HIV/AIDS MENTAL HEALTH SERVICE GUIDELINES FOR RYAN WHITE ELIGIBLE PATIENTS

DIVISION OF HIV AND STD PROGRAMS

PREPARED BY ALEJANDRINA JURADO, MSW – THE DIVISION OF HIV AND STD PROGRAMS

Revised 11/01/17

Table of Contents

ACKNOWLEDGEMENTS

The following people and organizations were instrumental in assisting with the development of this guideline:

Sonali Kulkarni, MD, MPH
Wendy Garland, MPH
Alejandrina Jurado, MSW
Megan Foley, MSW
Judy Wilson-Carter, LCSW
Patricia Wallace, Psy.D.
Angela D. Boger, BA

INTRODUCTION/PURPOSE

Recent studies have indicated that over one–third of clients presenting in HIV primary care clinics met screening criteria for one or more mental health disorders, and over 40% of these clients were not receiving any mental health treatment (Israelski et al., 2007). Similarly, another study found that 56% of clients attending HIV clinics screened positive for either posttraumatic stress disorder (PTSD), acute stress disorder (ASD) or depression, and over half of those screening positive were not receiving any psychiatric treatment (Soller et al., 2011). When all DSM IV-TR diagnostic categories are combined, between one third and one half of HIV positive persons suffer from a current mental disorder (Klinkenberg & Sacks, 2004).

This prevalence of co-occuring mental health diagnoses is of concern, as comorbid mood disorders negatively impact health-related quality of life (HRQoL) in HIV positive adults (Sherbourne et al., 2000). Comorbidities, both medical and psychiatric, were associated with deterioration in most dimensions of HRQoL for HIV positive men (Jia et al, 2007). Untreated mental illness has also been shown to result in worse outcomes for treatment of HIV infection and substance use disorders (Altice et al., 2010).

Offering mental health services for people living with HIV has been demonstrated to have a positive influence on primary care, in entry (Messeri, et al., 2002; Conviser & Pounds, 2002), utilization and retention (Lo, MacGovern & Bradford, 2002; Conviser & Pounds, 2002). HIV positive clients with psychiatric disorders are less likely to discontinue highly active antiretroviral therapy (HAART) if they are receiving consistent mental health treatment. Possible factors for this relationship include co-located HIV and mental health care that encourages treatment coordination and medication adherence (Himelhoch et al., 2009). Adherence to treatment for HIV, substance use, and comorbidities can be enhanced through a range of interventions: counseling, contingency management, supervised therapy (directly observed therapy), medication-assisted therapy, and integrated health service delivery (Altice et al, 2010). Improvement in mental health problems for people living with HIV can lead to improved health-related quality of life (Elliot, Russo, & Roy-Byrne, 2002).

Medication assisted therapy enhances adherence to antiretroviral therapy, treatment for comorbidities, and retention in HIV care, while decreasing HIV risk behaviors (Altice et al., 2010). A recent study of persons living with HIV found that greater mean psychotropic medication adherence was significantly associated with greater antiretroviral medication adherence (Cruess et al., 2011). Mental health favors adherence to antiretroviral drugs which slow the progression of illness, prevent medical complications and improve quality of life (Repetto and Petitto, 2008). Psychopharmacological treatment is effective and can improve psychiatric problems in HIV-infected individuals (Repetto and Petitto, 2008).

According to the California Code of Regulations, Title 9, " 'Mental Health Services' means individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral." (§ 1810.227)

Mental health treatment for people living with HIV/AIDS attempts to enhance access to and retention in primary HIV medical care and promote health and quality of life. Counseling and psychotherapy have been shown to be helpful in alleviating or decreasing psychological symptoms that can accompany a diagnosis of HIV/AIDS.

These guidelines are designed as a tool for mental health treatment providers and other program staff in Los Angeles County to implement best practices, and promote uniformity and consistency in delivering specialized program services to individuals living with HIV/AIDS who suffer from mental ailments that keep them out of primary HIV medical care and treatment. The primary purpose of HIV/AIDS mental health care in Los Angeles County is to assist PLWH/A with mental health stressors in becoming mentally ready to access HIV primary health care and to reduce transmission of HIV.

Mental Health Services for people living with HIV/AIDS includes the following components:

- Psychotherapy
  - Individual
  - Group
  - Family psychotherapy
  - Multi-family psychotherapy
- Psychiatric diagnostic evaluation
- Medication Management
- Crisis Intervention
- Psychotherapy for Crisis
- Targeted Case Management
- Neuropsychological Testing

GOALS AND OBJECTIVES

Services are aimed at alleviating mental health symptoms that can accompany a diagnosis of HIV. Mental health treatment for people living with HIV also attempts to enhance access to and retention in primary HIV medical care, reduce HIV transmission risk behaviors, and promote health and quality of life. Mental health treatment services are for patients living with HIV/AIDS experiencing mental health distress and treatment consists of Psychotherapy (individual, group, and family), Psychiatric Evaluation, Medication Management, Crisis Intervention, and Targeted Case Management.

The goals of HIV/AIDS mental health services are to:

- Innovatively support access, maintenance, and adherence to HIV care and treatment.
- Enhance access to and retention in primary HIV medical care and mental health services; and,
- Improve understanding of the behaviors and emotions that contribute to overall well-being in relation to living with HIV.
- Provide guidance on how to maintain a sense of control and pleasure in life, while coping with the challenges associated with living with HIV/AIDS.
- Provide guidance on how to reduce behaviors that jeopardize overall well-being, including substance use and HIV risk-taking behavior.

Objectives of HIV mental health treatment services are:

- Reduction in the proportion of HIV positive individuals diagnosed with a mental health disorder who report an inability to cope with mental health stressors;
- Increase in the proportion of HIV positive individuals diagnosed with a mental health disorder who are linked to and retained in HIV-related medical care;
- Increase in the proportion of HIV positive individuals diagnosed with a mental health disorder who disclose their HIV status to sexual and/or needle-sharing partner(s); and
- Reduction in the proportion of HIV positive individuals diagnosed with a mental health disorder who report engagement in behaviors that increase the risk for transmitting HIV.

Mental health treatment includes mental health diagnostic evaluation and diagnosis, treatment planning, treatment provision such as psychotherapy, medication monitoring, crisis intervention, and may include targeted case management. Services include integration of the following into mental health treatment provision:

Retention in HIV Medical Care: Mental Health treatment providers shall strive to retain patients in primary HIV medical care services. As such, the mental health clinician shall maintain on-going contact with a patient's HIV medical provider, to ensure continuity of services. Mental health providers shall contact the patient's HIV provider at a minimum of once every ninety (90) days to ensure that the patient is in HIV medical care. These activities shall be documented through progress notes and maintained within the patient record.

a. **Medical Care Coordination** - For patients intermittently in HIV care, the mental health provider shall communicate with and/or refer patient to the Medical Care Coordination team at the patient's HIV medical home.

b. **Linkage and Reengagement** - For patients who have dropped out of treatment without notice, Contractor shall make follow-up attempts to contact the patient via telephone, email, home visits, and written correspondence. Patients that the contractor is unable to locate after reasonable efforts shall be referred to DHSP's Linkage and Reengagement Program (LRP) within thirty (30) days of the last attempted contact.

Prevent Adverse Medication Interactions - Contractors shall be responsible for increased coordination of HIV and mental health care services for patients taking psychotropic medications given the potential for difficulty in adherence and adverse drug interactions. Contractors shall initiate or change psychotropic medications only in consultation with the HIV medical care provider to assess and l routinely monitor for any possible adverse drug-to-drug interactions between psychotropic and HIV medications.

Reduce HIV Transmission: Mental health services provider shall engage patients in addressing disclosure and partner notification for patients engaging in behaviors that risk transmission of HIV. Mental health clinicians shall assess for issues such as Interpersonal Violence to ensure patient safety and shall refer only those patients where safety is optimized. Mental health treatment provider shall build skills, including problem-solving, decision-making and assertive communication skills, among patients to increase their ability to reduce risk taking behaviors and disclose their HIV status to needle-sharing and/or sexual partners, as appropriate.

- Linkage to care: for all partners who are identified as HIV-positive, mental health providers shall refer those partners to DHSP's Linkage and Reengagement Program to ensure they are linked to HIV/AIDS medical services. Additionally, newly diagnosed patients shall be enrolled in **Targeted Case Management** services.

- Mental health services providers shall ensure that patients discuss **Post-Exposure Prophylaxis (PEP)** and **Pre-Exposure Prophylaxis (PrEP)** with sexual and/or needle sharing partners that have been identified as possibly being exposed to HIV.

PATIENT ELIGIBILITY FOR SERVICES

Contractors receiving Ryan White funds must have systems in place to ensure and document client eligibility based on HIV Status, income, Los Angeles County residence and insurance status. To maintain eligibility for RWHAP services, clients must be recertified at least **every six (6) months**. The primary purpose of the recertification process is to ensure that an individual's Los Angeles County residence, income, and insurance statuses continue to meet grantee eligibility requirements and to verify that the RWHAP is the payer of last resort. The recertification process includes checking for the availability of all other third party payers.

Clients eligible for mental health services include individuals that are:

- HIV-Positive; and
- Los Angeles County residents[1]; and
- Living below 500% of the Federal Poverty Level (FPL): and
- Uninsured/or underinsured for mental health services; and
- Experiencing a mental health issue that warrants service provision.

HIV Status - Grantees and funded contractors must be able to make an explicit connection between any service supported with Ryan White HIV/AIDS Program funds and the intended recipient's HIV status.

- **Primary documentation-HIV Diagnosis Form** signed by a physician or current Labs indicating CD4/viral load. Required for initial eligibility determination, no *re-certification required*

Income – All clients receiving Ryan White services must meet the following income eligibility criteria. Financial eligibility is based on 500% of the Federal Poverty Level (FPL). Clients above 500% of FPL are not eligible for services. FPL varies based on household size and is updated semi-annually. Financial eligibility is calculated on the gross income available to the household, excluding Medicare and Social Security withholding and the cost of health care coverage paid by the applicant.

- Proof may include pay stubs for the prior 3 consecutive months, W-2 or 1099, disability award letter, benefit receipt or check stub, or signed support affidavit confirming financial eligibility. See Appendix B for an example of an affidavit.

Updated Federal Poverty Guidelines may be accessed by visiting:
http://aspe.hhs.gov/poverty/index.shtml

Los Angeles County residence[2]-Los Angeles County residence is required; U.S. citizenship is not required. Incarcerated individuals receiving services in jails or prisons are exempt from this requirement.

- Proof may include a state issued driver's license or identification card with a Los Angeles County address, rental agreement or lease with client's name listed on the agreement t, recent utility bill or bank statement with a Los Angeles County residence

[1] Ryan White clients do not have to be citizens or legal residents of the United States to receive services, they must, however, be able to prove they reside in Los Angeles County.
[2] Proof of "residence" does not mean proof of "residency." Clients must prove they live in Los Angeles County. They do not have to prove they are documented visitors, residents or citizens.

address and the client's name, or a signed affidavit confirming residence in Los Angeles County (e.g., staying with family or friends, at a shelter, treatment center, homeless).

Insurance

By statute, RWHAP funds may not be used "for any item or service to the extent that payment has been made, or can reasonably be expected to be made…" by another payer source. This means grantees must assure that funded providers make reasonable efforts to secure non-RWHAP funds, whenever possible for services rendered to individual clients. Contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.

Client Registration

Clients who agree to participate in mental health services shall be registered after determining client's eligibility for services, collecting client information, and obtaining required consents and other documentation. **Clients must consent to receive Mental Health Services PRIOR to services rendered.** Documentation includes:

- **Client Registration** which may include date of registration, client name, home address, mailing address, emergency contact name and contact information, telephone number, e-mail addresses, etc. Ensure an emergency contact is collected and updated regularly. This may reduce the likelihood of losing clients who are hard to reach, particularly those who are transient and/or have unreliable means of communication (e.g., instable housing, lost cell phones, inability to pay for phone services).

a) **Notice of Privacy Practices and Health Insurance Portability and Accountability Act (HIPAA) Policy** which notes that the agency and its staff shall not disclose the client's Protected Health Information without the client's permission, except in situations that involve a client being at risk of harming himself or others, or suspected abuse or neglect of a child or dependent adult. Such statement shall be signed and dated by the Mental Health Clinician and the client.

Clients seeking mental health services frequently have concerns about confidentiality, and these concerns often act as barriers to accessing services. Any breach in confidentiality, however unintentional, could irreversibly harm the provider-client relationship and lead to legal sanctions.

- Ensure the client's right to privacy and confidentiality when sharing information about the client to others. Information may be released to other professionals and agencies only with the written permission of the client. This release should detail what information will be disclosed, to whom, and for what purpose. The client has the right to revoke this release by written request at any time.

- While Mental Health Clinicians discuss many intimate topics with clients given the nature of HIV and how it is transmitted, avoid soliciting private information from clients unless it is essential to providing quality care and services. Once private information is shared, standards of confidentiality apply. Mental Health Clinicians may disclose confidential information when appropriate with valid consent from a client.

