person.”  MCM: “It’s not just people who are reading the questions from the piece of paper, no, they’re professionals. These are licensed behavioral health consultants and can definitely identify if there is a problem…but also how to address some issues. You have to know exactly what to do and, of course, do no harm. You can try to help clients, but again, [if you’re not licensed] you’re just going to do worse.”  SUP: “If there's a glitch, it would be that the worker's trying to hold hands. Nope, give it to the mental health worker, they know their job, they do it well. Because you get caught up in the story and trying to be helpful, and they are, but this person is just as capable and helpful as you are." |
| **Perceptions of “ideal” clients** | MCM: “With interest, I feel like that depends on the person. I wouldn't refer that to somebody that didn't really have the mental health need. I feel like if somebody is in need of these more intense services or more practice or more assistance with these skills, I feel like the interest would be there.”  MCM: “I think for people who are experiencing maybe some generalized anxiety and some mild to maybe slightly moderate depression, the sounds like this could be really helpful or just kind of reframing their thought process and introducing some coping skills that maybe they didn't even know that they had to utilize or giving them more positive coping skills as opposed to what they might now as ways to cope with what's bothering them.”  MCM: “Language definitely would be a big barrier because we have a lot of Spanish-speaking clients. We have a lot of clients that speak a lot of different languages. We're here in Chicago. So, definitely if there is an option to have more languages, that would be great just to add more of that accessibility. I know that with Spanish-speaking folks especially that would be even more helpful because we have such a huge bilingual population.”  MCM: “That might be a little bit more difficult to answer, I mean, because we're talking, like, it's a case-by-case situation for each person. I mean I have people that I think about as you speak about ORCHID, where I'm like, ‘Oh yeah, that'll probably work good for them,’ but then I have people like, ‘No, he probably ain't going to do that.’ It's kind of like a case by case. I really can't say. I think some are more motivated than others, and those that have a higher level of motivation to want to do and improve themselves in some way or another, will be more inclined to engage and do the program and do the process. Others that haven't yet arrived at that point in their journey might be a little bit more difficult.” |
| **Implementation expectations and boundaries** | MCM: “You know the thing with that is like I said a lot of my clients are Latino and they do have technology issues, but if I see that it's something that's going to help them, and I need, they need to do it, and I want them to do it, I could always help them. You know, I don't have a problem translating, because that's part of my job. I help them translate stuff. But for them to do it alone, they wouldn't be able to because it's only English, you know. But if I’m like ‘Okay, we need to do this today or tomorrow, or whatever’ and they're willing to come out to my office, I have no problem helping them with that. It's just for them to do it alone, they wouldn't know what to do.”  SUP: I will set up time to meet with each of my staff individually to review it after they like practice it, role play, after they have had a little time to review it. I would actually mandate that they set a specific time, like an hour where they’re actually going to sit down and review it and I said, you know what. I would love to be able to buy my team lunch, you know, and they could do it at lunchtime, you know doing this review while eating. You know I want them to be calm when they're doing it and we tend to calm when we’re eating, I think in most cases we do.”  SUP: And I'll probably have them label it as ORCHID, so that I could easily find it. I would have to still go to the case notes but I have to look up ORCHID but I could tell AFC look up ORCHID. And they could do it easier and they could find it. And they could give me a report, ‘Oh 80% of your staff at least put a case note in ORCHID.’” |
| **Training and resource needs** | MCM: “I think training is just always the most effective thing. To know what I'm talking about and know what I'm doing with a client makes me feel more comfortable, and therefore I'm going to give better services…”  MCM: “First, [training on] how to initiate these conversations or how to raise this kind of conversation with our clients, and how to encourage our clients, maybe they will be not so... I mean, if I tell them that is going to be a while for a screening, vendor referral, so if they feel discouraged, maybe if they see it's going to be a long process. So how to make it simple for them, how to simplify this process over time.”  SUP: “Definitely a training issue, how to comfortably ask the fearful. I noticed young clinicians, young case managers, they’re not sure when someone says they're depressed, they're suicidal, homicidal, et cetera. I could see them getting stuck, like, "Oh, what do I do? I didn't expect it."  MCM: I think more of the background on how it was developed and the fact that it is based in real science, and that there are a lot of other online tools that work for people. This is just going to be another one that, hopefully, probably, will also work. |
| **Recommended strategies** | SUP: Training for the case managers on start to finish, from screener to all the things involved with ORCHID. And then, release good marketing materials, so the case managers have language around why it would benefit their clients.”  MCM: “Hopefully, there's, like, a support service or something. You know, like, we have problems with AFC, we call AFC. We have a problem with something, we could email you guys and you guys will get back to us...a support that we could say ‘hey let me call them and let me talk to them really quick and I know you, they’ll be there. ‘They’ll email me within a day or two and I could get ahold of them…a supportive person that will be like, ‘okay, let me run to them and talk to them real quick about this.’”  MCM: “Like I said, this program is new for this agency. The agency is very strict about following rules that are set up by whichever governing agencies that they're credentialed by, or whatever. They're not apt to just try new things. But I think if the people who are in charge of the grant here at our agency were to meet with people from your team to help show the importance of, and how critical it would be, if they heard it from someone besides us, they'd be more apt to implement changes that might... beneficial for the patient and client. I think if there was some sort of format for them to meet and see the benefits of it themselves, rather than hearing it from us, that might be helpful for us, because we've run into challenges trying to suggest things that... Most of us have worked in the Ryan White program for at least five years or more, some of us 15. We've run into challenges suggesting things that we've known to work in the past, but no, that's not the way things are done here. If they heard it from you, that might be helpful.”  SUP: “I like to say our team is really good with offering gratitude, so maybe just making sure that's being shouted out or doing the email blast. ‘Hey, the team did really good. We're implementing this new program, and thus far 80% of our people have already done the ORCHID or the wellness questionnaire, and then they were connected’ or whatever like that. Having those numbers to report back or just making a statement in front of the whole staff I think is good. People find value in that, they do.”  SUP: “... for my team, I think they find value in when we run our monthly reports and we look at the dashboards and people see--I color code them with green for current and yellow for due and orange for overdue--and then I do a blue for NOF. I think they love to see all the green pop up on their screens. I think that in and of itself is a reward for them. Now don't get me wrong, would they love to be given another incentive for doing some extra stuff? Sure they would, but we kind of go with the greens on the dashboard because that's what we're about. And, what we can do on our end is still be like, "Hey, you had a really good month with your dashboards, looking great," blah, blah, blah, blah, blah, and then I might just treat the team to a pizza party. We do things to help to motivate them and encourage them and build morale and stuff like that…” |

*Abbreviations*. BH=Behavioral Health; BHS=Behavioral Health Screener; MCM=Medical Case Manager; SUP=Supervisor