HUMAN SERVICES DEPARTMENT
COMMUNITY PARTNERSHIPS DIVISION
115 S Andrews Avenue, Room A360 • Fort Lauderdale, Florida 33301 954-357-8647 • FAX 954-357-8204

BEHAVIORAL HEALTH NETWORK MEETING
Friday, July 17, 2020
WebEx Virtual Conference Room

MINUTES

PROVIDERS PRESENT
David Shelton; AHF
Joel Montgomery; AHF
Hugo Rocchia; Care Resource
Elizabeth Johnson; Memorial
Jamie Powers; Broward House
Nilda Montalvo; BCFHC

GUESTS
None

CLINICAL QUALITY MANAGEMENT (CQM) SUPPORT STAFF
Debbie Cestaro-Seifer
Marcus Guice
Jessica Seitchick

PART A RECIPIENT STAFF
Kelsey Giglioli
Neil Walker
Shackera Scott

I. Call to Order

The meeting was called to order at 3:00 p.m.

II. Welcome/Introductions

CQM Support Staff welcomed everyone, made a statement of the goal for the meeting, and individual introductions were made during roll call.

III. Mental Health Service Delivery Model Review

The Mental Health Service Delivery Model can be found in the meeting packet.

The CQM has revised the Mental Health Service Delivery Model (SDM), and a draft of the revised SDM was distributed to the Network members before the meeting. The CQM Team requested that the Network members bring feedback to the meeting and make recommendations for any changes that need to be made.

There was a discussion regarding the period described in the standards in which the Mental Health providers were to conduct the initial biopsychosocial assessment. In the previous version of the SDM, providers are to complete the assessment within three client visits. A provider described that this takes valuable time away from the client and adds a barrier to the assessment process. In the revised SDM, this period is not a part of the standard, and there is no time-sensitive requirement for completion of the assessment.

Moreover, providers discussed the ability to use provisional treatment plans. There are two notable billing limitations within the Mental Health service delivery component as it relates to the Ryan White Management Information System. Before providers can bill for Mental Health Services, the provider must (1) determine a diagnosis for the client, and (2) develop a treatment plan for the client. However, to mediate these barriers, providers can develop provisional treatment plans to begin providing behavioral health therapy for clients more expeditiously. These treatment plans can also be developed using provisional diagnoses from client files or referral notes.

Providers also discussed what clinical scales are appropriately billed under Ryan White Part A services. The CQM Team affirmed that the Ryan White Part A Program in Broward closely follows the same Behavioral Health standards as the State of Florida Medicaid Program. It was recommended that the revised Mental Health SDM include a link to Ryan White Part A recommended and approved behavioral health clinical scales.

IV. Behavioral Health Client Assessment

The Brief Behavioral Health Assessment can be found in the meeting packet.

A provider from Broward House has researched a mental health brief assessment and implemented it in their practice. The CQM Team sent this assessment out to the Network before the meeting for their input. One of the considerations in the revised Mental Health SDM was to supplement the biopsychosocial assessment with a brief behavioral health assessment similar to the assessment Broward House has implemented. The Recipient staff noted that whichever assessment is required within the standards will be programmed into the HIV Management Information System to streamline and standardize the assessment process within the service category.

After discussing each assessment's strengths and limitations, the CQM Support Staff called for a vote from the providers on which assessment they would ideally like to see in the HIV Management Information System as a minimum requirement in the standards of care. The majority of the group recommended a brief assessment similar to the assessment provided by Broward House.

V. Agency Updates

VI. Announcements

VII. Adjournment

The meeting was adjourned at 4:25 p.m.

Next Meeting Date: October 16, 2020

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BROWARD COUNTY
RYAN WHITE PART A PROGRAM
Mental Health Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

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I. Service Category Definition

HRSA Definition

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

Local Definition

MHS are psychotherapeutic services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State of Florida to render such services. These services are grounded in an understanding of and responsiveness to the impact of trauma; emphasizes physical, psychological, and emotional safety for both providers and survivors; and creates opportunities for clients to rebuild a sense of control and empowerment.

