Comments on Mental Health

Standards

#	Location	Comment	DSHS Response	Determination
1	p. 1 Services Bereavement support is available for non-HIV infected family members or significant others.	Is this new? I like this, but it raises the issue of how we enter that person into ARIES and what data/documentation we are obligated to collect for them.		
2	Documentation of appropriate and valid licensure and certification of mental health professionals as required by the State of Texas for the following professions:	Are specific levels of licensure required for certain services? Is there an allowable time frame for staff to obtain licensure?		
3	Mental health staff are trained and knowledgeable regarding HIV/AIDS and the affected community.	What constitutes as applicable training for HIV/AIDS knowledge? A class in school? A CEU training? Number of years of experience working with the population?		
4	-Psychiatric nurse	Change wording to the following: -Advanced practice nurse practitioner recognized by the Board of Nurse Examiners as a clinical nurse specialist or nurse practitioner with a specialty in psych-mental mental health (APNP/MH).		

5	All agencies will provide the full continuum of mental health services either directly or through referral agreements.	We will need instruction in order to account for family members in our session/client counts as it is difficult to meet the eligibility requirements necessary for ARIES documentation when the family member is not HIV+. Waterloo has learned a lot about this through trying to document having affected/related folks in our psychosocial support groups. It really messes up the RSR and other DIP data.		
6	All agencies will provide the full continuum of mental health services either directly or through referral agreements.	Is DSHS implying that we can arrange for low cost psychological testing for Ryan White clients? I do not know where such a service exists. As a small outpatient mental health facility, we cannot afford the services of a psychiatrist or a psychologist. For psychiatric services, most clients will have to be referred to Integral Care and we will have no control over whether or not the client meets Integral Care's eligibility requirements. The same concern about the client meeting the eligibility requirements for the referral entity is true for Psychiatric rehabilitation (do not know of a resource for this) and inpatient services.		
7	All agencies will provide the full continuum of mental health services either directly or through referral agreements.	While referrals made can be documented in the client record, follow-up is not an appropriate level of service for a therapist, this falls into the category of case management.		

8	All agencies will provide the full continuum of mental health services either directly or through referral agreements	Staffing pattern does not mention the need for intake and referral, although those services are required.		
9	All staff providing direct mental health services to clients must be licensed and qualified within the laws of the State of Texas and practice within their licensure requirements.	Is CIT code for LPC Intern and LMFT Associate? In Texas there is a level of licensure that is LPC Intern or LMFT Associate that follows the conference of the Master's degree and precedes full licensure during which time the licensee is under the clinical supervision of a board approved supervisor.		
10	Documentation of supervision during client interaction with Counselors In Training (CIT) or Interns as required by the Texas Department of State Health Services (DSHS).	During client interaction? Does this mean live supervision of sessions? Is DSHS willing to sacrifice the therapeutic relationship in order to have a supervisor present in the session? Is Ryan White willing to pay for the time for two therapists to be present in the session in order to meet this standard?		

11	Orientation must be provided to all staff providing direct services to patients within ninety (90) days of employment, including at a minimum:	This implies that we will do crisis intervention. Waterloo is not a 24 hour facility and we do not address crises with people who are not currently clients of Waterloo. It is also a matter of professional assessment whether what a client believes to be a crisis is actually requiring of a "crisis" /out of schedule appointment. For example, in the case of a client who deals with Borderline or Narcissistic Personality traits, labeling their frequent feelings of being "out of control" as a crisis can lead to further labeling of situations a crisis and need of multiple crisis appointments that do not help the client learn to manage his own feelings . Unlike Case Managers, therapy notes are not entered into ARIES. Documentation in ARIES is done by administrative staff to show eligibility for the service and that the service occurred.		
12	Mental health staff are trained and knowledgeable regarding HIV/AIDS and the affected community.	Will the TA provide this ongoing training at low/no cost to therapists?		

13	Agency has written policy for supervision. Supervisors' files reflect notes of weekly supervisory conferences.	Clinicians who are licensed at the highest level of their discipline do not require weekly (or any) clinical supervision by another clinician. Waterloo uses the model for fully licensed clinicians meeting on a weekly basis to discuss cases in peer supervision. Clinicians who are eligible, but not fully licensed do meet with their state board approved supervisor on a weekly basis, as required by their license and in order to attain the highest level of licensure in the state of Texas in their discipline.		

