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IMPLEMENTATION MANUAL

VIRGINIA DEPARTMENT OF HEALTH

SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

SYSTEMS LINKAGES AND ACCESS TO CARE INITIATIVE

OCTOBER 2015

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Background: System Linkages and the HIV Continuum

This manual offers insights on ways to implement state and local level efforts to revise systems of care to improve linkage, retention, and viral suppression under the HIV Care Continuum.

The concept called the continuum of engagement in HIV care emerged in 2004-2005 as a framework for defining the extent to which persons living with HIV (PLWH) are engaged in care. At one end of the spectrum are the undiagnosed, who are not in HIV care because they do not know their status. At the other end are those who are virally suppressed.[1] The value of the continuum in managing the HIV epidemic is compelling. PLWH who are fully engaged in care, fully adherent to antiretroviral therapy and achieve viral suppression, can manage their HIV infection as a chronic condition and simultaneously reduce the risk of transmitting the virus to others. The continuum concept was developed by the Health Resources and Services Administration (HRSA), an agency within the U.S. Department of Health and Human Services (HHS), as part of a national initiative to improve care engagement. This version has since been refined and is now called the HIV Care Continuum (HCC)[2] and is part of the National HIV/AIDS Strategy,[3] most recently updated in 2015.

[1] Outreach: Engaging People In HIV Care. HRSA HIV/AIDS Bureau. 2006.

[2] HRSA, HIV Continuum of Care, 2010. http://hab.hrsa.gov/data/reports/continuumofcare/continuumabstract.html

[3] National HIV/AIDS Strategy. Available at: http://aids.gov

Virginia's SPNS Systems Initiative

Virginia's Systems Linkages and Access to Care Initiative focuses on the HIV Care Continuum by enhancing existing and establishing new collaborative relationships among Ryan White and other non-traditional HIV organizations. The overall goals are to increase the percentage of newly-diagnosed patients who engage in care within three months post-diagnosis, to increase the retention rate in care, and to develop a referral system maximizing funding and linkage resources while coordinating and streamlining patient services.

- **Linkage**. Increase the percentage of newly diagnosed HIV-positive patients in Virginia who link to HIV care within 90 days of diagnosis.
- **Referrals**. Develop a referral system maximizing funding and linkage resources while coordinating and streamlining patient services.
- **Retention**. Increase the percentage of HIV-positive patients in Virginia who remain in HIV care over a period of 12 and 24 months.
- **Viral Suppression**. Increase the percentage of HIV-positive patients in Virginia who have undetectable viral loads.

Strategies

VDH crafted four strategies to address the HCC and gaps identified in the HIV care system. While the end product of each intervention was a standardized protocol for linking and retaining patients in HIV care, implementation ranged in scope from statewide to regional, covering urban and rural sites, consistent with the epidemic's impact in the state. Strategies included:

- An Active Referral model under which Disease Intervention Specialists (DIS) staff and testing and referral agencies across the state worked to ensure patients were rapidly linked to care upon diagnosis. DIS staff accomplished this by working directly with referral sources as well as with the assistance of Patient Navigators where available (another strategy under this project) and medical providers.
- A Patient Navigation model was implemented in the Central and Southwest regions of the state to link and retain patients in the treatment process. Patient Navigators were hired through contracts with clinics to carry out linkage and retention activities.

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- A Care Coordination system was operationalized to enhance statewide linkages with the Virginia Department of Corrections to more effectively ensure HIV care and medication access for recently released HIV-positive inmates. Coordination work with local jails was also implemented in latter stages of the project.
- A Mental Health screening and referral system was implemented at a comprehensive service site with a focus on addressing the mental health barriers to linkage and retention in HIV care.

Table 1: Summary of SPNS Linkages Strategies in Virginia

Goal	**Active Referral**	**Care Coordination**	**Mental Health**	**Patient Navigation**
Educate persons at the time and/or after of their HIV diagnosis	■			■
Start HIV medical care shortly after a positive HIV test result	■	■		■
Support long-term retention in HIV medical care		■	■	■
Re-engage into HIV medical care persons if they have dropped out of care	■	■	■	■
Outcomes				
Linkage	■	■		■
Retention		■	■	■
Suppression		■	■	■

Guiding Implementation: Collaborative Learning Model

All four strategies of the SPNS Systems Linkages Initiative were implemented through robust collaboration among state, regional and local entities as well as internal collaboration within VDH units. Those efforts were guided by use of an innovative project design combining the Institute for Healthcare Improvement's Collaborative Learning Model to develop and pilot interventions with a more traditional approach to outcome evaluation in the analysis phase of the project. The Collaborative Learning Model is a systematic approach to health care quality improvement in which systems, organizations and providers implement and measure small-scale interventions, then share their experiences in an effort to accelerate learning and widespread implementation of successful ideas for change. The combination of these approaches allowed for continuous refinement of interventions and process and outcome evaluation to improve linkage, retention and viral suppression for PLWH.