Do not discuss confidential information in any setting unless the Mental Health Clinician can ensure privacy, including public or semipublic areas such as hallways, waiting rooms, elevators, staff lounge areas and other common work areas. This confidentiality extends to clients' written and electronic records, whether in storage, being transmitted electronically or transported by person.

Inform clients about any reporting obligations *before* a client may disclose sensitive information, i.e., prior to the start of each session with every client. While Mental Health Clinicians ARE mandated reporters[3], agency policies may require Mental Health Clinicians to involve their supervisor in the event that clients disclose child abuse, suicidal ideation, or homicidal intent. It may be helpful to have signs in the waiting area or counseling rooms to inform clients of agency policies.

C. Statement of Informed Consent for Medication Services (see Appendix F for an example, Only for Medication Support Services)

A client shall be treated with psychotropic medications only after s/he has been informed by the physician of his/her right to accept or refuse such medications (CCR Title 9, §851). The Information received by the client and documented by the physician shall include**,** but shall not be limited to (CCR Title 9, §851):

- Nature of the client's mental condition
- Reason(s) for taking the medication(s), including the likelihood of improving or not improving without the recommended medication and reasonable alternative treatments available
- Type, range of frequency and amount, and method and duration of taking medication(s)
- Probable side effects which commonly occur.
- Reasons for changes in medication and/or dosage shall be clearly documented by the psychiatrist
- A description of what was attempted and/or accomplished at the time the service was provided is to be included in the progress note
- Consent once given may be withdrawn at any time
- Signature of person providing the service, type of professional degree and licensure/job title

[3] The following are mandated reporters in the adolescent health service field: Physicians, Surgeons, Psychiatrists, Psychologists, Psychological Assistants, Mental Health and Counseling Professionals, Dentists, Dental Hygienists, 9) Registered Dental Assistants, Residents, Interns, Podiatrists, Chiropractors, Licensed Nurses, Optometrists, Marriage, Family and Child Counselors, Interns and Trainees, State and County Public Health Employees, Clinical Social Workers, EMT's and Paramedics, and Pharmacists.

D. Client Bill of Rights documentation

This statement outlines the rights and responsibilities of the patient to receive timely mental health services delivered by courteous staff and the patient's role in the development of their treatment plan and achieving the goals established therein.

E. Grievance Procedures Policy

All patients should be informed and sign the agency's grievance procedure policy during the registration process. Additionally, the DHSP Grievance Poster shall be posted in a visible location that patients have access to, such as the reception areas or waiting rooms.

Policy should include information about DHSP Grievance Line and additional methods of communication:

Phone: 1-800-260-8787

Email: DHSPgrievance@ph.lacounty.gov

Web: www.publichealth.lacounty.gov/aids/aidsresrc/grievance.htm

Address: Attention: QM Grievance Coordinator
600 S. Commonwealth Ave., 10th Floor
Los Angeles, CA 90005

REIMBURSABLE SERVICES

The following section describes the services reimbursable for Ryan White eligible clients in Los Angeles County. Reimbursement is made on a fee-for-service (FFS) basis. Contractors must follow state and federal laws, rules and regulations in the provision of services.

Diagnostic Assessment

Completed as part of a formal and comprehensive Mental Health Assessment, the diagnostic Interview is a clinical analysis of the history and current status of a client's mental, emotional or behavioral disorder; relevant cultural issues and history; and diagnosis (CCR § 1810.204). Psychiatric evaluations also may be helpful in obtaining a consultation related to diagnoses or further evaluation of neuropsychiatric symptoms. Clients with a history of psychotic mental illness or those with past or current diagnoses of mood disorders (e.g., depression and bipolar disorder) and anxiety disorders may benefit from taking medications that alleviate their symptoms.

The evaluation may include communication with family or other sources, and review and ordering of diagnostic studies. It may also include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

Service	Billing Code	Allowable Discipline
Psychiatric Diagnostic Evaluation/interview (Client Present)	90791	• MD/DO (Licensed) • PhD/PsyD (Licensed or Waivered) • SW (Licensed, Registered or Waivered) • MFT (Licensed, Registered, or Waivered) • Authorized (NP) or Authorized CNS (Certified) • PCC (Licensed or Registered)

Psychiatric Diagnostic Interview: this code should be used when completing an Initial Assessment or Re-assessment or when preforming subsequent assessment activities that are documented on an assessment form.

Medication Management

Medication management includes one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication management services are individually tailored to address the client's need and are provided by a consistent provider who has an established relationship with the client.

Service Activities may include but are not limited to:

- Evaluation of the need for medication
- Evaluation of clinical effectiveness and side effects
- Obtaining informed consent
- Medication education
- Instruction in the use, risks and benefits of and alternatives to medication
- Collateral and plan development related to the delivery of the service and /or assessment of the client
- Prescribing and monitoring of psychiatric medications or biologicals

For each client receiving medication monitoring services, provider shall:

- Conduct Psychiatric Diagnostic Evaluation Assessment
- Develop a Treatment Plan
- Provide follow up as indicated in treatment plan, noting outcome of mental health intervention in Progress Notes
- Coordinate the provision of psychiatric care with primary HIV care medical clinics. Maintain regular contact with a client's primary care clinic and related providers to ensure integration of services and maintain continuity of care.

Component	Determining Factors	Types and Elements of each Type
History	**Refers to the amount of history that is gathered** which is dependent upon clinical judgment and on the nature of the presenting problem(s)	**Problem focused**-chief complaint, brief history of present illness or problem **Expanded problem focused**-chief complaint, brief history of present illness, problem pertinent system review **Detailed**-chief complaint, extended history of present illness, problem pertinent system review extended to include a review of a limited number of additional systems, pertinent past/family/and or social history directly related to the client's problem **Comprehensive**-chief complaint, extended history of present illness, review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems, complete past/family/social history.
Examination	**Refers to the body and/or organ that are examined** which is dependent on clinical judgment and on the nature of the presenting problem(s) "Psychiatric" is considered an Organ System and must be included in the examination. Addition	**Problem focused**-a limited examination of the affected body area or organ system **Expanded problem focused**-a limited examination of the affected body area or organ system and other symptomatic or related organ system(s) **Detailed**-an extended examination of affected body area(s)

	Organ Systems include: Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Skin, Neurologic, and Hematologic/Lymphatic/Immunologic. Additional Body Systems include: Head (including the face), Neck, Chest (including breasts and axilla), Abdomen, Genitalia/Groin/Buttocks, Back, and Each Extremity.	**Comprehensive**-a general multisystem examination or a complete examination of a single organ system.
Medical Decision Making	**Refers to the complexity of establishing a diagnosis and/or selecting a management option based on** 1) the number of diagnosis and/or management options 2) the amount and/or complexity of medical records, diagnostic tests and/or other information that must be obtained, reviewed, analyzed 3) the risk of significant complications, morbidity, and/or mortality associated with the presenting problem(s), diagnostic procedure(s) and /or possible management options.	**Straightforward**-minimal diagnoses and/or management options, minimal or no data to be reviewed, minimal risk complications. **Low complexity**- limited diagnoses and/or management options, limited data to be reviewed, low risk of complications **Moderate complexity**-multiple diagnoses and/or management options, moderate data to be reviewed, moderate risk of complications **High Complexity**-extensive diagnoses and/or management options, extensive data to be reviewed, high risk of complications.

Medication Prescribing must be facilitated by an appropriately licensed provider.

Medication Management includes the following procedure codes:

Service	New Client Codes	Severity of problem	Required components	Allowable Discipline
Medication Management: Office or other outpatient visit for the evaluation and management of a new patient which requires all three (3) components listed in the "required components" column Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's need.	99201	Minor	• Problem focused history • Problem focused examination • Straightforward medical decision making	MD/DO NP
	99202	Low to moderate	• Expanded problem focused history • Expanded problem focused exam • Straightforward medical decision making	MD/DO NP
	99203	Moderate	• Detailed history • Detailed examination • Medical decision making of low complexity	MD/DO NP
	99204	Moderate to high	• Comprehensive history • Comprehensive examination • Medical decision making of moderate complexity	MD/DO NP
	99205	High	• Comprehensive history • Comprehensive examination • Medical decision making of moderate complexity	MD/DO NP

Service	Established Client Codes	Severity of problem	Required components (Minimum 2 of 3)	Allowable Discipline
Medication Management: Office or other outpatient visit for the evaluation and management of an established patent which requires at least two (2) of the three (3) components listed in the "required components" column Counseling and/or coordination of care with other providers or agencies are provided consistent with the client's and/or family's needs.	99212	Minor	• Problem focused history • Problem focused examination • Straightforward medical decision making	MD/DO NP
	99213	Low to moderate	• Expanded problem focused history • Expanded problem focused exam • Medical decision making of low complexity	MD/DO NP
	99214	Moderate to high	• Detailed history • Detailed examination • Medical decision making of moderate complexity	MD/DO NP
	99215	High	• Comprehensive history • Comprehensive examination • Medical decision making of high complexity	MD/DO NP

Service	Code	Allowable Discipline
Comprehensive Medication Service Medication Support Services to clients, collaterals, and/or other pertinent parties (e.g. PCP). Services may include: Prescription by phone, medication education by phone or in person, discussion of side effects by phone or in person, medication plan development by phone or in person, and medication group in person.	H2010	

Service	Code	Allowable Discipline
Medication support/Care Plan development/document	H0034	Any staff operating within his/her scope of practice.

Plan Development

A stand-alone Mental Health Service that includes developing the treatment plan, approval of the treatment plan and/or monitoring of a client's progress. Plan development may be done as part of an interdisciplinary inter/intra-agency conference and/or consultation with other mental health providers in order to develop and/or monitor the client's mental health treatment. Plan development may also be done as part of a contact with the client in order to develop and/or monitor the client's mental health treatment.

Service	Billing Code	Allowable Discipline

Plan Development / Treatment Plan Development	H0032	Any staff operating within their scope of practice.

Note:

- For Team Case Conference: Time should only be claimed for actual time a staff person participated in the conference and any other time a staff person actually spent related to the conference, such as travel or documentation. Participation includes time when information was shared that can be used in planning for client care or services to the client.

Psychotherapy

California Code of Regulations, Title 9, Therapy: *"'Therapy' means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present." (§ 1810.250)*

Individual, group, family and multifamily therapy codes are used to document therapeutic interventions consistent with the client's goals. These services include various treatment modalities, utilized within a professional relationship, to assist the client to achieve better psychosocial adaptation. Therapy may also be used to help the client modify internal and external conditions to allow the client to improve functioning in terms of behavior, emotions and thinking. This improvement in functioning may occur with respect to self, significant interpersonal relationships, the larger community, or in all of these domains.

Psychotherapy with a person with HIV can occur at many levels, through diverse modalities, and from different theoretical perspectives. Psychotherapy can help clients develop greater self-awareness, stronger coping skills, and greater motivation to engage in meaningful and productive activities. For example, clients with a history of substance use often discover and begin to heal as they go through the therapeutic process and begin to understand the underlying pain against which they have long sought to medicate themselves.

Patients also work to identify factors that trigger emotional functioning that interferes with their ability to: 1) attend HIV medical care; 2) reduce HIV risk behaviors; 3) adhere to HIV medication treatment; and 4) improve their health and well-being. The clinician can utilize clinical interventions such as psycho-education, health affirmations, engagement and motivational interviewing techniques to help the client improve their insight in regards to how emotional and mental health affects their overall physical health. Mental health services can be delivered through a variety of formats, including:

Individual Psychotherapy

Individual psychotherapy insight oriented, behavior modifying, and / or supportive psychotherapeutic intervention delivered to one client. Individual psychotherapy is short term in

duration and can last up to 36 sessions and can be most useful when client goals are specific. Mutually defined goals are recommended to focus treatment and measure progress.

If treatment goes beyond 36 sessions during the program year, additional sessions may be requested through the Division of HIV/STD Programs, utilizing the HIV/AIDS Mental Health Treatment Service Authorization Request Form located at: http://publichealth.lacounty.gov/dhsp/ under the tab designated "For Contractors".

For each client in individual therapy, provider shall:

- Conduct a Mental Health Assessment (Psychiatric Diagnostic Interview) on an annual basis.
- Develop a Treatment Plan
- Provide Follow Up as indicated in treatment plan, noting outcome of mental health intervention/s and treatment progress in Progress Notes

Service	Duration of Face to Face	Code	Allowable Discipline
Psychotherapy 0 minutes	0-15 minutes	H0046	• MD/DO (Licensed) • PhD/PsyD (Licensed or Waivered) • SW (Licensed, Registered or Waivered) • MFT (Licensed, Registered, or Waivered) • Authorized (NP) or Authorized CNS (Certified) • RN (Masters in Psychiatric Mental Health Nursing % listed as a psychiatric-mental health nurse with the BRN) • Professional Clinical Counselor (Licensed or Registered)
Psychotherapy 30 minutes	16-37 minutes	90832	
Psychotherapy 45 minutes	38-52 minutes	90834	
Psychotherapy 60 minutes	53+ minutes	90837	

Psychotherapy for Crisis

Psychotherapy for Crisis is defined as an implementation of psychotherapeutic interventions to minimize the potential for psychological trauma while a client is in a crisis state. It is delivered to clients who are experiencing a life event that adversely affects ability to adhere to HIV care or engage in risk reduction activities. The presenting problem is typically complex and requires immediate attention to a client in distress. The treatment includes psychotherapy,

mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma.