II. Key Service Components and Activities

In addition to the Mental Health Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers are subject to Florida's Statute Title XXIX, Chapter 394. Per Florida Law, professional staff providing treatment, counseling, or support group facilitation must be a licensed professional or supervised by a licensed professional. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of MHS are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Trauma-Informed Approach to Service Delivery

MHS must be rendered with a trauma-informed approach, acknowledging that traumas may have occurred or be active in clients' lives and can manifest physically, mentally, and/or behaviorally. Trauma-informed services are grounded in an understanding of and responsiveness to the impact of trauma; emphasizes physical, psychological, and emotional safety for both providers and survivors; and creates opportunities for clients to rebuild a sense of control and empowerment. Providers must focus on prevention strategies that avoid re-traumatization in treatment, promote resilience, and prevent the development of trauma-related disorders.

III. Broward EMA Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Improvement in client's symptoms and/or behaviors associated with primary mental	1.1. 85% of clients achieve treatment plan goals by designated target date.	1.1.1. Treatment plan documented in HIV MIS.

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health diagnosis.		
2. Increased access, retention, and adherence to primary medical care.	2.1. 85% of clients are retained in primary medical care.	2.1.1. Client appointment record in designated HIV MIS.

IV. Assessment and Treatment Plan

Assessment

Prior to the development of a treatment plan, providers must conduct an assessment of the client's mental health status, substance use concerns, functional capacity, strengths, and service needs. The assessment must be reviewed and signed by a licensed practitioner. The assessment, at minimum, must include the following:

- Source of referral
- Presenting problems
- History of the presenting illness or problem
- Identification of client's immediate clinical care needs, including psychological, medical, social, or physical conditions that impact the psychiatric condition
- List of current prescriptions and over-the-counter medications
- Alcohol and other drug use history
- Relevant personal and family medical history
- Need for referrals and further evaluation by other health care professionals

Treatment Plan

Providers must work with each client to develop a detailed treatment plan that directly addresses the primary diagnosis(es) that is(are) consistent with the assessment. The treatment plan must be an individualized, structured, and goal-oriented schedule of services with measurable objectives. The provider must assist the client to define goals and document the progress and assistance provided to the client. Treatment plans become effective on the date the plan is signed and dated by the licensed practitioner and the client.

Treatment plans must contain, at minimum, the following components:

- The client's diagnosis code(s) consistent with assessments
- Modality of treatment to be provided
- A list of the services to be provided to client (treatment plan development and review, and evaluation/assessment services provided to establish a diagnosis; however, information gathered by the provider for the development of the treatment plan need not be listed)
- The amount, frequency, and duration of each service to be provided to the patient as part of the six month in duration treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the client will receive a service "x to y times per week"
- Goals that are individualized, strength-based, and appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the client
- Measurable objectives with target completion dates identified for each goal
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed provider

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- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs
- Discharge criteria (individualized, measurable criteria that identifies the client's readiness to transition to a new level of care or out of care)

Treatment Plan Review

A formal review of the treatment plan must be conducted every six months, at a minimum. Treatment plans may be reviewed more than once every six months when significant changes occur. The treatment plan review requires the participation of the client and the treatment team members identified in the client's individualized treatment plan. Activities, notations of discussions, findings, conclusions, and recommendations must be documented during the treatment plan review. Any modifications or additions to the treatment plan made during the review must be documented. The treatment plan must be signed and dated by a licensed practitioner and the client.

The formal treatment plan review must contain, at minimum, the following components:

- Current diagnosis code(s) and justification for any changes in diagnosis
- Client progress toward meeting individualized goals and objectives
- Client progress toward meeting individualized discharge criteria
- Updates to aftercare plan
- Findings/interpretive summary
- Recommendations
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed practitioner who participated in the review of the plan
- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs

V. Standards for Service Delivery

Table 2. MHS Standards for Service Delivery

Standard	Measure
1. Client is asked to give express and informed consent for treatment.	1.1. Signed informed consent form in the client file.
2. Provider conducts an assessment with each client prior to the development of a treatment plan.	2.1. Completed assessment signed by licensed practitioner in the client file.
3. Provider conducts additional behavioral health examination/monitoring scale(s) where appropriate.	3.1. Completed clinical scale(s) in the client file, when clinically indicated.
4. Provider works with each client to develop a detailed treatment plan.	4.1. Treatment plan signed and dated by licensed practitioner and client in the client file.
5. Provider conducts a formal treatment plan review at least every six months.	5.1. Updated treatment plan with signature and date of licensed practitioner and client in the client file.

