N-S EMA MENTAL HEALTH STANDARDS OF CARE

QAM Approved 6-25-15

Service standards[1] outline the elements and expectations a RWHAP Service provider follows when implementing a specific service category. The purpose of service standards are to ensure that all RWHAP service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a RWHAP funded agency or provider may offer within a state, territory or jurisdiction.

N-S HIV Health Services Planning Council

www.longislandpc.org

NASSAU-SUFFOLK EMA
HIV HEALTH SERVICES PLANNING COUNCIL

MENTAL HEALTH SERVICE STANDARDS

DEFINITION:
Mental Health Services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers.

CARE AND TREATMENT GOALS: To provide eligible individuals with mental health counseling and treatment in either an individual or group setting that permits them to enter, and maintain, HIV medical care. Mental health services will be provided in a culturally and linguistically appropriate manner to facilitate access to and maintenance in primary HIV medical care, and adherence to HIV treatments. Services target populations that are out-of-care, uninsured, under-insured, and disproportionately impacted by HIV/AIDS in the Nassau-Suffolk EMA.

OBJECTIVES:
1. Assist HIV positive clients with reduction of symptoms related to mental health disorders thereby reducing barriers to medical care.
2. Provide psychiatric evaluation and medication monitoring if indicated.
3. Connect clients with necessary supportive services to maintain retention in care.

PROGRAM COMPONENTS:
- Comprehensive Assessment and Reassessments of mental health status.
- Intensive mental health therapy and counseling provided solely by Mental Health Practitioners licensed in the State of New York.
- Individual and group counseling sessions with qualified staff.
- Psychiatric/Psychological consultation (testing and medication) provided by a licensed, mental health practitioner.
- Coordination and linkage to medical and other necessary service providers.

Program outcomes:
- 75% of clients with mental health concerns and/or illness will comply with or complete mental health treatment plan.
- 70% of clients with mental health concerns and/or illness will remain in primary medical care.

Indicators:
- Number of clients attending Mental Health Services who are engaged in treatment.*
- Number of clients who comply with or complete mental health treatment

**Engaged =individual actively participates in treatment and attends a minimum of 50% of mental health appointments.*

Service Unit(s): Face to face individual and/or face-to-face group level Mental Health visit in CAREWare

PROGRAM DATA REPORTING: Part A service providers are responsible for documenting and keeping accurate records of Ryan White Program Data/Client information, units of service, and client health outcomes. Reporting units of service are a component of each agency's approved workplan. Please refer to the most current workplan, including any amendments, for guidance regarding units of service. Summaries of service statistics by priority will be made available to the Planning Council by the Grantee for priority setting, resource allocation and evaluation purposes.

HRSA Program Monitoring Standard:

STANDARD	PERFORMANCE MEASURE/METHOD	MONITORING STANDARDS
Funding of **Mental Health Services** that include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers.	Documentation of appropriate and valid licensure and certification of mental health professionals as required by the State. Documentation of the existence of a detailed treatment plan for each eligible client that includes: The diagnosed mental illness or condition • The treatment modality (group or individual) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date, • Any recommendations for follow up • The signature of the mental health professional rendering service Documentation of service provided to ensure that: • Services provided are allowable under Ryan White guidelines and contract requirements • Services provided are consistent with the treatment plan	Obtain and have on file and available for grantee review appropriate and valid licensure and certification of mental health professionals; Maintain client records that include: • A detailed treatment plan for each eligible client that includes required components and signature • Documentation of services provided, dates, and consistency with Ryan White requirements and with individual client treatment plans

PERSONNEL:

Staff Qualification	Expected Practice
All staff providing direct mental health services to clients must be at least 21 years of age with good moral character. All mental health professionals must be licensed and qualified within the laws of the State of New York to provide mental health services in one of the following professions: • Licensed Clinical Social Worker (LCSW); • Licensed Master Social Worker (LMSW); • Licensed professional counselor; • Psychologist; • Psychiatrist; • Psychiatric Nurse; • Psychotherapist; • LMHC (Licensed Mental Health Counselor) • LMFT (Licensed Marriage & Family Therapist) • Counselor in Training (CIT) supervised by an appropriate licensed/certified professional.	Current License/Certification will be maintained on file. Personnel records/resumes/applications for employment reflect requisite experience/education. Documentation of supervision during client interaction with Counselors in Training (CIT) or Interns as required by the State of New York.
LMSW and LCSWs are required by the NYS Education Law to complete 36 hours of acceptable formal continuing education during each three year registration period. (Effective January 1, 2015).	CEUs on file in personnel files.
Trainings in cultural competency, HIV confidentiality and at least 1-2 HIV specific trainings annually.	Documentation of training on file.
A mental health supervisor must be licensed and registered in New York State to practice Mental Health Counseling and medicine, as a physician assistant, psychologist, licensed clinical social worker, or as a registered professional nurse or nurse practitioner and competent in the practice of Mental Health Counseling, or must have the equivalent qualifications as determined by the Department for experience completed in another jurisdiction. The supervisor must provide an average of one hour per week or two hours every other week of in-person individual or group supervision.	Current License/Certification will be maintained on file.
Staff participating in the direct provision of services to patients must satisfactorily complete all appropriate CEUs based on individual licensure requirements at a minimum, as per the license requirement for each licensed mental health practitioner.	Documentation on file.