14	Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active client at least once every 6 months	How would multidisciplinary be defined? Currently Waterloo only has (and can only afford) three kinds of disciplines among our therapists: Counseling (LPC, LPC-intern), Marriage and family Counseling (LMFT, LMFT-associate), and Social Workers (LMSW, LCSW). If it is an interdisciplinary case conference it should be signed by representatives of the different disciplines. Since the supervisor will be of the same discipline as the therapist presenting, this would not show evidence of multi-disciplinary staffing. The notion that clinical guidance is given to fully-independent practitioners does not grasp the nature of the therapeutic relationship. Administrative guidance may be given in the form of what documents need to be collected from a particular client to fulfill eligibility requirements, and suggestions of new clinical ideas may be indicated or requested by the therapist. However, "guidance" is a word that implies that one fully licensed therapist will know more about how the client should be treated that the therapist who is treating the client, and this is not best practice.	**Your agency would define multidisciplinary in your policy and procedure.** **This is not administrative guidance, but case conferencing held for each active client.**	

15	Agency/Provider will have a policy and procedure for clients to follow if they need after hours assistance. This procedure will be included in the client orientation process.	This assumes that crisis will be confined to clients who have been through the orientation process, and so are continuing clients at Waterloo Counseling Center. Waterloo does not offer emergency, or same day appointments, so there is a clear distinction we make between "emergency" and "urgent". An ongoing client may need to consult with their therapist in order to decide that it is time to check into inpatient psychiatric care or detox or drug and alcohol treatment. On the other hand, if a person is having a medical or psychiatric emergency, he or she needs to go to the emergency room.		
16	Eligibility information will be obtained from the referral source and will include: - Contact and identifying information (name, address, phone, birth date, etc.) -Language(s) spoken -Literacy level (client self-report)	We will need some clarification regarding what constitutes a client self- report literacy level.		
17	Before assistance is provided there should be written documentation in the client's file that Ryan White/State Services funding is being used as the payor of last resort.	Before assistance is provided? Or before Ryan White is billed for the service? Not sure it is ethical to refuse service based on inability to determine funding.		

18	-Orientation includes information on the following: • Services available o Clinic hours and procedures for after-hours emergency situations o Directory of mental health staff and contact numbers o Scheduling appointments o Client responsibilities for receiving program services and the agency's responsibilities for delivering them o Patient rights including the grievance process	This list of topics to which a client needs to be oriented appears to be severely limiting to our ability to assess the needs of the client and recommend the kinds of treatment indicated. Currently, there are some services that I would not tell certain clients about. For example, while psychotherapy groups are available, one that meets the needs of the client may not be available at the moment. This is hard to explain in orientation when the client is new to services. In addition, there is no need to give clients a directory of our service providers. They will have their therapist's contact information. We routinely and happily give them the contact information of the therapist's supervisor, when applicable and the grievance procedures. It is not our policy to have clients calling random therapists to ask questions or request additional sessions from a second therapist.		
19		Will we receive support in creating new documents and having them professionally translated at appropriate reading levels?		

20	In emergency circumstances, an appointment will be scheduled within twenty four (24) hours. If service cannot be provided within these time frames, the Agency will offer to refer the client to another organization that can provide the requested services in a timelier manner.	Again, how will emergency be defined? We don't define our services as emergency services. We have no ability to admit to hospitals or to provide emergency medications. We do not routinely encourage our outpatient clients to believe they can call and be given an appointment off schedule from their weekly appointment. While Waterloo can make referrals to other resources, Waterloo cannot have prior knowledge of another provider's schedule or guarantee that services will be available. In the event of an emergency, Waterloo refers clients to call 911, or go to their medical doctor or local emergency room.		
21	Contact with client and appointment scheduled will be completed within three (3) business days of a client's request for mental health services.	To clarify, this is an appointment must be scheduled within 3 days of a patient reaching out for an appointment or must the appointment occur within 3 days of contact?		