Psychotherapy for Crisis differs from Crisis Intervention in that it is a short-term intervention, lasting less than three weeks in duration, for the purpose of stabilizing a client's mental health status, whereas Crisis Intervention is focused on minimizing the immediate stress of a particular event and aims to immediately improve the individual's coping strategies in the moment that the crisis occurs, or initiate a psychiatric hospitalization if the client is having a life threatening mental health crisis.

Service	Code	Allowable Discipline
Psychotherapy for Crisis: Implementation of psychotherapeutic interventions to minimize the potential for psychological trauma while a client is in crisis state.	90839	Licensed, Registered or Waivered

Note:

- *There must be an objective on the Client Care Plan related to the services provided during Psychotherapy in Crisis or documented discussion of whether or not an objective on the Client Care Plan is needed.*

Recipients of psychotherapy for crisis must:

- Have a mental health diagnosis as determined by an emergency assessment
- Be in need of immediate response, due to an increase of mental health symptoms that put the recipient at risk of one of the following:
    - Needing a higher level of care
    - Worsening of symptoms without mental health intervention
    - Significant disruption of normal functioning in at least one life area, such as self-care or housing

A recipient may receive one session of psychotherapy (including psychotherapy for crisis) prior to receiving a diagnostic assessment.

Psychotherapy for crisis services must include:

- Emergency assessment of the crisis situation (does not take the place of a diagnostic assessment)
- Mental status exam
- Psychotherapeutic interventions to reduce the crisis
- Development of a post-crisis plan that addresses the recipient's coping skills and community resources

Group Psychotherapy

- Appropriate for individuals who because of the nature of their emotional, behavioral, or social dysfunctions can derive benefit from treatment in a group setting
- Provided by one mental health professional for 3-8 recipients
- Provided by two mental health professionals for 9-12 recipients
- Group size cannot exceed 12 recipients
- Group size applies regardless of the number of mental health recipients in the group
- May be used with interactive complexity add-on

Psychotherapeutic Groups are groups with the following components:

- Personal and group dynamics that are discussed and explored in a setting that allows for emotional catharsis, instruction, peer reinforcement and support
- Utilization of psychotherapeutic theories to assist clients with meeting goals
- Structure in terms of attendance policy, number of clients present, and format of the group
- Specific curriculum and interventions

For each client in group therapy, provider shall:

- Conduct Mental Health Assessment (Psychiatric Diagnostic Evaluation) for each person receiving group services to ensure that the client is appropriate for the group and to ensure that the group is an appropriate intervention.
- Develop Treatment Plan
- Provide follow up as indicated in treatment plan, noting outcome of mental health intervention in Progress Notes

Service	Code	Allowable Discipline
Family Psychotherapy with One Client Present: defined as Psychotherapy delivered to a family with the intent of improving or maintaining the mental health status of the client. Only one claim will be submitted. **Note: Family Psychotherapy without the client present**: is not a reimbursable service. Psychotherapy can only be delivered to the enrolled client.	90847	• MD/DO (Licensed) • PhD/PsyD (Licensed or Waivered) • SW (Licensed, Registered or Waivered) • MFT (Licensed, Registered, or Waivered) • Authorized (NP) or Authorized CNS (Certified) • RN (Masters in Psychiatric Mental Health Nursing %

Family Psychotherapy with More than One Client Present is defined as Psychotherapy delivered to a family with the intent of improving or maintaining the mental health status of the client. One claim will be submitted for each client present or represented. **Note: Family Psychotherapy without the client present**: is not a reimbursable service. Psychotherapy can only be delivered to the enrolled client.	90847	listed as a psychiatric-mental health nurse with the BRN) • Professional Clinical Counselor (Licensed or Registered)

Service	Code	Allowable Discipline
Multi-family Group Psychotherapy: is defined as psychotherapy delivered to more than one family unit each with at least one enrolled client. Generally, clients are in attendance.	90849	• MD/DO (Licensed) • PhD/PsyD (Licensed or Waivered) • SW (Licensed, Registered or Waivered) • MFT (Licensed, Registered, or Waivered) • Authorized (NP) or Authorized CNS (Certified) • RN (Masters in Psychiatric Mental Health Nursing % listed as a psychiatric-mental health nurse with the BRN) • Professional Clinical Counselor (Licensed or Registered)
Group Therapy (2 + clients present) - A therapeutic insight oriented, behavior modifying supportive services delivered in a group setting to more than one non-family client that focuses primarily on symptom reduction as a means to reduce functional impairments.	90853	

Family and Multi-Family Psychotherapy

The impact of HIV on the family system can be enormous. The overall goal of family psychotherapy is to help families improve their functioning, given the complications of living with HIV.

- For the recipient and one or more family members or caregivers whose participation is necessary to accomplish the recipient's treatment goals. *Family means* a person who is identified by the recipient (or recipient's parent or guardian) as being important to the recipient's mental health and may include (but not limited to) parents, children, spouse, committed partners, former spouses, person related by blood or adoption, or persons who are presently residing together as a family unit. Do not consider shift staff or other facility staff members at the recipient's residence as family
- Family members or primary caregivers do not need to be eligible for Mental Health Services
- If you believe the recipient's absence from the family psychotherapy session is necessary to carry out the recipient's treatment plan, document the length of time and reason for the recipient's absence; also document reason(s) for a family member's exclusion from family psychotherapy

Multi-family Psychotherapy

- Multiple family group psychotherapy is designed for at least two, but no more than five families, regardless of family members' mental health services eligibility status or the number of family members who participate in the family psychotherapy session
- Directed toward meeting the identified treatment needs of each recipient as indicated in the recipient's treatment plan
- If a recipient is excluded from a session, document the reason for and length of time of the exclusion
- Document reasons why a family member is excluded

Crisis Intervention

Crisis Intervention is an unplanned, expedited service lasting less than 24 hours, to or on behalf of a client to address a condition that requires a timelier response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a client to cope with a crisis, which may present as a life threatening mental health crisis. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting, and/or initiate a psychiatric hospitalization if the client is deemed a danger to self or others or is gravely disabled.

Examples of Crisis Intervention include services to clients experiencing acute psychological distress, acute suicidal ideation, the inability to care for themselves (including provision/utilization of food, clothing and shelter), or present as a danger to others, all due to a mental disorder.

Service activities may include, but are not limited to: assessment; collateral and therapy to address the immediate crisis; and when warranted, initiation of a psychiatric hospitalization. Crisis Intervention activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community.

EXAMPLE OF CRISIS INTERVENTION ACTIVITIES:

- Client in crisis - assess mental status and current resources related to immediate crisis.
- Danger to self and others – assess and provide immediate therapeutic responses to stabilize crisis.
- Gravely disabled client/current danger to self – provide therapeutic responses to stabilize crisis.
- Client is in **imminent** danger to self/others - assess mental status due to severe reaction to current stressors. Assess for suicidal ideation and if the client has a plan to harm self, intent to do so and access or means available to the client.
- Intimate Partner Violence- conduct safety assessment of client and client's living situation with partner.

Responding to a Crisis.

- Conduct a thorough imminent danger assessment;
- Establish the collaborative relationship;
- Identify the major problems, including crisis precipitants;
- Encourage an exploration of feelings and emotions;
- Explore alternatives and new coping strategies;
- Restore functioning through implementation of an action plan;
- Plan follow-up sessions.

Service	Code	Allowable Discipline
Crisis Intervention: a service lasting less than 24 hours which requires a timelier response that a regularly scheduled visit and is delivered at a site other than a Crisis Stabilization program. (§1810.209)	H2011	Any staff operating within his/her scope of practice.

Note: A Crisis Intervention progress note documents a service to address an immediate mental health emergency and describes the nature of the crisis, the crisis stabilization interventions used, and the client's response and the overall outcome.

Targeted Case Management Services

Mental Health Targeted case management (MHTCM) interventions require a high level of clinical social work expertise. Mental health Targeted case management (MHTCM) is a comprehensive service that aims to enhance treatment effectiveness and outcomes with the goal of maximizing mental health recovery and resilience options and natural supports for the patient.

The mental health targeted case manager is often a "first responder," addressing complex crises involving both psychological and environmental components. For example, if a person with a mental health disorder

decompensates, he or she is often at risk for homelessness. Preventing relapse may involve directly supporting the "holding environment," while preventing homelessness may involve temporarily removing the relapsing client from a stressful living situation. In such situations, the clinical case manager may simultaneously be working psychotherapeutically with the client, collaborating with a psychiatrist and consulting with family members.

Targeted case management involves assessment of mental health disorder, engagement of the patient, treatment planning, linkage with resources, collaboration with psychiatrists, patient psychoeducation, and crisis intervention. At least 51 percent of contacts need to be face-to-face.
Targeted case management is a service that assists mental health clients gain access to needed medical, social, educational, vocational, financial and other necessary services as they relate to the patient's mental health and HIV medical needs.

Targeted Case Management Treatment plan to include:

- Goals and objectives of treatment;
- Treatment strategy;
- A schedule for accomplishing treatment goals and objectives, and
- Treat the symptoms and dysfunctions determined in the diagnostic assessment;
- Enhance daily living skills;
- Improve functioning in education and recreation settings;
- Improve interpersonal and family relationships;
- Assist in obtaining transportation, housing, health services, and employment.

Service	Code	Allowable Discipline	Calendar Year Threshold
Targeted Case Management Services needed to access HIV related medical, alcohol and drug treatment programs and other social services. These services, whether face-to-face, by telephone, or through correspondence, provide for the continuity of care within the mental health system and related social service systems. Services include linkage and consultation, placement and plan development in the context of targeted case management services.	T1017	Licensed, Registered or Waivered	

Community Outreach Services

Community Outreach Services enable the mental health system to reach the community-at-large, and provide a proactive way for the system to address the needs of those who do not or will not utilize traditional mental health services, especially populations at risk. Community Outreach Services are composed of: Mental Health Promotion and Community Client Services.

Mental Health Promotion

Staff share general or specific information about the availability and use of mental health services to the general community and/or particular target populations. These efforts are designed to reduce the stigma of mental health disorders to maximize normalization of life style for those who have mental disorders. The goals of such services are to develop community awareness of its mental health resources, and the factors that call for mental health interventions. Such information may assure a higher comfort level in utilizing services. This activity may include dissemination of information about mental health resources in the community, hours of operation, program changes, etc. Providing education and/or consultation to individuals' and communities' regarding mental health services programs, in order to prevent the onset of mental health problems.

Community Client Services

This includes targeted outreach to identify clients living with HIV suffering from mental health issues such as meeting newly diagnosed clients at HIV counseling and testing sites upon learning of their HIV diagnosis. Strengthening individuals' and/or communities' skills and abilities **during** a stressful life situation through short-term intervention (e.g., "secondary, tertiary prevention"). Enhancing or expanding knowledge and skills of human service agency staff to handle mental health problems of a specific client.

Service	Code	Allowable Discipline
Community Outreach Services-Mental Health Promotion Services delivered in the community-at-large to special groups, human service agencies, and to individuals and families who are not clients of the mental health system. Services shall be directed toward: (1) enhancing and/or expanding agencies or organizations' knowledge and skills in the mental health field for the benefit of the community-at-large or special population groups, and (2) providing education and/or consultation to individuals and communities regarding mental health service programs in order to prevent the onset of mental health problems.	P200	All disciplines
Community Outreach Services-Community Client Services Services delivered in the community-at-large to special populations, human service agencies, and to individuals and families who are not clients of the mental health system. Services shall be directed toward (1) assisting individuals and families for whom no case record can be opened to achieve more adaptive level of functioning	P201	All disciplines

Neuropsychological Assessment

Neuropsychological services:

- Include assessment and testing
- Identify the internal and external restrictions of a recipient's cognitive, emotional, behavioral and social impairments
- Are skills-based interventions provided to recipients with neurological disorders that result in cerebral dysfunction

Neuropsychological assessment is a specialized clinical assessment of the recipient's underlying cognitive abilities related to thinking, reasoning and judgment. The assessment must be conducted by a qualified neuropsychologist.

The following components are included in the service. Do not bill for them separately:

- Face-to-face interview
- Interpretation of test results
- Preparation and completion of a written report
- Face-to-face feedback provided to recipient as part of the assessment process

A recipient is eligible for a neuropsychological assessment if at least one of the following criteria is met:

1. A brain disorder is known or strongly suspected to exist because of the patient's medical history or a neurological evaluation.

2. Cognitive or behavioral symptoms suggest the recipient has an organic condition that cannot be readily attributed to functional psychopathology.

