DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STI, TB Administration

Mental Health Services

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

I. SERVICE CATEGORY DEFINITION

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to customers living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers

II. INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White customers to maintain proof of eligibility annually, with recertification every six months. Supporting documentation is required to demonstrate customer eligibility for Ryan White Services.

A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting CD4 count and viral load. Laboratory results should be within 6 months of the date of certification.

2. **Residency:** The following are acceptable methods of meeting the burden for residency:

   - Current lease or mortgage statement
   - Deed settlement agreement
   - Current driver's license
   - Current voter registration card
   - Current notice of decision from Medicaid

- Fuel/utility bill (past 90 days)
- Property tax bill or statement (past 60 days)
- Rent receipt (past 90 days)
- Pay stubs or bank statement with the name and address of the applicant (past 30 days)
- Letter from another government agency addressed to applicant
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, a written statement from case manager, facility or a letter from landlord that customer is a resident

3. **Income:** Customer income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the applicant and any household members for whom applicants have legal responsibility. For each income source the applicant must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

   The following are acceptable forms of proof of income:

   - Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub
   - A notarized letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
   - Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A notarized statement from the applicant projecting current annual income must be included
   - Copy of the tenant's lease showing customer as the landlord and a copy of their most recent income tax return
   - SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
   - Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the applicant

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate

5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. RECERTIFICATION (6 months) REQUIREMENTS

To maintain eligibility for Ryan White services, the customer must complete the six-month recertification process. Providers may elect to have customers sign a self-attestation of no change in eligibility at the six-month recertification.

III. KEY SERVICE COMPONENTS & ACTIVITIES

INTAKE	
Standard	**Measure**
Intake must be performed within 3 business days of applicant's first contact with the mental health agency and must be completed within 5 business days of scheduled intake. Intakes for customers who are current hospitalized, homebound or incarcerated may take more than 3 business days to initiate and more than 5 business days to complete. Customers referred/requesting outpatient mental health services are seen at the mental health agency to initiate substance abuse services unless they are currently hospitalized, homebound or incarcerated (Pre-release within 6 months). If the applicant has a non-emergency crisis, the mental health provider will provide immediate assistance through the resources of the agency or link the applicant to a more appropriate agency.	Documentation of intake in customer record.
INITIAL ASSESSMENT OF SERVICE NEEDS	
Standard	**Measure**
An assessment will occur prior to the initiation of any formal treatment to determine the need for mental health services. The assessment tool used must be in compliance with the jurisdiction's regulations and approved by HAHSTA. In addition, all customers must be screened for mental health and substance abuse problems at intake and annually thereafter, using an approved standardized assessment tool, and other standardized instruments may be used if they meet evidence-based and professionally recognized criteria.	The customer's medical record will include an initial assessment completed within 10 business days of completing the intake. Prior assessments of customers who are being readmitted or admitted from another program within 20 business days of discharge can be updated. The initial assessment must be maintained in the medical record indefinitely. The assessment shall assess the following areas: 1. Current Mental Health issues;

The assessments shall be conducted by a certified or licensed mental health provider, depending on jurisdictional regulations. The DSM-V diagnosis will be determined and documented in the customer's chart at time of admission and at time of discharge. Agencies can choose to use additional diagnostic, comprehensive and/or brief assessment tools such as the Structured Clinical Interview (SCI), Diagnostic Interview Schedule (DIS), Beck Depression Inventory (BDI), Michigan Alcoholism Screening Test (MAST), Senior Michigan Alcoholism Screening Test (S-MAST), Drug Addiction Severity Test (DAST) and/or the Cut Down, Annoyed, Guilty, Eye-Opener (CAGE), Alcohol Use Disorders ID Test (AUDIT), Addiction Severity Index (ASI) to better assess the customer's individual needs and situation. In addition, any screening identified by SAMHSA's Treatment Improvement Protocol manual may be used.	2. Physical health, including co-occurring disorders and eating behaviors, etc.; 3. Treatment history, including medications; 4. History of trauma; 5. Substance Abuse History; 6. Psychiatric history; 7. Functional limitations; 8. Sexual behavior; 9. Legal involvement; 10. Family and social history; 11. Employment or financial support; 12. Education and 13. Strengths and barriers to care. If the customer is already enrolled in Medical Case Management, the medical case manager must appear on the ROI. All above information and accompanying documentation can be submitted by the medical case manager to expedite enrollment in Mental Health Services. The Mental Health supervisor must review, approve and sign assessments completed by non-licensed Mental Health staff. The DSM-V diagnosis will be determined and documented in the customer's chart at time of admission and at time of discharge. Copies of any additional assessments completed to assess the customer must be in the customer's medical record. All assessments must be signed and dated by the clinical staff administering the tool.
TREATMENT PLAN	
A treatment plan is developed collaboratively with the customer within 20 business days of completing the initial assessment: ● A description of the customer's current medical and psychological conditions and current services received; ● Customer's presenting issue; ● Identification of needs and barriers; ● Specific measurable objectives and action steps to resolve each need or barrier; ● Long-range and short-range treatment plan goals and objectives; ● Strategy for implementation of treatment plan goals and objectives; ● Goals and objectives to eliminate and mitigate Barriers to Medication and Appointment Adherence; ● Criteria for successful completion of treatment;	Documentation of initial treatment plan must be maintained in the customer record. ● Target dates for completion of treatment goals and objectives; ● Schedules for clinical services, including individual, group, and if appropriate family counseling; ● Signature of customer/guardian documenting their participation and approval of plan; ● Signature and title of mental health provider who completed plan; ● Date plan developed; ● Projected dates the treatment plan shall be reviewed; and ● Discharge planning which includes education on relapse prevention. The current treatment plan must be filed in the customer's chart.