22	A psychosocial assessment will be completed within 10 business days of intake or no later than and prior to the third counseling session and will include the following:	Waterloo relies on our experienced mental health professionals to listen to the client's needs and to assess when it is appropriate for the therapist to push for information that the client does not present of his or her own choice. We are client led in our treatment and our treatment plans reflect this. We may ask a question about domestic violence early on, but "Domestic Violence assessment" may not be completed within 10 days as the client may unfold information that helps the therapist put together the risk of the client coming to harm in their home or the risk of the client causing harm to a domestic partner over the course of the developing therapeutic relationship. Requiring a detailed history within three sessions may not be indicated if the client's presenting issues are current events and stressors and may detract from the client's willingness to return for further treatment if he/she does not feel "heard" by the therapist.		
23	A psychosocial assessment will be completed within 10 business days of intake or no later than and prior to the third counseling session and will include the following:	Clarification, is this for all clinic patients or only patients receiving mental health services at the clinic?		
24	Clients are assessed for care coordination needs, and referrals are made to case management programs as appropriate.	Waterloo does refer to case managers as needed, but our agency is commonly at the end of the referral chain and the Ryan White clients we see are referred to us most frequently by their case manager who provides coordination needs.		

25	In emergency circumstances, an appointment will be scheduled within twenty four (24) hours. If service cannot be provided within these time frames, the Agency will offer to refer the client to another organization that can provide the requested services in a timelier manner.	It seems that Release of Information needs to be included somewhere.		
26	A treatment plan shall be completed within 30 business days of completed assessment specific to individual client needs.	Is Ryan White funding proposing to dictate the timing of our process? Currently our procedure is a Diagnostic Assessment which also include preliminary treatment planning in the first two sessions. We will do an interim treatment plan by the end of the 4th session and quarterly treatment plans thereafter.		
27		The standards also include family therapy.		
28	A treatment plan shall be completed within 30 business days of completed assessment specific to individual client needs. The treatment plan shall be prepared and documented for each client. Individual, and family case records will include documentation of the following:	Is this required if a patient is initially screened at our clinic, but subsequently receive mental health services at another site?		

29	Diagnoses of the mental health illness or condition according to DSM- V	DSM-V diagnoses are not being used by Medicare and Medicaid until October of 2015. Are we being required to use two different DSMs to diagnose cases based on their funding source?		
30	Treatment, as appropriate, will include counseling about (at minimum):	"…as appropriate" and "(at minimum)" seem to be contradictory phrases for treatment. I do not understand what this standard is stating. Again, we are client driven in our treatment. If what we need to be focused on in therapy is dictated by the funding source, we may be less efficacious with clients than if we are allowed to follow the lead of the client until he or she is prepared to face the issues outlined here. For example, if we are minimally required to counsel about the role of spirituality and religion in the client's death and dying, we could be imposing our agenda on a client who is not ready to consider spirituality, or not at all interested in discussing religion, or is not interested or able to consider the issue of death and dying at that moment, or in the near future.		
31		Is the proposal dropping the guidance that forced us to have clients sign off on the treatment plan every time a new one was created?		

32	There is a procedure in place to determine which clients require a psychiatric evaluation. Psychiatric evaluations are conducted for all clients needing one. If the provider is a LCSW, referral for psychiatric evaluations will be completed.	I'm assuming this will not pertain to Waterloo as we are not funded for psychiatric evaluation and treatment, however, I have many concerns about these standards. As a client driven agency, it is always in our power to recommend a psychiatric evaluation and to explain the potential costs and benefits of meeting with a psychiatrist. We can also use our expertise as mental health professionals to determine that the therapy is not likely to be beneficial to the client until or unless he/she is evaluated by a psychiatrist, however, the word "require" indicates that the client's views and prejudices and fears are irrelevant in this discussion.		
33	Psychiatric evaluations are available as soon as possible based on client need or within 30 business days of referral to psychiatrist.	Since Waterloo does not have psychiatric services, we cannot control when the evaluation will be done or how soon the report will be given to the client, or whether the client will authorize the psychiatrist to release the report to our therapists.		
34	A psychiatrist is available for consultation with mental health program staff.	My experience is that psychiatrists (who are outside our agency) are not available for consultation unless the consultation time is paid for. Since the evaluation and the consultation with Waterloo would be two separate services, it seems unlikely that consultations will be funded.		
35	Psychotropic medication management services are available for all clients of the program either on-site or through referral.	Will we be put in touch with Psychotropic medication management services? I do not know of any in our community, except through Integral Care (depending on eligibility).		