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Standard	Measure
6. Assistance provided to client and progress made toward achieving treatment plan goals is documented in the client file within three business days of meeting with the client.	6.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the client file.
7. All client communication is documented in client file and include: a date, length of time spent with client, person(s) included in the encounter, summary of what was communicated, and provider signature.	7.1. Detailed documentation with provider signature of all client communication in the client file.
8. Progress notes in the client file are linked to a treatment plan goal.	8.1. Progress notes in the client file.

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Broward House

Integrated Medical Brief Assessment Tool

Date of Assessment: _____

Interviewed: ☐ Client and/or ☐ Other (name and relationship): _____

Special Service Needs:

☐ Non-English Speaking, specify language needs: _____

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

☐ Cultural Considerations, specify: _____

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

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

I. Reason for Referral/Chief Complaint

Reason for Referral

Current Symptoms/Behaviors

Impairments in Life Functioning (daily living activities, social, employment/education, housing, financial, etc)

II. Psychiatric History

Outpatient and Inpatient, include dates, providers, interventions, and responses ☐ See information on IS Screen Prints

III. Current Risk and Safety Concern

In depth Risk Assessment completed ☐Yes ☐No

Current Thoughts of Self-Harm/Suicide	☐Yes	☐No	Current Thoughts of Harming Another Person	☐Yes	☐No
Past Thoughts of Self-Harm/Suicide	☐Yes	☐No	Past Thoughts of Harming Another Person	☐Yes	☐No
Prior Suicide Attempts/If yes, #____	☐Yes	☐No	History/Pending Criminal Charges	☐Yes	☐No
Probation/Parole Involvement	☐Yes	☐No	History of Injuring Another Person	☐Yes	☐No
Current/History of Injuring Animals	☐Yes	☐No	School Issues or IEP in place for minor children	☐Yes	☐No
Recent Trauma Exposure	☐Yes	☐No	Current Substance Use/Abuse	☐Yes	☐No
Recent Job Loss	☐Yes	☐No	Past Substance Use/Abuse	☐Yes	☐No
Victim of Violence/Abuse	☐Yes	☐No	Perpetrator of Violence/Abuse	☐Yes	☐No
DCFS Involvement	☐Yes	☐No	Homeless	☐Yes	☐No
Access to Guns/Weapons	☐Yes	☐No	Other (specify):		

For any risk/safety concerns marked yes, please explain. Identify if any safety measures are needed, required or taken.

IV. Relevant Medical Conditions

Hearing Impairment ☐ Yes ☐ No Visual Impairment ☐ Yes ☐ No Motor Impairment ☐ Yes ☐ No

Other Sensory Impairment ☐ Yes ☐ No If yes, specify: _____

Allergies ☐ Yes ☐ No If yes, specify: _____

Other Medical Conditions ☐ Yes ☐ No If yes, specify: _____

Last Physical Exam Date: _____

HIV Status: ☐ HIV+ ☐ HIV+ Unknown ☐ HIV Negative ☐ AIDS ☐ AIDS Unknown ☐ Unknown

Other Comments Regarding Medical Conditions:

Client Name : _____ DOB: _____ URN: _____

V. Medications

Client is currently on medications: ☐ Yes ☐ No If yes, How many days of medication does the client have left? ____

If yes, specify medications (include name and if there are any side-effects/adverse reactions).

VI. Substance Use/Abuse

Perceived Stress Scale Completed ☐Yes ☐ No Scale Rating : ____

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

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?		Recently Used? (Past 6 Months)		Route of Administration or other comments (IV use, smoking, snorting, etc.)
	Yes	No	Yes	No	
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.):

VII. Psychosocial Assessment

Family & Relationships, Dependent Care Issues (Number of Dependents, Ages, Needs & Special Needs), Current Living Arrangement, Social Support Systems, Education, Employment History/Readiness/Means of Financial Support, Legal History and Current Legal Status which may impact linkage/referral.

VIII. Additional Client Contacts/Relationships

☐ Case Manager ☐ Peer Case Manager ☐ Housing Case Management ☐ Mental HealthProvider ☐ Substance Abuse Treatment Provider ☐ Consumer Run Supports
☐ Health Care Supports ☐ Other : ____