Mental Health Strategy

Purpose

People living with HIV have higher rates of mental health conditions that can impede an individual's ability to connect with or remain in HIV care. The SPNS Mental Health intervention was designed to enhance coordination among mental health professionals, medical case managers (MCMs), and HIV health care providers to increase access to mental health services. The intervention screened patients for mental health issues and referred them to specialty mental health services such as therapy, counseling, neuropsychological testing, and substance abuse treatment.

The intervention developed and utilized a standardized screening and referral protocol for HIV-positive patients to help address mental health barriers to linkage and retention in HIV care. VDH's protocol eventually developed into an in-house model utilized at an urban university medical center. However, it was piloted at both the university medical center (able to screen and provide psychotherapy, psychiatry and neuropsychiatry services) and at a smaller medical center whose intent was to complete the patient screening and then build and use community-based treatment networks. Both settings planned on referring patients to external substance abuse treatment. The implementation at the smaller medical center was ultimately not sustainable, and an attempt was made to replicate the strategy at a mid-size university medical center serving more rural populations. This replication was also not sustainable.

This manual will note successes of the strategy, areas that did not work as planned, and future considerations.

Target Populations

The SPNS mental health protocol targeted persons who met one or more of the following criteria:

- Persons newly diagnosed with HIV/AIDS.
- Persons new to HIV care.
- Persons non-adherent to HIV care due to symptoms of mental health, substance abuse or psychosocial stressors.

- Persons adherent to HIV care but with mental health, substance abuse or psychosocial stressors that may cause non-adherence or loss-to-care (LTC).
- Persons transitioning or released from correctional facilities within the past six months.

Summary of the Mental Health Process

Mental health providers work with HIV-positive patients to increase retention in HIV care and improve mental health care outcomes through:

- Developing and delivering comprehensive screening using validated standardized depression, anxiety, cognitive functioning, alcohol, and substance abuse instruments to assess patients for mental health issues.
- Using a standardized referral process to refer HIV-positive patients to specialized mental health, psychiatry, and neuropsychiatry services provided by internal and external resources as well as community agencies.
- Developing and using client-centered treatment and counseling plans aimed at improving both mental health and HIV care outcomes (including viral suppression).
- Assessing patients for transition from specialized mental health services to less acute community or other services based on mental health and medical care outcomes.
- Building relationships with HIV care and mental health providers to facilitate use of mental health resources to support HIV-positive patients.
- Developing a wider network of mental health and substance abuse treatment providers willing and able to treat HIV-positive patients in the community.

Implementation Insights

This manual is not an evaluation. Formal quantitative and qualitative evaluation of SPNS strategies is being conducted at VDH and across all SPNS Linkages sites through the national SPNS Evaluation and Technical Assistance Center at the University of California at San Francisco. Rather, this document has a related goal: to explore and present implementation insights that can help other projects as they seek to revise their HIV systems of care to better engage people in HIV care.

The manual presents the following core components of its mental health intervention, which culminated in development of a Mental Health Protocol, crafted during the multi-year process of input and refinement.

- Up Front and Ongoing Planning
- Collaborative Framework
- Staffing
- Training
- Collaborative Activities
- Protocol Development
- Implement Mental Health Strategy
- Sustainability and Program Integration
- Measuring Program Effectiveness

Each of these areas is described with a narrative overview followed by tangible implementation ideas, in the form of tips, task lists, and essential considerations that can guide others looking to implement a similar project.

For replication purposes, others should be aware that these activity areas were carried out in both a sequential and overlapping manner. This fluidity is reflective of efforts to address the SPNS goal of exploration but also the reality of implementation—that incorporating new activities is by necessity a constant process of adjustment, tweaking, and involvement by end users to make additional improvements.

Implementation Insights

Up Front and Ongoing Planning

- Build Upon Existing Planning
- Be Flexible to Adjust to Real World Circumstances – What Worked and What Didn't

Collaborative Framework

- Collaborative Learning Model
- Collaborative Entities

Staffing

- Identify Experienced and Credentialed Professionals
- Establish Clear Job Roles

Training

- Design Training to Adjust to Existing Training
- Identify Training Topics/Curricula
- Use Multiple Training Methods

Collaborative Activities

- Secure Buy-In
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- Collaborate within the Clinic

Protocol Development

- Identify Key Staff Members
- Use What's Already in Place—and Find What's Missing

Implement Mental Health Strategy

- Determine the Fit within the Primary Care Clinic
- Manage Referrals
- Focus on Retention and Viral Suppression

Sustainability and Program Integration

- Enhance Third Party Billing
- Review and Revise Protocol
- Expand by Linking with Other Partners
- Secure Ongoing Agency Support
- Use Ryan White HIV/AIDS Program Funding

Measuring Program Effectiveness

- Outcome Goals
- Variables for Data Collection
- Outcome Measures
- Data Sources
- Data Entry and Data Quality
- Data Analysis
- Mental Health Data Collection & Evaluation Lessons

Up Front and Ongoing Planning

Each component of the SPNS Systems Linkages Initiative built upon existing VDH engagement in care activities. On the strategic planning level, this involved review and incorporation of insights from needs assessment and planning activities, particularly those under Ryan White legislative and policy directives. On the programmatic side, SPNS work was designed to enhance and expand existing mental health services to create a more comprehensive and sustainable service. Mental health services have long been identified as a need for PLWH in Virginia, although efforts to establish high capacity and sustainable models has been challenging. SPNS provided an opportunity to learn what feasible models could be established and replicated. The Mental Health intervention faced challenges replicating the intervention at two sites. Understanding what was unsuccessful is as valuable as understanding what worked, providing insights into what approaches to take in the future. These planning steps and adjustments are described below.