36	There is evidence that the prescribing clinician is aware if the client has a history of addiction, so that medications can be prescribed and managed accordingly.	How do we influence what the prescribing clinician takes a history about? What they provide in the way of medication education, how they do their informed consent? How do we find psychiatrists who are current regarding HIV medications and the side effects/interactive effects? How do we insure that the psychiatrist will give us the documentation.		

37	Services will be provided according to the individual's treatment plan and documented in the client's primary record. Progress notes are completed for every professional counseling session and must include:	Again, this feels very intrusive into the course of therapy when DSHS is dictating what must be covered in every progress note, and thus what must be covered in every session. We abide by the ethical guidelines of our licensing boards to create progress notes that are complete in the key areas. Progress notes are to be about progress on treatment goals. These standards appear to outline specific process notes, or almost a new treatment plan every week in note form. The idea that we are going to formally note our observations, focus, assessment, and the client's response in accordance with JCAHO standards is an incredibly heavy burden on the therapist trying to see clients back to back to back in an outpatient setting. We are not JCAHO accredited and the standards of care should not force a small outpatient organization to reach standards more appropriate for intensive inpatient/hospital settings when we are not able to support the administrative burden such high standards require. Most standards for progress notes would allow the therapist to choose to utilize DARS or SOAP method of Progress Note writing.		
38	Care will be coordinated across all medical care coordination team members.	How will team be defined? How will coordination be funded? This is time intensive and involves meetings and travel since the medical team will not be on site here.		

39	-The client is involved in the decision to initiate or defer treatments.	If the client is involved in the decision, why did an earlier standard ask that Waterloo have a procedure for determining when a client MUST be assessed for psychiatric intervention? How will we, as mental health counselors, influence the medical care providers and psychiatrists to provide their input in this coordination of care? Why are only LCSW mentioned here? No LPC, no LMFT.		
40	As needed, providers will refer clients to full range of mental health services including: -Neuropsychological testing -Day treatment programs -In-patient hospitalization	Again, will we be provided with information regarding neuropsychologists who are willing to see clients for testing on a sliding fee scale? I know of none in Austin that do so for adults. Will day treatment programs for HIV clients be started somewhere? How will this be funded? Again, why only LCSW mentioned? We have more LPCs than any other licensure. LMFTs also need to be mentioned. How do we influence psychiatrists outside our agency (since we have no psychiatrists) to provide the services the standards are demanding?		

41	Discharge planning will be done with each client when treatment goals are met and include:	Discharge planning is a Social work construction used most often for hospitalizations or inpatient settings. Termination of services is a psychotherapeutic construct used in outpatient services. Treatment goals may be met and new goals set over the course of treatment. Again, JCAHO standards are very high for small outpatient agencies with little administrative support.		
42	Services may be discontinued when the client has: -Reached goals and objectives in their treatment plan -Missed three (3) consecutive appointments in a six (6) month period. - Became eligible for benefits or other third-party payor (e.g., Medicaid, medical insurance, etc.) -Continued non-adherence to treatment plan -Chooses to terminate services -Unacceptable patient behavior -Death	This is dictating how we define Waterloo's attendance policy and is much more generous than we currently have in our policies and procedures. The cost of having a therapist sit idle when a client chooses to attend sporadically is high. That time could be used by a client who is willing to come weekly. On the other hand, Discharging a client who wishes to continue in counseling, simply because the funding source changes, is considered abandonment by many licensing boards and is often clinically damaging to a client who has established a therapeutic relationship with the therapist.		

43	Services may be discontinued when the client has: -Reached goals and objectives in their treatment plan -Missed three (3) consecutive appointments in a six (6) month period.	Do they necessarily have to be consecutive?		
44	The following will be documented in the agency's client record. -All intake and eligibility documentation, to include at a minimum: o Proof of HIV positivity o Proof of residency o Verification of financial eligibility o Client demographics o Intake and assessment information -Documentation of referrals and results -Documentation of all services provided with dates and results -Documentation of reason for discharge	This does not include the many details that were in the progress note section of the standards. I'm confused about the difference since both eligibility documents, treatment plans, assessments, and progress notes are included in client records.		