Client Name : ____ DOB: ____ URN: ____

IX. Mental Status

General Description

Grooming & Hygiene: ☐ Well Groomed
☐ Average ☐ Dirty ☐ Odorous ☐Disheveled
☐ Bizarre
Eye Contact: ☐ Normal for culture
☐ Little ☐ Avoids ☐ Erratic
Motor Activity: ☐ Calm ☐ Restless
☐ Agitated ☐ Tremors/Tics ☐ Posturing ☐ Rigid
☐ Retarded ☐ Akathesis ☐ E.P.S.
Speech: ☐ Unimpaired ☐ Soft ☐ Slowed
☐ Mute ☐ Pressured ☐ Loud ☐ Excessive
☐ Slurred ☐ Incoherent ☐ Poverty of Content
Interactional Style: ☐ Culturally congruent
☐Cooperative ☐ Sensitive
☐ Guarded/Suspicious ☐ Overly Dramatic
☐ Negative ☐ Silly
Orientation: ☐ Oriented
☐ Disoriented to:
☐ Time ☐ Place ☐ Person ☐ Situation
Intellectual Functioning: ☐ Unimpaired
☐ Impaired
Memory: ☐ Unimpaired
☐ Impaired re: ☐ Immediate ☐ Remote ☐ Recent
☐ Amnesia
Fund of Knowledge: ☐ Average
☐ Below Average ☐ Above Average

Mood and Affect

Mood: ☐ Euthymic ☐ Dysphoric ☐ Tearful
☐ Irritable ☐Lack of Pleasure
☐ Hopeless/Worthless ☐ Anxious
☐ Known Stressor ☐ Unknown Stressor
Affect: ☐ Appropriate ☐ Labile ☐ Expansive
☐ Constricted ☐ Blunted ☐ Flat ☐ Sad ☐ Worries

Perceptual Disturbance

☐ None Apparent
Hallucinations: ☐ Visual ☐ Olfactory
☐ Tactile ☐ Auditory: ☐ Command
☐ Persecutory ☐ Other
Self-Perceptions: ☐ Depersonalizations
☐ Ideas of Reference

Thought Process Disturbances

☐ None Apparent
Associations: ☐ Unimpaired ☐ Loose
☐ Tangential ☐ Circumstantial
☐ Confabulous
☐ Flight of Ideas ☐ Word Salad
Concentration: ☐ Intact ☐ Impaired by:
☐ Rumination ☐ Thought Blocking
☐ Clouding of Consciousness
☐ Fragmented
Abstractions: ☐ Intact ☐ Concrete
Judgments: ☐ Intact
☐ Impaired re: ☐ Minimum ☐ Moderate
☐ Severe
Insight: ☐ Adequate
☐ Impaired re: ☐ Minimum ☐ Moderate
☐ Severe

Thought Content Disturbance

☐ None Apparent
Delusions: ☐ Persecutory ☐ Paranoid
☐ Grandiose ☐ Somatic ☐ Religious
☐ Nihilistic ☐ Being Controlled
Ideations: ☐ Bizarre ☐ Phobic ☐ Suspicious
☐ Obsessive ☐ Blames Others ☐ Persecutory
☐ Assaultive Ideas ☐ Magical Thinking
☐ Irrational/Excessive Worry
☐ Sexual Preoccupation
☐ Excessive/Inappropriate Religiosity
☐ Excessive/Inappropriate Guilt
Behavioral Disturbances: ☐ None
☐ Aggressive
☐ Uncooperative ☐ Demanding ☐ Demeaning
☐ Belligerent ☐ Violent ☐ Destructive
☐ Self-Destructive ☐ Poor Impulse Control
☐ Excessive/Inappropriate Display of Anger
☐ Manipulative ☐ Antisocial
Suicidal/Homicidal: ☐ Denies ☐ Ideation Only
☐ Threatening ☐ Plan ☐ Past Attempts
Passive: ☐ Amotivational ☐ Apathetic
☐ Isolated ☐ Withdrawn ☐ Evasive
☐ Dependent
Other: ☐ Disorganized ☐ Bizarre
☐ Obsessive/compulsive ☐ Ritualistic
☐ Excessive/Inappropriate Crying

Comments on Mental Status:

X. Clinical Summary

Summary/ Clinical Impression (including strengths and attitude towards treatment):

Diagnosis: ICD 10 Code: _____ Provisional Diagnosis ☐ Yes ☐ No

ICD 10 Code: _____ Provisional Diagnosis ☐ Yes ☐ No

ICD 10 Code: _____ Provisional Diagnosis ☐ Yes ☐ No

Disposition/Recommendations/Plan:

_____ _____
Clincian Signature Date

_____ _____
Print Name

_____ _____
Signature of Licensed Clinician Date

_____
Print Name

Client Name : _____ DOB: _____ URN: _____