● Identification of and referrals to entities to provide services ● Infectious Disease Education and HIV transmission risk reduction counseling; ● Defined activities/services and time frames to initiate and reach each objective. ● Documentation of who will provide the service; ● Appropriate Evidence- based therapeutic framework/model being used that adheres to professional standards; ● Identify resources for after hours crisis or other emergencies and ● Treatment plan is updated/redeveloped as required by local jurisdictions' regulations. A copy of the treatment plan must be offered to the customer and their legal representative or members of the customer's health care interdisciplinary team, if applicable. With permission from the customer or their legal representative, if applicable, a copy of the treatment plan will be shared with other interdisciplinary team members from outside of the mental health agency.	
Treatment is guided by the individual's treatment plan and the jurisdiction's requirements. Treatment using psychotropic medications must be administered by appropriately licensed professionals. As part of all new customers' treatment, education on infectious diseases and a risk assessment for infectious diseases are required. All face-to-face encounters must be documented in the customer medical record. Psychiatrists or psychiatric nurses must assess customers for side effects of medications on a regular basis. Psychotropic medication adherence must be monitored. Mental health counselors must note in customer records when customers are non-adherent with their psychotropic medication regimen and steps being taken to address the issue including sending notification to prescribing provider.	Documentation the treatment plan was initiated within the timeframe required by the local jurisdiction's regulations. Documentation that Infectious Disease Education was provided to all new customers within the time specified by the jurisdiction's regulatory body. The education must include the following topics: 1. Human Immunodeficiency Virus (HIV), including self-monitoring of symptoms; 2. Hepatitis; 3. Sexually Transmitted Diseases (STD); 4. Tuberculosis. Documentation that all new customers received: 1. Risk assessment for infectious diseases; 2. Risk reduction education and if appropriate; 3. Referral for counseling and testing. Documentation of progress notes and contacts (phone/in-person) in the customer's chart for each face-to-face encounter, based on the frequency required by the local jurisdiction's regulations. Documentation of any potential negative side effects from psychotropic medications. Documentation of non-adherence in customer's medical record.
REFERRALS	