Neuropsychological Testing

Neuropsychological testing means administering standardized tests and measures designed to evaluate the recipient's ability to attend to, process, interpret, comprehend, communicate, learn and recall information use problem solving and judgment. Neuropsychological testing must be administered or clinically supervised by a qualified neuropsychologist, validated in a face-to-face interview between the recipient and a qualified neuropsychologist.

A recipient is eligible for neuropsychological testing when the recipient has one of the following:

- A significant mental status change that is not a result of a metabolic disorder and has failed to respond to treatment
- In children or adolescents, a significant plateau in expected development of cognitive, social, emotional or physical function relative to peers

- In children or adolescents, a significant inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional or physical demands
- A significant behavioral change, memory loss or other organic brain injury
- Suspected neuropsychological impairment in addition to functional psychopathology
- Traumatic brain injury
- Stroke
- Brain tumor
- Substance abuse or dependence
- Cerebral anoxic or hypoxic episode
- Central nervous system infection or other infectious disease
- Neoplasms or vascular injury of the central nervous system
- Neurodegenerative disorder
- Exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction
- Systemic medical condition known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathies, cardiac anomalies, sickle cell disease and related hematologic anomalies, and autoimmune disorders such as lupus erythematosus or celiac disease
- Condition presenting in a manner making it difficult for a clinician to distinguish between the following:
- the neurocognitive effects of a neurogenic syndrome (such as dementia or encephalopathy) and
- A major depressive disorder when adequate treatment has not resulted in improvement in neurocognitive functioning, or another disorder (for example, autism, selective mutism, anxiety disorder, or reactive attachment disorder)

Service	Code	Allowable Discipline
Neurobehavioral Status Exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities)	96116 Interpretation and report writing	Licensed PhD/PsyD Trained MD/DO
Neuropsychological Testing (e.g. Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Care Sorting Test)	96118 Face to face administration; interpretation and report writing	Licensed PhD/PsyD Trained MD/DO

Neuropsychological Testing (e.g. Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Care Sorting Test)	96119 Face to face administration; interpretation and report writing	Qualified Health Care Professional
Neuropsychological Testing (e.g. Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Care Sorting Test)	96120 Administration by computer; interpretation and report writing	Qualified Health Care Professional

Psychological tests and other psychometric instruments are used to determine the status of a recipient's mental, intellectual, and emotional functioning. Tests must meet psychological standards for reliability and validity, and be suitable for the diagnostic purposes for which they are used. Except when psychological tests are computer administered the following components of psychological testing are considered to be ***all-inclusive*** and cannot be billed separately:

- A face-to-face interview to validate the test;
- Administration and scoring
- Interpretation of results; and
- A written report to document results of the test(s).

Computer administered testing may be billed separately when the other components are conducted by a psychologist or psychological technician.

Service	Code	Allowable Discipline
Psychological Testing (Includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g, MMPI, Rorschach, WAIS)	96101 Face to face administration; interpretation and report writing	Licensed PhD/PsyD Trained MD/DO
Psychological Testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg MMPI, Rorschach, WAIS)	96102 Administration by computer; interpretation and report writing	Qualified Health Care Professional

Psychological Testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology)	96103 Administration by computer; interpretation and report writing	Qualified Health Care Professional

Notes:

- Providers must document and submit a claim for the administration of tests on the day of the administration indicating which tests were administered.
- Interpretation and report writing must be completed in accord with documentation timelines and by the same person as testing. The note should document tests administered, interpretation, and writing of the report; the interpretation and report writing time should be "other time".
- When interpretation and report writing are completed on another day, a separate note for that activity should be documented with no face-to-face time and referencing the report filed in the clinical record. When testing and interpretation and report writing are done by different staff categories (one by licensed and the other by Qualified Health Professional) each staff should document their activities and time independently.
- Scoring time is NOT reimbursable

Service	Code	Allowable Discipline
Review of Records Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for: • Assessment and/or diagnostic purposes • Plan Development (development of client plans and services and/or monitoring a client's progress) when not in the context of another service.	90885	All disciplines
No-contact Report Writing Preparation of reports of client's psychiatric status, history, treatment, or progress to other treating staff for care coordination when not part of another service.	90889	All disciplines

Notes:

- When claiming for Review of Records there must be clear documentation regarding how the information reviewed will inform the assessment, diagnosis, and/or treatment plan.
- No Contact-Report Writing does not include activities such as writing letters to notify clients that their case will be closed.

CLINICAL DOCUMENTATION

It is the clinician's responsibility to adequately and accurately document the results of the mental health session. Clinical documentation shall be maintained in the client record (electronic or paper).

Services that are not supported by required documentation in the client's record are subject to recoupment.

Clients for whom services are billed must have the following documentation included in their records and the documentation must comply with these standards:

- All entries must be clearly documented and legible to individuals other than the author.
- All entries must be dated (month/day/year) and signed by the performing provider.

Documentation:

- Notations of the beginning and ending session times

All pertinent information regarding the client's condition to substantiate the need for services, including but not limited to the following:

- Diagnosis
- Behavioral observations during the session
- Narrative description of the counseling session
- Narrative description of the assessment, treatment plan, and recommendation

Psychiatric Diagnostic Interview

Use form DHSP-532 to complete a full mental health assessment/diagnostic interview.
See Appendix E.

he mental health assessment The Psychiatric Diagnostic Interview is designed to provide a comprehensive clinical picture of the client, to establish service necessity, to help treatment teams and clients define goals and objectives, and to fulfill State and Federal requirements. **Assessments to be updated annually**.

ASSESSMENT INCLUDES:

- Assessor Information
  - Name
  - Discipline
- Identifying Information

    - Name of Client
    - Date of Birth
    - Gender
    - Ethnicity
    - Preferred language
    - Other relevant information
- Presenting problem(s): The client's chief complaint, history of presenting problem(s), including current level of functioning, relevant family history and current family information;
    - Precipitating Event
    - Current Symptoms/Behaviors Including intensity, duration, onset and frequency
    - Impairments in Life Functioning
    - Client Strengths: Documentation of the beneficiary's strengths in achieving client plan goals;
        - Client strengths to assist in achieving treatment goals
    - Mental Health History: Previous treatment, including providers, therapeutic modality (e.g. medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;
        - Psychiatric Hospitalizations including dates, locations and reasons
        - Outpatient Treatment, Recommendations, Satisfaction with Treatment
        - Past Suicidal/Homicidal Thoughts or Attempts
        - Other relevant information
    - Risks: Situations that present a risk to the beneficiary and/or others, including past or current trauma;
        - History of Trauma or Exposure to Trauma
        - Other relevant information
    - Medications: Information about medications the beneficiary has received, or is receiving to treat mental health and medical conditions (i.e. HIV/AIDS, psychotropic medication). Including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;
        - Medication
        - Dosage/frequency
        - Period Taken

The completion of a **Psychiatric Diagnostic Interview** establishes the foundation for an included diagnosis and impairments in life functioning.

The **Treatment Plan** is the point where the diagnosis and impairments are used to establish treatment goals/objectives and the proposed interventions to effect the identified objectives.

The **Progress Notes** document a service delivered that is related back to an intervention identified in the Client Treatment Plan. Progress notes should also note the progress the client is making towards his/her objectives.

    - Effectiveness, Response, Side Effect, Reactions
    - HIV Medication and treatment adherence issues, including: history, barriers, side effects, and coping skills
    - Other relevant information
- Substance Exposure/Substance Use: Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter and illicit drugs;
    - Risks
    - Use
    - Attitudes
    - Exposure
    - Other Relevant Information
- Medical History: Relevant physical health conditions reported by the client or a significant support person. Include name and address of current source of medical treatment. For children and adolescents: include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;
    - Doctor's name and contact information
    - HIV-related medical history;
        - including: month and year of HIV diagnosis, date and results of last T-cell count and viral load, and history and current presence of any HIV-related illnesses or symptoms
    - Sexually Transmitted Infections, diagnosed within the last year
    - Allergies
    - Relevant medical information
    - Developmental History (for children)
    - Developmental milestones and environmental stressors (for children)
- Relevant conditions and psychosocial factors affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;
    - Education/School history, status, aspirations
    - Employment History/Vocational Information including means of financial support (for adults)
    - HIV Risk Behaviors and Risk/Harm Reduction
        - History of sexual risk behaviors, barriers to change, and risk/harm reduction concerns
        - Partner Disclosure/Notification
    - Legal/Juvenile court history and current status
    - Child Abuse/protective service information (for children)
    - Dependent Care Issues (for adults)
    - Current and past relevant Living Situations including Social Supports
    - Family History/Relationships
    - Family Strengths (for children)
    - Other relevant information
- Mental Status Examination;
    - Mental Status Examination

- Clinical formulation based on presenting problems, history, mental status examination and/or other clinical data;
    - Clinical formulation
- A diagnostic descriptor consistent with the clinical formulation
    - Diagnostic descriptor
- A code from the most current ICD codes set shall be documented consistent with the diagnostic descriptor;
    - ICD diagnosis code
    - Specialty Mental Health Services
- Signature of a staff person allowed to perform a Psychiatric Diagnostic Assessment per the procedure code guide
    - Staff signature, discipline/title, identification number (if applicable) and date

Note: assessments must be done at least annually, however, updates can be done at any time:

- When there is a significant change in the client's level of functioning or diagnostic impressions
- Annually, prior to the expiration of the previous period of authorization
- When an initial assessment has not sufficiently addressed the required elements to justify necessity (e.g. level of impairment).

Friends or family members should not be expected to provide language interpretation services for clients

Returning Client Assessment

Assessments for returning clients (i.e. clients returning for services after termination of services or 180 days of inactivity and not requiring a new Clinical Record) must be completed within 60 days of the initiation of services related to assessment and treatment. For clients returning to services the Re-Assessment should be used.

Supplemental Co- Occurring Disorders Assessment

USE FORM DHSP 633 to access for Co-Occurring Disorders. See Appendix G.

- Substance Exposure/Substance Use: Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter and illicit drugs;
    - Family History
    - Risks
    - Use
    - Attitudes
    - Exposure
    - Other Relevant Information
    - Readiness to change/treatment plan identification

Treatment Plan

Use form DHSP-636 to complete client treatment plan. See Appendix H.

All treatment services provided under the following types of services must be associated with an objective(s) on the Client Treatment Plan:

- Mental Health Services
- Medication Support Services
- Targeted Case Management Services

The plan of care is a primary way of involving clients in their own care. The development of the Client Treatment Plan is an interactive process with the client designed to establish the client's treatment goals, to develop a set of objectives that clearly address the symptoms, behaviors/and or impairments identified in the client assessment and utilize the client's strengths to help them achieve their goals.

Evidence of client participation in the treatment process is documented by obtaining the signature of the client and providing a copy of the plan to the client. Giving a copy of the plan to the client is an important acknowledgment of their participation in its development and of the clinician's commitment to involving clients/families as full participants in their own recovery process.

Treatment plans are developed in collaboration with the client and focuses on individualized, strengths-based services, involving supports and family to determine the course of treatment. Treatment plan goals should address mental health issues that prevent access to and retention in primary HIV medical care.

Treatment plans must be completed for all treatment services provided to the client and must be at a minimum updated **every six (6) months** with the client and/or when services are added or modified. Treatment plan reviews and updates shall be documented in a progress note, which includes outcome(s) from the previous plan.

TREATMENT PLAN ELEMENTS

- Statement of long-term goals (treatment outcome)
- Goals/treatment objectives related to the client's mental health needs and functional impairments that are specific, measurable/quantifiable, achievable, realistic, time-bound (SMART);
- Proposed types(s) of service including modality (e.g. individual vs group, rehabilitation vs therapy) (when appropriate);
- Detailed description of the proposed interventions designed to address the identified functional impairments;
- Proposed frequency and duration (if less than one year) of interventions;
- Client and family involvement
- Evidence the client was offered a copy of the plan

- Required staff signature, discipline/title, identification number (if applicable) and date (see below for additional information)
- Client/Responsible Adult Signature and Date (see below for additional information)

Treatment Plan Update:

Each objective associated with treatment services on the client treatment plan shall be reviewed, renewed, updated/modified or deleted (as appropriate) prior to the due date to services being provided after the review date.

An updated client treatment plan shall also be completed **annually** or as **clinically appropriate** (i.e. when a change in treatment is warranted). This would include adding an objective(s) and/or intervention(s) or editing an objective(s) and/or intervention(s) on the current client treatment plan.

Psychotherapy in Crisis

- The mental health professional or clinical trainee must clearly document:
- Factors that make the mental health crisis life threatening or complex
- History of the crisis
- Results of the mental status exam
- Recipient's coping skills used to reduce the crisis
- Community resources used
- Psychotherapy techniques and interventions used and the recipient's response
- Protective and risk factors that influenced the outcome of the intervention
- Reason for the particular services chosen
- Steps taken to assure the recipient's safety after the intervention

Progress Notes

Use form DHSP-515 to document individual and group progress notes and all other service contacts. See Appendix D.

Use form DHSP-655 to document medication management progress notes. See Appendix I.