Mental Health License/Certification Requirements found on *http://www.op.nysed.gov/prof/mhp/mhclic.htm*

Client Verification of Eligibility:

As required by HRSA/HAB Policy Notice #13-02. Ryan White Eligibility and proof of documentation are required at intake/assessment and must be updated every 6 months. Please refer to the N-S EMA's Ryan White Client Eligibility Guidelines for specific information and acceptable forms of documentation.

Standard	Provider/Sub-grantee Responsibility
Eligibility determination of clients to determine eligibility for Ryan White services within a predetermined timeframe	**Initial Eligibility Determination Documentation Requirements:** • HIV/AIDS Diagnosis (at initial determination); • Proof of residence (Nassau or Suffolk); • Proof of Income- 435% of the Federal Poverty Level; • Proof of Insurance Status- Uninsured or underinsured status (insurance verification as proof); • Determination of eligibility and enrollment in other third party insurance programs including Medicaid, Medicare; • For underinsured, proof this service is not covered by other third party insurance programs including Medicaid and Medicare
Determination of program eligibility for enrollment in Ryan White Part A/MAI Mental Health services based on client diagnosis of mental illness.	Documentation in client file of diagnosis of mental illness must include Diagnostic and Statistical Manual (DSM)-V diagnosis or diagnoses, utilizing at least Axis I.
Recertification of clients at least every 6 months to determine continued eligibility	**Recertification (minimum of every six months) documentation requirements**: • Proof of residence; • Low income documentation; • Uninsured or underinsured status (insurance verification as proof); • Determination of current or new eligibility and enrollment in other third party insurance programs including Medicaid and Medicare; • Document that the process and timelines for establishing initial client eligibility, assessment, and recertification takes place at a minimum every six months; • Document that all staff involved in eligibility determination have participated in required training; • Sub-grantee client data reports are consistent with eligibility requirements specified by funder, which demonstrates eligible clients are receiving allowable services. **Note:** Full documentation must be provided and placed in the client file at least once per year. At the six month recertification providers may use a signed client checklist to show eligibility review and no change. If any change has occurred, proof of new documents must be collected and placed in client file.

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
INTAKES					
An appointment will be scheduled no later than three (3) working days of a client's request for mental health services. In emergency circumstances, an appointment will be scheduled within twenty-four (24) hours. If service cannot be provided within these time frames, the Agency will offer to refer the client to another organization that can provide the requested services in a timelier manner.	Documentation in patient's file on referral date and appointment date scheduled.	Number of clients with less than or equal to 3 working days documented between client request and appt.	Number of clients referred for Mental Health Services	Client Files CAREWare	% of clients will have an appointment scheduled within three working days of request for mental health services.
ASSESSMENTS					
A comprehensive baseline assessment is to be completed upon initial intake outlining services needed prior to start date.	Comprehensive Assessment in client chart containing: • Verification of enrollment in medical care • Medical history and primary care Information • Intake date • Baseline mental health global assessment of functioning (GAF) and • DSM-V diagnostic code • Medical history • Substance abuse history • Psychiatric history • Complete mental status evaluation (including cognitive impairment,	Number of new client charts with assessment completed within 10 days of intake	Number of new clients accessing Mental Health Services	Client Files CAREWare	90% of new client charts have documented comprehensive assessments completed within **10 days of intake.**

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
	depression, anxiety, PTSD, suicide/homicide ideation, psychosocial status, sleep and appetite assessments) • Existing barriers to treatment including legal, financial, or employment • Consideration of underlying Medical or Medical treatment reasons, such as dementia or drug reactions				
TREATMENT PLANS					
A treatment plan shall be completed within 30 days that is specific to individual client needs. The treatment plan shall be prepared and documented for each client.	Documentation of **client** signed/dated treatment plan which includes: • type of MH service (individual, group, etc.) to be provided • treatment start and projected end dates • HIV medical care engagement and referral information. • Name of staff completing assessment • Progress notes following each client session • Evidence of supervisory review and staff monitoring of service plan documented in progress notes.	Number of client charts with treatment plans within 30 days of first visit	Number of clients accessing Mental Health Services	Client Files CAREWare	75% of client charts will have documentation of a treatment plan within 30 days of first visit.

