Mental Health Services Standards

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02:
Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients with HIV. The services are based on treatment plans 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.

Program Guidance:
Mental Health Services are allowable only for HIV-diagnosed clients.

Virginia Ryan White Part B Service Unit Definition:
One mental health provider visit (in-person or virtual) per day* for uninsured client OR one mental health visit copayment or cost share for insured client.

*An additional visit on the same date of service at a different practice/site = one unit. All categories assume one or more client encounters per day with the same practice/site = one unit (A mental health counselor and a psychiatrist visit on the same day at the same facility = 1 unit).

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV (PWH), including the following:

1.0 Intake and Eligibility
As outlined in HRSA HIV/ AIDS bureau (HAB) Policy Clarification Notice (PCN) 21-02 Clarifications on Ryan White Program Client Eligibility Determinations and Recertification Requirements, people are eligible to receive RWHAP services when they meet each of the following factors:

1. **HIV Status:** A documented diagnosis of HIV. 2 (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02.

2. **Low- Income:** The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL), which is measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).

3. Residency: The RWHAP recipient defines its residency criteria, within its service area. Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services. RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies.

Standard	Measure
Referral	
1.1) Documentation of referral for Mental Health Services by a Part B provider or individual prior to initiation of the service.	1.1) Documentation of referral for Mental Health Services is present in the client's record, signed and dated.
Eligibility	
1.2) The client's eligibility for Ryan White Part B services must be determined prior to providing the service. To be eligible for this service, clients must: a) Have an HIV diagnosis (one time only) b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Be ineligible for other payer sources covered by Federal or State programs such as Medicare, Medicaid, all other forms of insurance or third party payers such as private and commercial insurance plans, and other payers that provide the service they are seeking. • Client Access Reviews (CARs) - refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility. • Provide continuation of eligibility every 24 months with proof of income, changes in insurance coverage, or any changes in residency • Client eligibility ensures the use of Part B services as the payer of last resort while vigorously pursuing other funding sources**.** Client must agree to participate in the insurance option that	1.2) Documentation of the client's eligibility is present in the client's record that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client's Medicaid status verified (gap of services) • Ongoing CARS and complete Continuation Eligibility Assessment every 24 months • Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

the client is eligible for and that best meets the client's medical needs regardless of preference. Submission of eligibility assessments should be through the Provide Enterprise® data system.	
Intake	
1.3) Complete eligibility screening and intake within 15 days of initial contact with client.	1.3) Documentation of intake and eligibility screening in record signed and dated.
Client Access Reviews/Continuation of Eligibility	
1.4) Client Access Reviews (CARs) refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility and continuation of eligibility conducted every 24 months to continue to receive Ryan White services. There is no grace period.	1.4) Documentation of CARS and continuation of eligibility is present in the client's record.
2.0 Key Services Components and Activities	
Standard	**Measure**
Documentation	
2.1) Documentation of all mental health services provided in client record. If psychotropic medications are used, include the medication list, assessment of side effects, and treatment education information.	2.1) Documentation of mental health service is in client's record signed and dated.
2.2) When a third-party payer provides service, the sub-recipient must maintain a client record. At a minimum, the payer's record must contain: • Referral • Initial assessment • Individualized treatment plan, including treatment modality and frequency and quantity of treatments • Documentation of all contacts & dates of service	2.2) Documentation of provided service is signed and dated in client record.

• Reassessment of treatment plan to include monitoring and assessment of client progress • Referrals and follow-ups • Discharge plan Must sign and date all reports.	
Assessment/Service Plan/Provision of Services	
2.3) Completion of a mental health screening for determination is required. Mental health screenings include: a) PHQ-9 b) GAD-7 c) AUDIT-DAST d) Rx Abuse Screener e) MOCA	2.3) Documentation of screening signed and dated by mental health service provider.
2.4) If mental health services are deemed appropriate, a service plan is developed within 15 days of the initial screening to include: • Diagnosed mental illness or condition • Service modality (individual or group or both) • Treatment goals • Start date for mental health services • Projected end date for services • Recommended number of sessions • Reassessment dates of client progress every 90 days.	2.4) Documentation of service plan in client's record signed and dated by mental health service provider. If client unable to sign the treatment plan, progress note should include documentation that the client has received a copy.
2.5) A complete psychosocial assessment will be completed, and the result of the assessment will be used to complete the service plan as necessary.	2.5) Documentation of complete psychosocial assessment in client's record signed and dated.
2.6) Mental health services, provided as group or individual sessions, should be specific to individual client needs and can include counseling regarding:	2.6) Documentation of mental health services provided in client's record signed and dated.