There must be a brief written description in the client record each time services are provided.

Progress Notes provide a means of communication and continuity of care between all service delivery staff as well as provide evidence of the course of the client's illness (behavior) and/or condition. Progress notes must be used to describe how services reduced impairment, restored functioning or prevented significant deterioration in an important area of life functioning as outlined in the Client Treatment Plan. Use your judgment; progress notes are used to inform the on-duty clinician and other clinicians about the client's treatment, to document and claim for services, and to provide a legal record. Progress notes may be read by clients and/or family members and should be written in a manner that supports client-centered, recovery based and

culturally competent services. Aim for clarity and brevity when writing notes – lengthy narrative notes are discouraged when recording ongoing services.

The following elements MUST be present in a Progress Note:

- date of service;
- procedure code;
- duration of service (face to face time and all other time);
    - Face to face time is the time spent providing a service to a client who is physically present.
    - Other time includes time spent documenting or travelling to a reimbursable service.
- description of the service provided and relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
- Staff signature, discipline/title, license number (if applicable) and date documented;
- Progress towards treatment plan goals;
- Interventions applied, location of interventions and the client's response to interventions;
- Results of education about medication side effects, and counseling regarding psychotropic medication adherence;
- Document adherence to HIV medication/medical care and interventions provided
- Document Risk Behaviors and interventions provided (if clinically necessary)
- Referrals to community resources and other agencies, when appropriate;
- Client follow-up activities, including contacts, attempted contacts, and written correspondence provided;

<u>Group Summary Notes</u>

- For Group Therapy, the group log shall list the total number of participants in the group regardless of Ryan White eligibility status
- For groups with a mix of clients by eligibility status, clinicians shall write the full name of Ryan White clients, along with initials of non-Ryan White clients. For this group service to be documented properly, **the log must reflect the total number of people that received treatment in the group**
- Group log (sign-in sheet) shall be signed
- Group log date shall correspond with group note date
- The group intervention provided by the therapist may be the same because it is presented in a group format
- A group note must be completed and indicate the name, date and signature of the licensed therapist for each group delivered
- Group summary note shall indicate the group issues, dynamics and discussions of the group participants
- Group summary note shall indicate the group interventions provided by the group therapist

- Group summary note shall be placed in a separate binder with the sign-in sheet for that group.

Group Notes for Individual Group Members

- Individual client group note shall be placed in the client chart.
- Individual group member progress noted are kept in the client's chart
- Note must indicate client participation
- Interventions provided by therapist for the client
- Group note shall NOT be identical for each client/group participant note. (The theme may be the same for each note, but the ***behavior*** of the client should be individualized along with the client's ***response*** to the intervention)

Code of Federal Regulations, title 45, section 164, parts 501 (45 CFR 164.501) (psychotherapy notes)
Code of Federal Regulations title 45, section 160, parts 203 (45 C.F.R. 160.203 (b)) (Release of Privacy)

Medication Consent

Use form DHSP-556 to document individual and group progress notes and all other service contacts. See Appendix F.

If medications are prescribed, there must be a medication consent form (DHSP Form 556) completed that includes the following elements:

- The reason for taking such medications
- Reasonable alternative treatments available, if any
- Type of medication
- Range of frequency (of administration)
- Amount (dosage)
- Method of Administration
- Duration of taking the medication
- Probable side effects
- Possible additional side effects if taken longer than 3 months
- Consent once given may be withdrawn at any time
- Date of medication consent
- Signature of person providing the services, type of professional degree and licensure/job title

REIMBURSEMENT RULES

Key Points Applicable to One or More Mode of Services

- Every claim must be supported by a progress note that must be present in the clinical record prior to the submission of the claim.
- All covered services must be provided under the direction (CCR 1840.314) of an Authorized Mental Health Discipline (AMHD) and as designated by the Program Manager: Examples of service direction includes, but are not limited to:
    - Being the person providing the service
    - Acting as a clinical team leader
    - Director or Functional supervision of service delivery or
    - Approval of Treatment Plans

    - Services shall be provided within the scope of practice of the person delivering the service, if professional licensure is required for the service (CCR 1840.314) and his/her employer's job description/responsibility. The local mental health director shall be responsible for assuring that services provided are commensurate with the professionalism and experience of the staff utilized.
    - Services should be provided in the setting and manner most appropriate to the treatment and service needs of the client (State DMH Letter No.: 02-07)

General Documentation Rules

- Special client needs as well as associated interventions directed toward meeting those needs must be documented (LACDMH Policy 401.03):

    Visual and hearing impairments

    Client's whose primary language is not English - Clients should not be expected to provide interpretive services through friends or family members. (See LACDMH Policy #200.03, "Language Interpreters", for further information.). Oral interpretation and sign language services must be available free of charge (State Contract)

- All entries in the client record shall include:
    - The date of service
    - The signature of the person providing the service (or electronic equivalent)
    - The person's type of professional degree, licensure, or job title
    - Relevant identification number (if applicable)
    - The date the documentation was entered in the client record

NOTE: The signature (or electronic equivalent) of EACH person providing a service must be present

NOTE: When identifying professional license, abbreviations are acceptable so long as they are industry accepted abbreviations (e.g. LCSW, RN, MFT Intern, MD, etc). If staff does not have a professional license/title, then job title should be identified. Job title should be based on functional role such as case manager, mental health rehabilitation

specialist, and care coordinator. Abbreviations for job title should not be used unless the Agency has an official list of job titles and their abbreviations. The relevant identification number includes License, certification or registration numbers.

- Co-signatures may **NEVER** be used to allow a staff person to perform a service that is not within his/her scope of practice. Co-signing a document means the co-signer has supervised the service delivery and assumes responsibility and liability for the service.
- A service is an individual service when services are directed towards or on behalf of only one client.
- A service is a group service when services are directed towards or on behalf of more than one client at the same time. For group services, the staff members' time must be prorated to each client based on the total number of persons receiving the service.

NON-REIMBURSABLE SERVICES

- Crisis Stabilization is a package program and no other specialty mental health services are reimbursable during the same period this service is reimbursed [CCR Title 9, §1840.368(b)].

- Mental Health Services are not reimbursable when provided to persons aged 22 through 64 who are residents of an Institution for Mental Disease (IMD) [CCR Title 9, §1840.312(g). An IMD is defined as a hospital nursing facility, or other institution that has minimally more than 16 beds and is primarily engaged in providing diagnosis, treatment or care of persons with mental illness, including medical attention, and related services (CCR Title 9, §1810.222.1); [Title 42, CFR §435.1009(b)(2)]. As such, a free standing Psychiatric Hospital or a State Hospital qualifies as an IMD.

- A client under 21 years of age resides in an IMD other than a Psychiatric Health Facility (PHF) that is a hospital or an acute psychiatric hospital, except if the client under 21 years of age was receiving such services prior to his/her 21st birthday. If this client continues without interruption to require and receive such services, the eligibility for Federal Financial Participation (FFP) dollars continues to the date he/she no longer requires such services, or if earlier, to his/her 22nd birthday.

- **Services provided to children or adolescents in a juvenile hall setting are only reimbursable when the minor has been adjudicated and is awaiting suitable placement.** (Title 22 CCR 50273 and State DHCS Letter No. 12-2). Judicial legal orders from the court must be issued and indicate that the continuing detention in the juvenile hall setting is for the safety and protection of the minor based on criteria outlined in (WIC 628); i.e. the minor is not being detained for reasons related to arrest or violation of probation.

- Services of clerical support personnel are not reimbursable [CCR Title 9, §1830.205(b) (3)]. While it may be appropriate at times to record in the clinical record activities or observations of these personnel, their cost is included in overhead rates, for which the

Department receives a percent of reimbursement, so these services should not be separately claimed.

- Clerical activities performed by any staff are not reimbursable. While it is important to document in the clinical record when information is faxed or mailed, these activities are clerical and are not reimbursable. They should be documented in a separate note from the reimbursable service identifying that no time was claimed for these activities.

- Travel time between two provider sites (i.e. two billing providers) is not reimbursable. Travel time may only be claimed from a provider site to an off-site location.

- Supervision time is not reimbursable. Supervision focuses on the supervisee's clinical/educational growth (as when meeting to monitor his/her caseload or his/her understanding of the therapeutic process) and is NOT reimbursable time. Supervision time required by Department policy or State licensing boards always falls within this definition and thus, is never reimbursable.

- Missed Appointments, documentation in clinical record regarding missed appointment, leaving a note on a door, scheduling or re-scheduling an appointment.
- Administration of outcome measures for research purposes, such as submitting or analyzing results to measure the EBP treatment efficacy.
- Inputting of data (e.g., symptom scale scores) into an EBP developer's 'treatment progress monitoring website'
- Phone calls to remind clients of appointments including leaving a message on an answering machine
- Transportation services
- Computer search time
- Consultation with the developer of a treatment practice/protocol
- Administrative Discharge Summary
- Services provided after the death of a client may not be claimed
- Conservatorship investigations
- Payee related services
- Vocational, educational, recreational, socialization activities (i.e. assisting with coursework or group outing)
- Translation or interpretive services
- Providing therapy to a client's significant support person. This would not be billed as individual
  Therapy.
- Facilitating drop-in groups and presentations by pharmaceutical companies

Appendices

This section provides samples of forms for use when providing services. They may be downloaded at: http://publichealth.lacounty.gov/dhsp/InfoForContractors.htm#PROGRAMS.

Appendix A: HIV/AIDS Mental Health Diagnosis and Assessment Measure Form

The Mental Health Diagnosis and Assessment Measure is a clinician administered tool that track changes in the individual's symptom presentation and captures their DSM-5 diagnosis category over time. It is intended to help clinicians identify additional areas of inquiry that may have significant impact on the individual's treatment and prognosis. Each item asks about how much (or how often) the individual has experienced the specific symptom during the past 30 days.

Each item on the measure is rated on a 5-point scale (0=none or not at all; 1=slight or rare, less than a day or two; 2=mild or several days; 3=moderate or more than half the days; and 4=severe or nearly every day). The score on each item within a domain should be reviewed. Because additional inquiry is based on the highest score on any item within a domain, the clinician is asked to indicate that score in the "Highest Domain Score" column. A rating of mild (i.e., 2) or greater on any item within a domain (except for substance use, suicidal ideation, sexual behavior and psychosis) shall serve as a guide for additional inquiry. For substance use, suicidal ideation, sexual behavior and psychosis, a rating of slight (i.e., 1) or greater on any item within the domain indicates a need for further follow-up to determine if a more detailed assessment and/or immediate action is needed.

This tool shall be completed at regular intervals as clinically indicated, **but at a minimum at baseline and every 90 days thereafter. Results shall be captured in the Casewatch data system.** Consistently high scores on a particular domain may indicate significant and problematic symptoms for the individual that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide decision making. This measure consists of 27 questions that assess 15 domains and includes collection of the mental health diagnosis, medication status and HIV risk behavior practices.

Domain	Domain Name	Threshold to guide further inquiry
I.	Depression	Mild or greater
II.	Anger	Mild or greater
III.	Mania	Mild or greater
IV.	Anxiety	Mild or greater
V.	Trauma	Mild or greater
VI.	Suicidal Ideation	Slight or greater
VII.	Psychosis	Slight or greater
VIII.	Sleep Problems	Mild or greater
IX.	Memory	Mild or greater
X.	Repetitive Thoughts and Behaviors	Mild or greater
XI.	Stigma	Mild or greater
XII.	Personality Functioning	Mild or greater
XIII.	Substance Use	Slight or greater
XIV.	Sexual Behavior	Mild or greater
XV.	Dissociation	Mild or greater

Mental Health Diagnosis Collection Form

Name: _____ **Date of Birth:** _____ **Today's Date:**

Gender: ❑ Male ❑ Female ❑ Transgender **Date of last HIV primary care visit** _____

Legal: Was client incarcerated within the past 90 days? ❑ Yes ❑ No

Currently:

HIV Medications**:** ❑ Prescribed ❑ Not Prescribed

HIV Medication Adherence**:** ❑ Taking as prescribed ❑ Non-compliant

Psychotropic Medications**:** ❑ Prescribed ❑ Not Prescribed

Psychotropic Medication Adherence: ❑ Taking as prescribed ❑ Non-compliant

Risk Behaviors in the past 90 days:

❑ Unprotected Sex
❑ Any Sex without disclosing HIV status
❑ Used Illicit drugs in order to engage in sexual activities
❑ None

DSM-5 MAJOR CATEGORIES OF MENTAL DISORDER* (Choose ONE from List Below)**

- ❑ Trauma- and Stressor-Related Disorders
- ❑ Anxiety Disorders
- ❑ Obsessive-Compulsive and Related Disorders
- ❑ Depressive Disorders
- ❑ Bipolar and Related Disorders
- ❑ Substance-Related and Addictive Disorders
- ❑ Disruptive, Impulse-Control, and Conduct Disorders
- ❑ Paraphilic Disorders
- ❑ Feeding and Eating Disorders
- ❑ Personality Disorders
- ❑ Schizophrenia Spectrum and Other Psychotic Disorders
- ❑ Dissociative Disorders
- ❑ Gender Dysphoria
- ❑ Neurodevelopmental Disorders
- ❑ Somatic Symptom and Related Disorders
- ❑ Sexual Dysfunctions
- ❑ Elimination Disorders
- ❑ Sleep-Wake Disorders
- ❑ Neurocognitive Disorders
    - **Major or Mild Neurocognitive Disorder Due to HIV Infection**