Customers receiving mental health services must be referred for a MCM biopsychosocial assessment, if they are currently not receiving MCM services. Referrals to MCM can happen at any stage of engagement (intake, assessment, treatment, and/or discharge). Mental health providers can refer customers directly to the following services, such as: ● Ambulatory/Outpatient Health (Medical Care); ● Medical Case Management; ● Other Mental Health Treatment Programs; ● Substance Abuse Treatment programs; ● Oral Health Care; ● Legal assistance ● Self-help groups and ● Community and social supports. The agency must maintain a referral system to request services for a customer and have a tracking system to follow-up on the status of the referral. A copy of the request and any ROI must be filed in the customer's chart.	Based on documentation of the customer's needs, copies of appropriate referrals and linkages to care are filed in the customer's medical record. Referral documentation must include the: 1. Reason for referral; 2. Customer's contact information; 3. Mental health provider's contact information; 4. Name and contact information of agency or staff accepting referral, including address; 5. Status of the referral and 6. Signed ROI form(s), if necessary 7. Copies of reports from accepting agency, when necessary for treatment and only with customer/guardian's consent to release.
REASSESSEMENT	
Customers shall be reassessed on an ongoing basis to measure their progress on treatment plan goals, review the appropriateness of treatment interventions, update the treatment plan, and determine if there is a need for relapse prevention. Ensure that the customer is engaged in primary medical care and, if necessary, medical case management. Share all information regarding the reassessment and updated/redeveloped treatment plan with members of the customer's health care interdisciplinary team**.** Each jurisdiction's regulatory body specifies the frequency for treatment plan updates.	An update of the assessment must be completed and filed in the customer's chart as required by local jurisdictions'' regulations. A new or updated treatment plan must accompany the reassessment in the customer record. Verification that the reassessment has occurred within six months of the approval of the previous assessment. If the customer does not have an HIV Medical care doctor or a case manager, there is documentation in their chart of the referrals and follow-up for these services.
TRANSITION & DISCHARGE	
Standard	**Measure**
Customer discharged when Mental Health services are no longer needed, goals have been met, upon death or due to safety issues. <u>Prior to discharge</u>: Reasons for discharge and options for other service provision should be discussed with customer. Whenever possible, discussion should be occurring face-to-face. If not possible, provider should attempt to talk with customer via phone. If verbal contact is not possible, a certified letter must be sent to customer's last known address. If customer is not present to sign for the letter, it must be returned to the provider.	Documentation of discharge plan and summary in customer's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable. <u>Documentation</u>: Customer's record must include: ● Date services began ● Special customer needs ● Services needed/actions taken, if applicable ● Date of discharge ● Reason(s) for discharge ● Referrals made at time of discharge, if applicable

Transfer: If customer transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If customer moves to another area, transferring agency will make referral for needed services in the new location. Unable to Locate: If customer cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the customer's last known mailing address within five business days after the last attempt to notify the customer. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made. Withdrawal from Service: If customer reports that services are no longer needed or decides to no longer participate in the Service Plan, customer may withdraw from services. Because customers may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the customer's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency customers should be referred to appropriate agencies. Administrative Discharge: Customers who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a customer for this reason, the case must be reviewed by the leadership according to that agency's policies. Customers who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the customer's last known mailing address within five business days after the date of discharge, and a copy must be filed in the customer's chart.	
CASE CLOSURE	
Standard	**Measure**
Case will be closed if customer: ● Has met the service goals ● Decides to transfer to another agency ● Needs are more appropriately addressed in other programs ● Moves out of the EMA ● Fails to provide updated documentation of eligibility status thus, no longer eligible for services	Documentation of case closure in customer's record with clear rationale for closure

● Fails to maintain contact with the insurance assistance staff for a period of three months despite three documented attempts to contact customer ● Can no longer be located ● Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan ● Exhibits pattern of abuse as defined by agency's policy ● Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program ● Is deceased	

IV. PERSONNEL QUALIFICATIONS

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance. Agencies are also responsible for maintaining documentation of the appropriate education, qualifications, training, and experience in personnel files.

These standards dictate that PLWH should receive their Mental Health services from a licensed mental health provider. Each jurisdiction within the EMA must adhere to their regulatory body's requirements. Mental health providers must be able to work effectively with their customers with regard to their mental health issues in addition to facilitating access to other needed services. The ability to accomplish these objectives requires specific skills that can best be acquired through education and previous work experience. The preferred qualifications are as follows:

- Mental Health Providers
  - Appropriately licensed by jurisdictional regulatory body, with at least a Master's degree in a Mental Health discipline. This typically includes psychiatrists, psychologists, and licensed clinical social workers.
- Mental Health Services Clinical Supervisors
  - As required by jurisdictional requirement (see Attachment XXX: Licensed providers by jurisdiction).

Mental Health Services supervisors must conduct quarterly record reviews of each mental health provider's customers' records to ensure a substantial number of the records adhere to standards of care.

Clinical supervision must occur at a minimum of one hour every month.

Mental Health provider or others who provide infectious disease and HIV transmission risk reduction education to customers in mental health counseling sessions must have completed one of the following curricula:

- HIV Facts and Fundamentals
- Jurisdiction-approved curricula
- CDC-approved curricula
- HRSA HAB-approved curricula

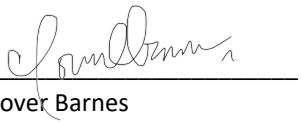
Each jurisdiction's regulatory body specifies the frequency for staff training.

Each jurisdiction's regulatory body specifies the frequency for customer contact.

Staff participating in the direct provision of services to customers must satisfactorily complete all appropriate continuing education units (CEUs) either based on license requirement or appropriate board requirements. Training documentation on file maintained in each personnel record.

V. APPROVAL & SIGNATURES

This service standard has been reviewed and approved on July 28, 2021. The next annual review is July 28, 2022.



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