a) Prevention and transmission risk behaviors, including root causes and underlying issues related to increased HIV transmission behaviors b) Substance abuse c) Treatment adherence d) Development of social support systems e) Community resources f) Maximizing social and adaptive functioning g) The role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals.	
2.7) Care will be coordinated across the agency and specifically address monitoring mental health and treatment adherence.	2.7) Documentation of consultation with medical staff, mental health, pharmacy and other support services, as needed.
2.8) Review of service plan at least every 90 days and modified as appropriate.	2.8) Documentation of review and update of service plan as appropriate signed and dated.
2.9) Refer client to other medical, mental health and other services as appropriate, e.g., psychiatric services, substance abuse treatment, neuropsychological testing, day treatment programs, in-patient hospitalization, case management.	2.9) Documentation of referrals made and status of outcome in client's record.
Transition and Discharge	
2.10) Client discharged when mental health services are no longer needed, goals have been met, upon death or due to safety issues. (*see 2.11*) <u>Prior to discharge</u>: Conduct discussion with client over reasons for discharge and options for other service provisions. Whenever possible, discussion should occur face-to-face. If not possible, provider should attempt to talk with client via phone. If verbal contact is not possible, a certified letter* must be sent to	2.10) Documentation of discharge plan summary and summary in client's record with clear rationale for discharge within 30 days of discharge, including certified letter*, if applicable. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge*

client's last known address. Must return to provider, if client is not present to sign for the letter. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.* <u>Documentation:</u> Client's record must include: a) Date services began b) Special client needs c) Services needed/actions taken, if applicable d) Date of discharge e) Reason(s) for discharge f) Referrals made at time of discharge, if applicable. <u>Transfer:</u> If client 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 client moves to another area, transferring agency will make referral for needed services in the new location. <u>Unable to Locate:</u> If client 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. The three attempts should start no later than three months prior to the due date. A certified letter* must be mailed to the client's last known mailing address within five business days after the last attempt to notify the client. The letter will state case closure within 30 days from the date on the letter if no appointment is schedule with the provider. **Exception: If the client has noted during*	*summary.* Discharge summary and other records send with the patient Document attempts made

the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary. <u>Withdrawal from Service:</u> If client reports no longer needing services or decides to no longer participate in the Service Plan, client may withdraw from services. Because clients may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure understanding reasons for withdrawal, or if client still needs services identify factors interfering with the client's ability to fully participate. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. <u>Administrative Discharge:</u> Clients who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a client for this reason, agency leadership according to that agency's policies must review the case. Provide clients discharged for administrative reasons written notification of and reason for the discharge, and notify of possible alternative resources. A certified letter* that notes the reason for discharge and includes alternative resources must be mailed to the client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the client's chart. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*	
Case Closure	

2.11) Case will be closed if client: a) Has met the service goals; b) Decides to transfer to another agency; c) Needs are more appropriately addressed in other programs; d) Moves out of state; e) Fails to provide updated documentation of eligibility status thus, no longer eligible for services; f) Fails to maintain contact with the mental health assistance staff for a period of three months despite three (3) documented attempts to contact client; g) Can no longer be located; h) Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; i) Exhibits any pattern of abuse as defined by agency's policy. j) Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program; or k) Is deceased.	2.11) Documentation of case closure in client's record with clear rationale for closure.
3.0 Client Rights and Responsibilities	
Standard	**Measure**
3.1) Services are available and accessible to any individual who meets program eligibility requirements. Each provider shall assist clients with conducting Ryan White Part B eligibility, regardless of whether they receive other Part B services at your agency. All providers shall be in compliance with all applicable federal, state, and local anti-	3.1) Written eligibility requirements and non-discrimination policy on file.

discrimination laws and regulations, including but not limited to the American's with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering services on the basis of the fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or HIV/AIDS diagnosis. Each provider shall make available to clients a process for requesting interpretation services, including American Sign Language.	
3.2) Each agency should have a Client's Rights and Responsibilities policy, which requires each client to sign & date a form indicating they have been offered: a) explanation of the policy, and b) copy of *'Client's Rights and Responsibilities* and to communicate client's understanding of the policy.	3.2) Written policy on file.
3.3) Provide explanation of *Client's Rights and Responsibilities* to each client. Client rights include: • Be treated with respect, dignity, consideration, and compassion; • Receive services free of discrimination; • Be informed about services and options available. • Participate in creating a plan of services; • Reach an agreement about the frequency of contact the client will have either in person or over the phone. • File a grievance about services received or denied; • Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; • Voluntary withdraw from the program;	3.3) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the rights and responsibilities.