*** See **DSM-5 Diagnostic Categories Details** for more information

Assessment Measure Form

Name: _____ **Date of Birth:** _____ **Today's Date:**

Clinician reads to client: "I will ask about things that you may have experienced during the **past Two (2) WEEKS**. Tell me on a scale of 0-5, 0 being lowest, that best describes how much/how often you have been affected/impacted/concerned by each issue." Once completed, enter results into Casewatch. **Conduct at baseline and every ninety (90) days thereafter.**

	During the past **TWO (2) WEEKS**, how much (or how often) have you:	**None** Not at all	**Slight** Rare, less than two days	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score**
I.	1. Had little interest or pleasure in doing things?	0	1	2	3	4	
	2. Felt down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Felt more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Slept less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Started lots more projects than usual or doing riskier things than usual?	0	1	2	3	4	
IV.	6. Felt nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Felt panic or were unusually frightened?	0	1	2	3	4	
	8. Avoided situations that make you anxious?	0	1	2	3	4	
V.	9. Directly experienced or witnessed a traumatic event?	0	1	2	3	4	
	10. Attempted to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event?	0	1	2	3	4	
VI.	11. Had serious thoughts of hurting yourself?	0	1	2	3	4	
VII.	12. Heard things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Felt that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Had problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Had problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Had unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Felt driven to perform certain behaviors or mental acts over and over?	0	1	2	3	4	
XI.	18. Felt that people treated you differently because of your HIV status?	0	1	2	3	4	
	19. Felt out of place in society or that you do not belong?	0	1	2	3	4	
XII.	20. Not known who you were?	0	1	2	3	4	
	21. Not felt close to other people or enjoyed your relationships with them?	0	1	2	3	4	
XIII.	22. Drank at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	23. Used any medicines ON YOUR OWN, that is, without a doctor's prescription, or greater amounts or longer than prescribed OR illicit drugs?	0	1	2	3	4	
	24. Tried to reduce or stop your drug or alcohol use?	0	1	2	3	4	
	25. Engaged in sexual activity to numb painful feelings and/or memories OR to reduce anxiety?	0	1	2	3	4	
XIV.	26. Felt guilt or shame either before or after engaging in sexual activity?	0	1	2	3	4	
	25. Engaged in sexual activity to numb painful feelings and/or memories OR to reduce anxiety?	0	1	2	3	4	
XV.	27. Feeling detached or distant from yourself, your body, your physical surroundings, or from your memories?	0	1	2	3	4	

Appendix B: Affidavit of Non-Documentable Income Form

Affidavit of Non-Documentable Income Form

NOTE: Use this form only for clients who have NO documentable income source. Clients must be recertified every six (6) months or whenever there is a change in client's income.

I, _____, understand that Health Resources and Services Administration (HRSA), the federal agency that funds Ryan White Program services, requires verification of income to determine eligibility for services.

*Clients who receive income from any of the sources listed below can **NOT** use this form. Clients **MUST provide documentation** from that specific income source.*

Does client receive income from the sources noted below?	
Wages from employment (including commission, tips, and bonuses.	☐ Yes ☐ No
Income from operation of a business	☐ Yes ☐ No
Rental income from real or personal property	☐ Yes ☐ No
Interest or dividends from assets	☐ Yes ☐ No
Social Security, annuities, insurance policies, retirement funds, pensions or death benefits	☐ Yes ☐ No
Unemployment or disability payments	☐ Yes ☐ No
Public assistance payments – GR, etc.	☐ Yes ☐ No
Periodic allowances such as alimony, child support or gifts received from persons not in the household	☐ Yes ☐ No
Sales from self-employed resources	☐ Yes ☐ No

Verification Statement

I declare that my gross monthly income at this time is: $_____, and hereby certify that I **do not receive income** from any of the above sources. I gain income by: _____

_____

I understand that it is my responsibility to report any change in income, from any source, within 15 days after such change. I verify that all statements regarding my income are true and I understand that false, misleading or incomplete information may result in termination of services.

_____ _____
Client Signature Date

_____ _____
Case Manager (or Witness) Signature Date

Revised 8-30-2017 Page 1 of 1 Affidavit of No Documentable Income Form

Appendix C: Treatment Extension Request

HIV/AIDS Mental Health Service Treatment Authorization Request Form

Division of HIV and STD Programs (DHSP) will consider treatment service authorization requests for clients living with HIV/AIDS that are Ryan White eligible, or for those whose medical insurance does not cover mental health treatment. **Requests for authorization must be submitted PRIOR to the requested service start date.** A completed Mental Health Services Treatment Service Authorization Request form must be sent to the attention of the Contracted Community Services Division via **secure fax** to **(213) 381-8022** along with a letter on agency letterhead detailing the necessity of the request. The letter must be signed by the agency's executive director or designee.

Submissions made outside of the above parameters will be returned **unprocessed**. Previous approval of initial therapy or submission of this form does not guarantee approval of treatment sessions.

Ryan White is the payer of last resort, and as such, all health insurance coverage, including Medi–Cal and Medicare, must be utilized **prior** to the Ryan White program covering mental health sessions. For insured clients, you must **also submit** a treatment denial from the insurance carrier noting that mental health treatment requested is not covered and/or detailing the maximum number of sessions have been exhausted.

Request Date: _____ **Agency:** _____ Client ID # _____

Treating Clinician Name _____Signature _____

License# _____Phone: _____Email _____

Requesting:

☐ **Authorization for Underinsured client**

Insurance Carrier: _____

Also submit *a treatment denial from the insurance carrier noting that mental health treatment requested is not covered and/or detailing the maximum number of sessions have been exhausted.*

☐ **Session Extension**

Number of sessions requested: _____

Last date client received services _____

Requested treatment start date: _____

HIV/AIDS Mental Health Service Treatment Authorization Request Form
Page 2

Request Date: _____ **Agency:** _____ Client ID # _____

Date of last HIV Medical Visit: _____ Date Mental Health Clinician spoke with HIV provider: _____

Prescribed HIV medications? ☐ No ☐ Yes Adherent to HIV medications? ☐ No ☐ Yes ☐ Unsure

DSM Diagnosis: _____ **Reason for treatment sessions:**

Submitted by:

Licensed Clinician Name _____Signature _____Date_____

DHSP Use Only

_____	_____	_____
DHSP Program Manager Signature	Print Name	Date
☐Denied	☐Approved (# of Sessions) _____	
_____	_____	_____
DHSP Clinician's Signature	Print Name	Date
☐Denied	☐Approved (# of Sessions) _____	

Reason for denial:

_____

_____

_____

(Rev September 11, 2017)

Appendix D: Progress Notes - DHSP 515

DHSP 515
Revised 06/7/16

PROGRESS NOTE

Date: _____ Telephone contact: ☐ Y ☐ N Time Spent* (Hrs:Mins): _____

Procedure Code: _____

MHS Activity Type: ☐ Assessment ☐ Individual Tx ☐ PsyT ☐ Medication Mgmt ☐ Team Conf/Case Conference ☐ TCM ☐ Crisis Int

☐ Group Tx, # of Clients Represented _____ Group Topic: _____

Date of last HIV Medical Visit: _____ Adherent to HIV Medication: ☐ Y ☐ N

☐ Continued (Sign & Complete claim information on last page of note)

_____ _____ _____ _____
Signature & Discipline Date Co-signature & Discipline Date

This confidential information is provided to you in accord with applicable Welfare and Institutions Code Section. Duplication of this information for further disclosure is prohibited without the prior written consent of the patient/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Client Name:

Los Angeles County-Department of Public Health

Division of HIV and STD Programs

*Adapted from the Los Angeles County Department of Mental Health

Appendix E: Adult Full Assessment - DHSP 532

DHSP 532
Revised 10/19/17

ADULT DIAGNOSTIC ASSESSMENT

CLEAR FORM

Date of assessment _____

ASSESSING PRACTITIONER (NAME AND DISCIPLINE): _____

Client/Others Interviewed: _____

I. DEMOGRAPHIC DATA & SPECIAL SERVICE NEEDS:

DOB: _____ GENDER: _____ ETHNICITY: _____ Marital Status: _____

Referral Source:

☐ Non-English Speaking, specify language used for this interview: _____

Were Interpretive Services provided for this interview? ☐ Yes ☐ No

☐ Cultural Considerations, specify: _____

☐ Physically challenged (wheelchair, hearing, visual, etc.) specify: _____

☐ Access issues (transportation, hours), specify: _____

II. Reason for Referral/Chief Complaint

Describe **PRECIPITATING EVENT\$(S)/REASON FOR REFERRAL**

CURRENT SYMPTOMS AND BEHAVIORS (INTENSITY, DURATION, ONSET, FREQUENCY) and **IMPAIRMENTS IN LIFE FUNCTIONING** caused by the symptoms/behaviors (from perspective of client and others):

CLIENT STRENGTHS (to assist in achieving treatment goals)

SUICIDAL THOUGHTS/ATTEMPTS: *"Columbia Suicide Severity Rating Scale Screener (LACDMH Version)"*

Wish to be Dead: *Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.*

1. Within the past 30 days, have you wished you were dead or wished you could go to sleep and not wake up? ☐ Yes ☐ No

Suicidal Thoughts: *General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.*

2. Within the past 30 days, have you actually had any thoughts of killing yourself? ☐ Yes ☐ No

If YES to 2, ask questions 3, 4, 5, and 6
If NO to 2, go directly to question 6

Suicidal Thoughts with Method (without Specific Plan or Intent to Act): *Person endorses thoughts of suicide and has thoughts of at least one method during the assessment period.*

3. Have you been thinking about how you might kill yourself? ☐ Yes ☐ No

Suicidal Intent (without Specific Plan): *Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts.*

4. Have you had these thoughts and had some intention of acting on them? ☐ Yes ☐ No

Name: _____ ID#: _____

Agency: _____

Los Angeles County – Division of HIV and STD Programs

ADULT DIAGNOSTIC ASSESSMENT

Suicide Intent with Specific Plan: *Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.*

5. Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan? ☐ Yes ☐ No

Suicidal Behavior:

6. Have you done anything, started to do anything, or prepared to do anything to end your life? ☐ Yes ☐ No

If yes, How long ago did you do any of these?
Additional comments regarding suicidal thoughts/attempts:

Self-Harm (without statement of suicidal intent) ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe

III. MENTAL HEALTH HISTORY/RISKS

History of Problem Prior to Precipitating Event: Include treated & non-treated history.

Impact of treatment and non-treatment history: on the client's level of functioning, e.g., ability to maintain residence, daily living and social activities, health care, and/or employment.

PSYCHIATRIC HOSPITALIZATIONS: ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe **DATES, LOCATIONS, AND REASONS**

OUTPATIENT TREATMENT: ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe **DATES, LOCATIONS, AND REASONS.**

TRAUMA or Exposure to Trauma: ☐ Yes ☐ No ☐ Unable to Assess
Has client ever (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) been a combat veteran or experienced an act of terrorism, (5) been in a severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) been the victim of a crime?

Name: ID#:

Agency: Los Angeles County – Division of HIV and STD Programs

ADULT DIAGNOSTIC ASSESSMENT

IV. HIV AND PSYCHOTROPIC MEDICATIONS

Has the client ever taken psychotropic medications? ☐ Yes ☒ No ☐ Unable to Assess
Has the client ever taken HIV medications? ◯ Yes ◯ No ◯ Unable to Assess
List present medications used, prescribed/non-prescribed, by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.