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
REASSESSMENTS					
Reassessment of the client's service needs is **required every 6 months,** or sooner if significant changes occur in patient's needs.	Documentation in file showing review and/or update of: • Personal information • Patient health history, health status, and health-related needs outlined in the Comprehensive Assessment; • Patient status and needs related to psychosocial issues and required services/referrals • Need for partner counseling and assistance services • Name of staff completing reassessment with date of completion noted in the patient file. • Signed treatment plan by all parties involved • Every 6 months RW client eligibility must be verified and documented in patient chart. Changes must be noted accordingly with supported dated documentation in client chart. (Providers may use a signed client checklist to show eligibility review and no change.)	Number of clients reassessed every six months	Number of clients accessing Mental Health Services	Client Files CAREWare	90% of clients will be reassessed every six months.

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
	• Annual client eligibility update is required and current documentation collected and placed in client file. • Documentation that grievance procedures were reviewed with the client and placed in the client chart. Evidence of client signature.				
Dual reassessments of mental health treatment and HIV medical care engagement.	Each client is assessed and verified for engagement in HIV medical care and assisted with establishing linkages to care if not currently receiving care.	Number of clients assessed/verified for medical care upon reassessment of mental health treatment plan	Number of clients accessing Mental Health Services	Client Files CAREWare	70% of clients are reassessed and verified for engagement in medical care during reassessment of their mental health treatment plan.
Clients accessing mental health services remain actively engaged in their mental health treatment plan.	Clients receiving mental health services remain engaged in their Mental health treatment plan	Number of clients engaged in their mental health treatment plan	Number of clients accessing mental health services	Client Files	50% of clients accessing mental health services remain engaged in their mental health treatment plan
Clients with a mental health diagnosis remain in primary medical care while receiving services for mental health.	Documentation of established primary care provider in client file.	Number of clients receiving mental health services that remain in primary medical care services	Number of clients accessing Mental Health Services	Client Files	75% of infected clients with mental health diagnosis who remain in primary medical care.
Medication Maintenance					
Clients accessing Psychiatric care for medication management are medically adherent and are engaged in their psychiatric treatment plans.	Documentation in progress notes number of psychiatric appointments and number of prescription refills in client file.	Number of psychiatric clients engaged in their psychiatric care for medication management.	Number of clients accessing Psychiatric services for medication management	Client Files	75% of clients accessing psychiatric care for medication management are medication adherent and are actively engaged in their psychiatric treatment plans.

Mental Health Monitoring Tool follows this page below.

	Mental Health Tool	1	2	3	4	5	6	7	8	9	10
STRUCTURE ("WHO")											
1	**Licensure, Certification**										
2	**Supervision** • Documentation of overall supervision and type (MD, DO, APRN)										
3	**Training** • Annual cultural competency, HIV confidentiality and an additional 1-2 HIV specific topics for each provider serving RW clients.										
	Charting & Monitoring										
4	**Recordkeeping Requirements** • Chart is properly stored and secured • Chart is clearly organized with legible entries including date of service and signed clinician notes by licensed provider of services or supervisor when necessary • Agency approved lab form with signature and credentials of individual ordering lab. • Completed dated lab results.										
5	**Program Eligibility & Enrollment Status** Current documentation of program eligibility & client enrollment; eligibility reassessed every 6 months										
6	**Client Consent, Rights and Responsibilities** Documentation signed & dated by client										

7	**Medical Record Release Forms** HIPAA Release forms (as necessary) present, current, & signed by client											
8	**Confirmation of HIV Diagnosis** HIV antibody test, confirmatory lab data, or letter of diagnosis											
9	**HIV Medication List** Present in chart, complete and up to date; Primary Care Provider clearly noted											
10	**Mental Health/Substance Abuse Medication List** Present in chart, complete and up to date; Provider clearly noted											
PROCESS ("How")												
Initial Evaluation												
11	**Client Demographics** Age, ethnicity, gender indicated											
12	**Site of Primary Medical Care for HIV Care**											
13	**Initial Assessment** Completed, signed/dated by client and provider of service											
14	**Baseline Assessment**	**In Primary Medical Care? Since When?**										
15		**Mental Health Assessment** DSM-V diagnosis and GAF Score										
16		**History of Substance Use** Age at first use, substances used, frequency of usage and last usage										
17		**Screening** Cognitive impairment, depression, anxiety, PTSD, suicidal/homicidal ideation, psychosocial status, sleep and appetite assessments										

18		**Psychiatric history** Mental Health treatment history including psychotropic medications, treating provider information and family mental health history										
19		**Barriers to Treatment** Legal, Employment, or others barriers to Treatment										
20		**Motivation for Treatment** Reasons to enter Treatment at this time										
21		**Possible underlying Medical conditions or reasons for treatment** Consideration of dementia, organic reasons, or drug reactions										
Treatment Plan Development												
22	**Clinical** Documentation of clinical status, connect to HIV medical care											
23	**Mental Health/Substance Abuse** Refer to MH and/or SA services, document location of services, type of service (Individual, Group Therapy), expected tenure (amount of time), frequency, Start date, and End Date											
24	**Psychiatrist Referral (if indicated)** Document signed and dated psychiatrist referral, treatment goals, expected outcome and duration											