• Have all records be treated confidentially; Have information released only when: • A written release of information is signed; • A medical emergency exists; • There is an immediate danger to the client or others; • There is possible child or elder abuse; or • Ordered by a court of law Client responsibilities include: • Treat other clients and staff with respect and courtesy; • Protect the confidentiality of other clients; • Participate in creating a plan of service; • Let the agency know any concerns or changes in needs; • Make and keep appointments, or when possible, phone to cancel or change an appointment time; • Stay in contact with the agency by informing the agency of change in address and phone number, respond to phone calls and mail • Avoid to subject the agency's staff to physical, sexual, verbal and/or emotional abuse or threats.	
4.0 Grievance Process	
Standard	**Measure**
4.1) Grievance policy exists which requires each client to sign & date indicating they has been offered: a) explanation of the policy, b) copy of *Grievance Procedure* and c) communication of client's understanding of the policy.	4.1) Written grievance procedure on file, available in languages and formats appropriate to populations served.

Policy shall describe the process for resolving client grievances, including identification of whom to contact and applicable timelines. Policy shall be available in languages and formats (e.g., for persons with disabilities) appropriate to populations served.	
4.2) Provide explanation of *Grievance Procedure* to each client. Clients may file a grievance if denied their request for services, if they have any complaint, or concern about the services received.	4.2) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.
4.3) Grievance process shall be fair and expeditious for resolution of client grievances.	4.3) Documentation of client grievances, status, and resolution.
4.4) Review the grievance policy yearly with client signature.	4.4) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the client's rights and responsibilities.
5.0 Personnel Qualifications (including licensure)	
Standard	**Measure**
5.1) All mental health professional will have appropriate and valid licensure and certification as required by the Commonwealth of Virginia. Licensure is required for: • Licensed Clinical Social Worker • Licensed Master Social Worker (LMSW) who is employed by or volunteer for an agency not owned in total or part by the LMSW and who is under a clinical supervision plan • Marriage and family therapist • Licensed professional counselor • Psychologist • Psychiatrist	5.1) Copy of current licensure in personnel file.

• Psychiatric nurse.	
5.2) Newly employed mental health professionals must complete orientation within 90 days of hire and include training on: • Referral for crisis intervention policy/procedures • Standards of care • Confidentiality • Client rights and responsibilities • Client abuse and neglect reporting policies and procedures • Professional Ethics • Emergency and safety procedures • Data management and record keeping.	5.2) Documentation of training completed in personnel file.
5.3) All mental health professionals must complete at least 2 hours of continuing education in HIV/AIDS treatment or care annually.	5.3) Documentation of training complete in personnel file
5.4) Supervision is required of all mental health professionals by a licensed clinical mental health practitioner.	5.4) Documentation of supervision according to agency policy.
6.0 Cultural and Linguistic Competency	
Standard	**Measure**
6.1) Health services are culturally and linguistically competent, client-guided and community based. At a minimum, provider's documentation should include: a) Experience with providing services to the diverse ethnic, linguistic, sexual or cultural populations targeted; b) Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services;	6.1) Documentation of site cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.

c) List of cultural competency trainings completed by staff.	
6.2) Easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area shall be available.	6.2) Culturally and linguistically appropriate materials and signage accessible.
7.0 Privacy and Confidentiality (including securing records)	
Standard	**Measure**
7.1) Client confidentiality policy exists which include: a) Release of information requirements, and b) Health Insurance Portability and Accountability Act.	7.1) Written Client confidentiality policy on file at provider agency.
7.2) Client's consent for release of information is determined.	7.2) Current *Release of Information Form* signed and dated by client and provider representative and located in client's record. Each release form indicates who may receive the client's information and has an expiration of not more than 12 months from date of signature.
7.3) Store each client's file in a secure location with electronic client records protected from unauthorized use.	7.3) Files stored in locked file or cabinet with access limited to appropriate personnel. Electronic files are secure with password protection and access limited to appropriate personnel.
7.4) Annual submission of *Verification of Receipt of Assurance of Key Requirements* document by all staff that handle client identifying information.	7.4) Documentation of signed *Verification of Receipt of Assurance of Key Requirement* forms.
8.0 Quality Management	
Standard	**Measure**
8.1) Measure and report client health outcomes using Mental Health Services measures approved by VDH.	8.1) Performance measurement data on the following indicators:

	• Percentage of people with HIV and receiving Mental Health Services, regardless of age, who will have at least two care markers in a 12-month period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date). • Percentage of people enrolled in RW Part B-funded Program with HIV and receiving Mental Health Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

References

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