PSYCHOTROPICS	DOSAGE/FREQUENCY	PERIOD TAKEN	EFFECTIVENESS/RESPONSE/SIDE EFFECTS/REACTIONS

HIV MEDICATIONS	DOSAGE/FREQUENCY	PERIOD TAKEN	EFFECTIVENESS/RESPONSE/SIDE EFFECTS/REACTIONS

Medication Comments (include medication adherence issues/history):

V. SUBSTANCE USE/ADDICTION Screening and Assessment

A. Alcohol Screening Questions — 1 Drink = 12 Ounces of beer, 5 Ounces of wine, or 1.5 Ounces of liquor

1. In the past year, how often did you have a drink containing alcohol? If "Never", proceed to Drug Screening Questions.	☐ Never (0)	☐ Monthly or less (1)	☐ 2-4 times a month (2)	☐ 3 times a week (3)	☐ 4+ times a week (4)
1a. In the past year, how many drinks containing alcohol did you have on a typical day when you are drinking?	☐ 1 or 2 (0)	☐ 3 or 4 (1)	☐ 5 or 6 (2)	☐ 7 to 9 (3)	☐ 10+ (4)
1b. In the past year, how often did you have six or more drinks on one occasion?	☐ Never (0)	☐ Less than monthly (1)	☐ Monthly (2)	☐ Weekly (3)	☐ Daily or almost daily (4)

Alcohol Screening Score: ☐ *(For a score of 4 or more, proceed to Assessment. A brief intervention is also indicated)*

Was a brief intervention provided? ☐ Yes ☐ No

B. Drug Screening Questions *("Yes" to any of the questions below indicates a positive screening)*

	Ever Used? Yes	Ever Used? No	Recently Used? (Past 6 Months) Yes	Recently Used? (Past 6 Months) No
1. Have you used nicotine products? *(Cigarettes, cigars, electronic cigarettes, smokeless tobacco)*	☐	☐	☐	☐
2. Do you use products containing caffeine, such as tea, coffee or high-caffeine energy drinks? *(Such as AMP, Monster, Red Bull or 5 Hour Energy*	☐	☐	☐	☐
3. Have you used opioids? *(Heroin, opium, non-prescribed pain medications)*	☐	☐	☐	☐
4. Have you used prescription medications, over the counter medications, and/or non-prescription supplements in a manner other than prescribed? *(For example, to get high)*	☐	☐	☐	☐
5. Have you used stimulants, such as cocaine or methamphetamine?	☐	☐	☐	☐
6. Have you used drugs intravenously?	☐	☐	☐	☐
7. Have you used drugs/alcohol as a means to engage in sexual activity?	☐	☐	☐	☐

C. Are you interested in changing your substance use patterns? ☐ Yes ☐ No ☐ NA

Name: ☐ **ID#:** ☐

Agency: ☐

Los Angeles County – Division of HIV and STD Programs

ADULT DIAGNOSTIC ASSESSMENT

Assessment/Additional Information (answer only if screening is positive)

PAST AND PRESENT USE OF TOBACCO, ALCOHOL, CAFFEINE, CAM (COMPLEMENTARY AND ALTERNATIVE MEDICATIONS) AND OVER-THE-COUNTER, AND ILLICIT DRUGS, if not determined by screener. Be sure to include route of administration, frequency (amount), withdrawals, etc.

VI. MEDICAL HISTORY

HIV Clinic: _____ **PHONE:** _____ **Last Medical Appointment** _____

Major medical problem (treated or untreated) (Indicate problems with check: Y or N for client, Fam for family history.)

Fam	Y	N		Fam	Y	N		Fam	Y	N		Fam	Y	N	
☐	☐	☐	Seizure/neuro disorder	☐	☐	☐	Cardiovascular disease	☐	☐	☐	Liver disease		☐	☐	Hepatitis
	☐	☐	Head trauma	☐	☐	☐	Tuberculosis	☐	☐	☐	Renal disease	☐	☐	☐	Cancer
	☐	☐	Sleep disorder	☐	☐	☐	Asthma/lung disease	☐	☐	☐	Hypertension		☐	☐	Syphilis
	☐	☐	Weight/appetite chg	☐	☐	☐	Gonorrhea	☐	☐	☐	Diabetes		☐	☐	Herpes

☐ ☐ ☐ **ALLERGIES** (If Yes, specify): _____

☐ ☐ Sensory/Motor Impairment (If Yes, specify): _____

☐ ☐ Pap smear If yes, date: _____ ☐ ☐ Mammogram If yes, date: _____ ☐ ☐ HIV Test If yes, date: _____ ☐ ☐ Pregnant If yes, due date: _____

Comments on above medical problems, co-occurring disorders, recent hospitalizations, etc.

VII. PSYCHOSOCIAL HISTORY

Please state specifically how mental health or HIV status impacts each area below; Be sure to include the client's strengths in each area.

EDUCATION/SCHOOL HISTORY

Special Education: ☐ Yes ☐ No ☐ Unable to Assess Learning Disability: ☐ Yes ☐ No ☐ Unable to Assess

Motivation, education goals, literacy skill level, general knowledge skill level, math skill level, school problems, etc:

Name: _____ **ID#:** _____

Agency: _____

Los Angeles County – Division of HIV and STD Programs

ADULT DIAGNOSTIC ASSESSMENT

HIV RISK BEHAVIORS/PARTNER SERVICES:

1. Have you had unprotected sex with anyone in the past six months? ○ Yes ○ No
2. Have you told all of your present and/or past sexual partners your HIV status? ○ Yes ○ No
3. Have you ever used Partner Services? ○ Yes ○ No
4. Do you want assistance disclosing your HIV status to anyone? ○ Yes ○ No

LEGAL HISTORYAND STATUS

Arrests/DUI, probation, convictions, divorce, conservatorship, parole, child custody, etc:

CURRENT LIVING ARRANGEMENT and Social Support Systems

Type of living setting, problems at setting, community, religious, government agency, or other types of support, etc:

DEPENDENT CARE ISSUES

Number of Dependent Adults: ☐ Number of Dependent Children: ☐

Ages of children, school attendance/behavior problems of children, special needs of dependents, foster care/group home placement issues, child support, etc:

FAMILY HISTORY/RELATIONSHIPS

History of Mental Illness in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess

Alcohol/Drug Use in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess

History of Incarceration in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess

Family constellation, family of origin, family dynamics, cultural factors, nature of relationships, domestic violence, physical or sexual abuse, home safety issues, family medical history, family legal/criminal issues

Name: ☐ ID#: ☐

Agency: ☐

Los Angeles County – Division of HIV and STD Programs

ADULT DIAGNOSTIC ASSESSMENT

VIII. MENTAL STATUS EVALUATION

Instructions: Check all descriptions that apply

General Description

Grooming & Hygiene: ☐ Well Groomed ☐ Average ☐ Dirty ☐ Odorous ☐ Disheveled ☐ Bizarre
Comments:

Eye Contact: ☐ Normal for culture ☐ Little ☐ Avoids ☐ Erratic
Comments:

Motor Activity: ☐ Calm ☐ Restless ☐ Agitated ☐ Tremors/Tics ☐ Posturing ☐ Rigid ☐ Retarded ☐ Akathesis ☐ E.P.S.
Comments:

Speech: ☐ Unimpaired ☐ Soft ☐ Slowed ☐ Mute ☐ Pressured ☐ Loud ☐ Excessive ☐ Slurred ☐ Incoherent ☐ Poverty of Content
Comments:

Interactional Style: ☐ Culturally congruent ☐ Cooperative ☐ Sensitive ☐ Guarded/Suspicious ☐ Overly Dramatic ☐ Negative ☐ Silly
Comments:

Orientation: ☐ Oriented ☐ Disoriented to: ☐ Time ☐ Place ☐ Person ☐ Situation
Comments:

Intellectual Functioning: ☐ Unimpaired ☐ Impaired
Comments:

Memory: ☐ Unimpaired ☐ Impaired re: ☐ Immediate ☐ Remote ☐ Recent ☐ Amnesia
Comments:

Fund of Knowledge: ☐ Average ☐ Below Average ☐ Above Average
Comments:

Mood and Affect

Mood: ☐ Euthymic ☐ Dysphoric ☐ Tearful ☐ Irritable ☐ Lack of Pleasure ☐ Hopeless/Worthless ☐ Anxious ☐ Known Stressor ☐ Unknown Stressor
Comments:

Affect: ☐ Appropriate ☐ Labile ☐ Expansive ☐ Constricted ☐ Blunted ☐ Flat ☐ Sad ☐ Worried
Comments:

Perceptual Disturbance

☐ None Apparent

Hallucinations: ☐ Visual ☐ Olfactory ☐ Tactile ☐ Auditory: ☐ Command ☐ Persecutory ☐ Other
Comments:

Self-Perceptions: ☐ Depersonalizations ☐ Ideas of Reference
Comments:

Thought Process Disturbances

☐ None Apparent

Associations: ☐ Unimpaired ☐ Loose ☐ Tangential ☐ Circumstantial ☐ Confabulous ☐ Flight of Ideas ☐ Word Salad
Comments:

Concentration: ☐ Intact ☐ Impaired by: ☐ Rumination ☐ Thought Blocking ☐ Clouding of Consciousness ☐ Fragmented
Comments:

Abstractions: ☐ Intact ☐ Concrete
Comments:

Judgments: ☐ Intact ☐ Impaired re: ☐ Minimum ☐ Moderate ☐ Severe
Comments:

Insight: ☐ Adequate ☐ Impaired re: ☐ Minimum ☐ Moderate ☐ Severe
Comments:

Serial 7's: ☐ Intact ☐ Poor
Comments:

Thought Content Disturbance

☐ None Apparent

Delusions: ☐ Persecutory ☐ Paranoid ☐ Grandiose ☐ Somatic ☐ Religious ☐ Nihilistic ☐ Being Controlled
Comments:

Ideations: ☐ Bizarre ☐ Phobic ☐ Suspicious ☐ Obsessive ☐ Blames Others ☐ Persecutory ☐ Assaultive Ideas ☐ Magical Thinking ☐ Irrational/Excessive Worry ☐ Sexual Preoccupation ☐ Excessive/Inappropriate Religiosity ☐ Excessive/Inappropriate Guilt
Comments:

Behavioral Disturbance

Behavioral Disturbances: ☐ None ☐ Aggressive ☐ Uncooperative ☐ Demanding ☐ Demeaning ☐ Belligerent ☐ Violent ☐ Destructive ☐ Self-Destructive ☐ Poor Impulse Control ☐ Excessive/Inappropriate Display of Anger ☐ Manipulative ☐ Antisocial
Comments:

Suicidality/Homicidality

Suicidal: ☐ Denies ☐ Ideation Only ☐ Threatening ☐ Plan
Comments:

Homicidal: ☐ Denies ☐ Ideation Only ☐ Threatening ☐ Target ☐ Plan
Comments:

Other

Passive: ☐ Amotivational ☐ Apathetic ☐ Isolated ☐ Withdrawn ☐ Evasive ☐ Dependent
Comments:

Other: ☐ Disorganized ☐ Bizarre ☐ Obsessive/compulsive ☐ Ritualistic ☐ Excessive/Inappropriate Crying
Comments:

Name: ID#:

Agency:

Los Angeles County – Division of HIV and STD Programs

ADULT DIAGNOSTIC ASSESSMENT

IX. Summary and Diagnosis

1. CLINICAL FORMULATION: (Be sure to include assessment of risk of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e. Work, School, Home Community, Living Arrangements, etc, and justification for diagnosis)

2. DIAGNOSTIC DESCRIPTOR

ICD DIAGNOSIS CODE (check at least one Primary)

☐ Primary Code
☐ Sec Code
Code
Code
Code
Code
Code
Code
Code
Code

3. HIV Medical Care Goals Does client's mental health status interfere with HIV medical care? ☐ Yes ☐ No

4. Disposition/Recommendations/Plan

5. SIGNATURE

Assessor's Signature & Discipline | Date | Co-Signature & Discipline | Date

CLEAR FORM

Name: ID#:

Agency: Los Angeles County – Division of HIV and STD Programs

Appendix F: Medication Consent Form - DHSP 556

DHSP 556
Revised 6/9/17

MEDICATION CONSENT

I have talked with my psychiatrist or nurse practitioner,_____, who has recommended that I / my child receive(s) medication(s) to treat symptoms of_____. We have also talked about reasonable alternatives, such as: _____

☐ No reasonable alternatives available at this time.

The type(s) of medications prescribed is identified below:

Medication(s)	**Type** Antidepressant, Anxiolytic, Mood, Stabilizer, Antipsychotic, Other	**Dosage** (including PRN)	**Frequency**	**Method** (Oral/Injection)	**Duration**
1.					
2.					
3.					
4.					
5.					
6.					

- I understand the dosage(s) and when to take the medication(s), and that any changes in medication dosage and/or frequency during the course of treatment will be discussed with me.
- I have been informed that some side effects are possible, including:
  - ☐ Muscle stiffness/tremor
  - ☐ Drowsiness
  - ☐ Dry mouth/blurred vision/constipation
  - ☐ Nausea/appetite changes
  - ☐ Sexual Problems
  - ☐ Pregnancy Issues
  - ☐ Dizziness
  - ☐ Interactions with other drugs, food & health conditions
  - ☐ Diabetes
  - ☐ Weight Gain
  - ☐ Other _____
- I understand that these are common side effects, and that there may be other less common ones. I also understand that I should promptly inform my psychiatrist or nurse practitioner about changes in my condition (e.g. dizziness, severe sedation, rash), if I become pregnant, and/or any new medications I may be prescribed/take for other conditions.
- **In addition to the above mentioned side effects, I understand there may be additional long term use side effects (present after 3 months)** such as: ☐ None other than those listed above
  - ☐ Describe long term side effects not identified above _____
- With some anti-psychotics I understand that there is a possible side effect, tardive dyskinesia, which may cause involuntary movement of the tongue, face, neck, limbs, or torso and may persist even after stopping the medication.
- I understand that the decision to take medication is up to me, but that I should always first discuss with my psychiatrist/nurse practitioner any decision to stop taking medication.
- I understand that my psychiatrist/nurse practitioner believes this medication will help me, but there is no guarantee as to the results.

☐ **I HAVE READ THIS FORM** ☐ **THIS FORM HAS BEEN READ TO ME**

☐ **THIS FORM WAS INTERPRETED IN_____FOR ME.**

If a translated version of this Form was signed by the client and/or responsible adult, the translated version must be attached to the English version.

THE INFORMATION ON THE FORM HAS BEEN EXPLAINED TO ME, AND I AGREE TO TAKE THE MEDICATION(S) AS PRESCRIBED. I UNDERSTAND THAT I MAY WITHDRAW CONSENT AT ANY TIME.

Signature:_____ **Signature:** _____
(Client) (Parent/Legal Guardian/Conservator)

I HAVE EXPLAINED THE BENEFITS, SIDE EFFECTS AND RISKS OF THE MEDICATION(S) LISTED ABOVE AND HAVE OBTAINED THE PATIENT'S/RESPONSIBLE ADULT'S INFORMED CONSENT.

Signature:_____ **Date:** _____
(Psychiatrist or Nurse Practitioner and Discipline)

Client Name: **Provider#:**

Los Angeles County – Department of Public Health
Division of HIV and STD Programs

*Adapted from the Los Angeles County-Department of Mental Health from MH 556

Appendix G: Co-Occurring Disorders Assessment - DHSP 633

DHSP 633
Revised 06/08/17

SUPPLEMENTAL CO-OCCURRING DISORDERS ASSESSMENT

k

I. Current Substance Use

A. Alcohol Screening Questions — 1 Drink = 12 Ounces of Beer

1. How often do you have a drink containing alcohol? If "Never", proceed to Drug Screening Questions.	☐ Never	☐ Monthly or less	☐ 2-4 times a month	☐ 3 times a week	☐ 4+ times a week
1a. How many drinks containing alcohol do you have on a typical day when you are drinking?	☐ 1 or 2	☐ 3 or 4	☐ 5 or 6	☐ 7 to 9	☐ 10+
1b. How often do you have six or more drinks on one occasion?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily

Alcohol Screening Score:_____Was a Brief Intervention Provided? ☐ Yes ☐ No

B. Drug Screening Questions

1. Have you used any drug in the past 30 days that was NOT prescribed by a doctor? ☐ Yes ☐ No

2. Drug Type(s) Used (Indicate with an "*" which substances are most preferred.)	Ever Used? Yes	Ever Used? No	Recently Used? (Past 6 Months) Yes	Recently Used? (Past 6 Months) No	Route of Administration or other comments (IV use, smoking, snorting, etc.)
Amphetamines (Meth, crank, ice, etc.)	☐	☐	☐	☐	
Cocaine or crack	☐	☐	☐	☐	
Hallucinogens	☐	☐	☐	☐	
Inhalants	☐	☐	☐	☐	
Marijuana	☐	☐	☐	☐	
Nicotine (Cigarettes, cigars, smokeless tobacco)	☐	☐	☐	☐	
Opiates (Heroin, codeine, etc.)	☐	☐	☐	☐	
Over the Counter Meds (Cough syrup, diet aids, etc.)	☐	☐	☐	☐	
Sedatives (Pain meds, etc.)	☐	☐	☐	☐	
Other (specify): _____	☐	☐	☐	☐	

C. Additional Comments (i.e. frequency, duration of use, etc.):

II. Family History of Alcohol and/or Drug Use

Please describe any history of family alcohol and/or drug use (i.e. mother, father, etc.)

III. Past and Current Substance Use Treatment/Self-Help

1. Have you received help in the past for substance use issues (e.g. Self-Help or Professional)? ☐ Yes ☐ No
   If yes, please list the dates you were enrolled: From_____To_____From_____To _____
   Was it beneficial? If so, how?

2. Are you currently enrolled in a substance use program? ☐Yes ☐ No
   If yes, what was your date of enrollment?_____Please specify the type of program it is:

   Were you referred to mental health services by this program? ☐ Yes ☐ No
   Referred by:_____ Contact Number: _____
   ☐ Records were requested on (date): _____

3. Additional comments:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

Los Angeles County – Department of Public Health

Division of HIV and STD Programs

SUPPLEMENTAL CO-OCCURRING DISORDERS ASSESSMENT

IV. Benefits of Substance Use

How true is the following about substance use for you:	Very True	Somewhat True	Not True	Comments
It is important in socializing with friends	☐	☐	☐	
It helps me meet and get to know people	☐	☐	☐	
It lowers my anxiety when I'm with people	☐	☐	☐	
It makes me feel less depressed or empty	☐	☐	☐	
It makes me feel less anxious	☐	☐	☐	
It helps me forget my problems	☐	☐	☐	
It helps me sleep better	☐	☐	☐	
It gives me something to look forward to	☐	☐	☐	
It is an important source of pleasure to me	☐	☐	☐	
It helps reduce my boredom	☐	☐	☐	
It is one of the only things that makes me feel okay	☐	☐	☐	
It is chiefly a habit or helps to avoid withdrawal	☐	☐	☐	
It enhances sexual experiences	☐	☐	☐	
It helps me lose weight	☐	☐	☐	

V. Costs of Substance Use

Is it possible that your substance use has played a role in or contributed to any of the following:	Yes	No
Problems keeping or getting housing (i.e. eviction, homeless)?	☐	☐
Problems at school or work?	☐	☐
Legal problems (i.e. DUI, possession, public intoxication, dealing)?	☐	☐
Money problems (i.e. lack of money)?	☐	☐
Developing or not attending to health problems (i.e. physical exams, dental exams, treatment)?	☐	☐
Feeling sick before or after using?	☐	☐
Ignoring my mental health treatment?	☐	☐
Increasing my mental health symptoms?	☐	☐
Not taking my medications as prescribed?	☐	☐
Being rejected or judged by others?	☐	☐
Conflicts with or losing friends and/or family?	☐	☐
Getting into dangerous situations (i.e. that involve weapons, unprotected sex, trading sex for drugs, sharing needles)?	☐	☐
Feeling a sense of anger/guilt/shame or feeling like a failure?	☐	☐

VI. Readiness for Change/Treatment Plan Identification

1. In looking over the benefits and costs of your alcohol/drug use, how do the costs compare to the benefits?

2. Which benefits seem most important to you?

3. If we could identify or develop healthier ways for you to achieve those benefits (identified in #2), do you think it might be easier for you to cut down on your alcohol/drug use? ☐ Yes ☐ No
4. Which of the costs do you think cause the most overall problems for you?

5. Are you willing or wanting to address any of these costs? If so, how?

6. Which of these costs do you think affects your Mental Health symptoms the most and might be important to try to reduce?

7. On a scale of 0-5, how ready are you to start working on finding new ways of achieving the benefits? _____
   On a scale of 0-5, how ready are you to start working on reducing the costs? _____

Assessor's Signature & Discipline	Date	Co-Signature & Discipline (if required)	Date

Name:

Los Angeles County – Department of Public Health

Division of HIV and STD Programs

*Adapted from Los Angeles County Department of Mental Health MH Form 633

Appendix H: Client Treatment Plan - DHSP 636

DHSP 636
Revised 07/21/17

CLIENT TREATMENT PLAN

Date: _____ **Next Review Date:** _____

Client Long Term Goals: (use client direct quote)

Short-term Goals / Objectives: Must be **SMART**: Specific, Measurable/Quantifiable, Attainable within this year, Realistic, and Time-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology as documented in the Assessment.

Objective # 1 Assigning Date: _____

Clinical Interventions: Must be related to the objective and achievable within the time frame of this Plan. Describe proposed intervention and duration

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup

Client Involvement	**Family Involvement:** ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

Short-term Goals / Objectives:

Objective # 2 Assigning Date: _____

Clinical Interventions:

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup

Client Involvement	**Family Involvement:** ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

*MHS includes therapy/rehab (individual, family, or group), collateral and, in some instances, plan development services.

Interpretation

Prefer a language other than English: ☐ Yes ☐ No This plan was interpreted: ☐ Yes ☐ No Language: _____

Name:

Casewatch ID#:

Los Angeles County- Department of Public Health
Division of HIV and STD Programs

CLIENT TREATMENT PLAN

- **A signature on line (A) OR (B) is REQUIRED for ALL objectives.**
- Signator or Co-Signator must be consistent with Scope of Practice.
- Signatures must be obtained when objectives are created (both initial and additional) and at each review period.
- One signature block can be used for multiple objectives created on the same day if the objectives are within the scope of the signator.

Objective Number(s) 1 & 2	(A) PhD/PsyD, LCSW, MFT, RN, CNS	Licensed or registered and waivered PhD/PsyD, licensed or registered/waivered Social Worker and MFT, RN, registered CNS. **Signature minimally signifies consultation/discussion w/service delivery staff.**
	(B) MD/DO, NP	MD/DO or NP required for objectives associated with Medication Support Services.**; signature minimally signifies consultation/discussion w/service delivery staff.**
	(C) All Other Staff/Title	Used for any staff not holding one of the licenses or registrations above. Second signature required.
	(D) Client*	Document reason for lack of signature below. Signature should be obtained as soon as possible with regular updates in Progress Notes until obtained.
	(E) Client Collateral*	Preferred: Parent, Authorized Caregiver, Guardian, Conservator, or Personal Representative for treatment.

*The signature of the individual signing the Consent for Services is preferred. If unavailable, the signature of one of the client collaterals is permissible.

Objective Number(s) _____	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	All Other Staff/Title		Date:
	Client*		Date:
	Client Collateral*		Date:

Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

Objective Number(s) _____	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	All Other Staff/Title		Date:
	Client*		Date:
	Client Collateral*		Date:

Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

*Adapted from the Los Angeles County Department of Mental Health form MH 636

Name:

Casewatch ID#:

Los Angeles County- Department of Public Health
Division of HIV and STD Programs

Appendix I: Medication Management Note - DHSP 655

DHSP 655
Revised 6/8/17

MEDICATION MANAGEMENT NOTE

(For use by MD/DO and NP and students of these disciplines)

Date:_____ **Rendering Provider Face-to-Face/Other Time* (Hrs:Mins):** _____
Procedure Code: _____

Chief Complaint /Client Goals:

Brief History of Present Illness/Problem:

Treatment Response/Medication Side Effects:

Adherence to Medication:

Mental Status:

Diagnosis: ☐ Diagnosis remains the same ☐ Diagnosis changed

Assessment/Intervention/Plan/Clinical Decision Making (Include explanation of changes in Plan and/or Medication):

Laboratory Tests Ordered: ☐ CBC ☐ LFT ☐ Electrolytes ☐ Lipids ☐ Glucose ☐ HgbA1C
☐ Tox Screen ☐ Med Levels ☐ TFTs ☐ Other/Details: _____

Medication(s) Prescribed: Medication Consent must be completed by the MD/DO/NP annually and any time a new medication is prescribed or resumed following a documented withdrawal of the medication.

Name	Dosage	Frequency	Route of Administration	Amount	# of Refills

☐ **Provided by the use of Telemental Health services. Client signed the Consent for Telemental Health Services and concerns were discussed.**
☐ **Continued** (Sign & complete information on **Medication Note Addendum**)

Signature & Discipline _____ Date _____ Co-signature & Discipline _____ Date _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **Provider #:**

Los Angeles County Department of Public Health
Division of HIV and STD **Programs**

*Adapted from Los Angeles County Department of Mental Health from MH 655

GLOSSARY

- **Allowable Disciplines:** Rendering Providers/Practitioners may only provide services consistent with their education/licensure (scope of practice), length of experience and/or job description. Include the following disciplines:
  - Licensed Psychiatrist/Physician, (MD/DO)
  - Certified Nurse Practitioner (NP), Registered Nurse Specialist (CNS), Registered Nurse (RN)
  - Licensed or waivered Psychologist (PhD/PsyD)
  - Licensed Clinical Social Worker (LCSW) or registered Masters in Social Work (Associate Clinical Social Worker-ASW) or out-of-state licensed-ready waivered Masters in Social Work
  - Licensed Marriage and Family Therapist (LMFT) or registered Marriage and Family Therapist (MFT Intern) or out-of-state licensed-ready waivered Marriage and Family Therapist
  - Licensed Professional Clinical Counselor (LPCC) or registered Professional Clinical Counselor (PCC) and
- **Face-to-Face time:** Assessment, Psychological Testing, and individual Medication all require Face-to-Face time that must be both documented on the clinical record and entered into the Casewatch system. No other Mental Health, Medication Support, or Targeted Case Management Services requires Face-to-Face time, but if it occurs, it should be both noted in the clinical record and entered into Casewatch. All groups require Face-to-Face time. Team Conference/Case Conference and No-Contact-Report Writing should always be reported with "0" Face-to-Face time.
- **Telephone Service:** Face-to-Face time is always "0" for telephone contacts. Some codes are not telephone allowable meaning; they may not be used for telephone services; only those codes specifically identified as telephone allowable may be claimed as a telephone service.