Build Upon Existing Planning

The SPNS mental health intervention was piloted at two settings – a large urban university medical center, Virginia Commonwealth University Health Systems (VCUHS), and a smaller rurally-based health center, Carilion Health. Prior to the SPNS project, VDH partnered with VCUHS to address gaps in mental health assessment and services for those recently released from state corrections. (Incarcerated and released individuals have higher rates of mental illness than the general population.[4]) Services included standardized assessments including neuropsychiatric screening, psychotherapy, referrals to community-based substance abuse treatment and other Community Services Board (CSB) services (public mental health and substance abuse services, typically for the seriously mentally ill), and help enrolling in Medicaid and Social Security disability coverage. The program was successful in supporting viral suppression in over 95% of its clients. The program was initially funded under Ryan White funding, and eventually transitioned to funding under the Centers for Disease Control and Prevention (CDC) administered by VDH's HIV Prevention unit. Building from the success of this program, VDH worked to develop a comprehensive mental health intervention to serve all HIV-positive individuals with a mental health need.

[4] James D, Glaze, LE. Mental Health Problems of Prison and Jail Inmates. Sept 2006. Bureau of Justice Statistics, NCJ 213600.

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Carilion historically provided limited mental health services under Ryan White funding, primarily psychotherapy. Services were inconsistent, dependent upon staff availability. However, the HIV clinical coordinator identified possible interest in expanding services through an in-house psychiatrist, neuropsychologist, and some community mental health providers. The goal was to build upon this interest and develop in-house screening for all patients; psychotherapy and psychiatry services for selected patients; and utilize a strong community-based treatment network for most of the mental health and substance abuse treatment needs.

VDH attempted replication of the strategy at a mid-size university medical center serving a large number of rural patients, the University of Virginia Medical Center (UVA). UVA provided limited psychotherapy and periodic psychiatry under Ryan White funding and had strong support for expanding services from clinicians in the HIV clinic. A community-based organization located near UVA recently restructured to provide increased mental health services to both HIV-positive and Lesbian, Gay, Bisexual and Transgender patients. This site could potentially serve as a referral point.

Be Flexible to Adjust to Real World Circumstances–What Worked and What Didn't

The goals of this strategy were ambitious—to develop comprehensive screening, to establish a standardized referral process, and to provide mental health treatment. Variability in institutional support, community resources and responsiveness, staffing issues, and space availability impacted the community partners' abilities to implement portions of the strategy.

VCUHS succeeded in most aspects of the model, implementing the standardized screening protocol, developing a referral process, and providing in-house treatment for most mental health needs through psychotherapists and psychiatrists. However, external community mental health and substance abuse treatment services were not well-established and had limited capacity, so VCUHS adjusted by continuing to focus on expanding in-house treatment services with some success. Time did not allow for applying the protocol to one of the target populations—those transitioning or released from correctional facilities within the past six months. That population continued to receive services under the existing program at VCUHS, funded through VDH's HIV Prevention unit noted above, and staff will move toward assessing how to integrate that program under the SPNS protocol.

Carilion secured time with a psychotherapist, psychiatrist and neuropsychologist and began implementing the standardized screening. However, the responsiveness of community mental health

and substance abuse treatment providers faded, and a community treatment network was not established. Despite efforts to revive this effort by the clinical coordinator, it was unsuccessful. Assessments declined and eventually stopped due to the lack of treatment resources. However, Carilion approached this challenge by considering a more flexible approach to providing services. Carilion and VDH mutually agreed that they were unable to follow the structured protocol at this time, and Carilion withdrew from the SPNS initiative. VDH and Carilion negotiated an agreement to begin building mental health treatment capacity utilizing Ryan White Part B funding. VDH allocated funds to establish consistent psychotherapy services, and Carilion will reassess implementing additional services including assessment elements as a basic infrastructure is solidified.

UVA began replication of the strategy by deciding to expand the role of who screened clients. Medical case managers administered the standardized screening protocol and decided to try to screen all patients in the clinic. Some limited time was secured with a psychiatrist, and the clinic began identifying options for provision of psychotherapy. Medical case managers quickly became overwhelmed by screening all patients. They were unable to fully attend to their core job responsibilities and provide the screening according to protocol. UVA was unable to identify additional psychotherapy and psychiatry time and was unable to secure additional space to see patients. At the same time, the community-based organization experienced a leadership change and eventually discontinued services and closed. Like Carilion, UVA and VDH mutually agreed that UVA would withdraw from the SPNS initiative and explore alternative ways to build much-needed mental health services for their patients. VDH agreed to provide UVA with Ryan White funding to fund additional mental health treatment services to the capacity UVA could handle, and VDH and UVA continue to work together to explore ways to build infrastructure for expanding services.

Collaborative Framework

Although the strategy was considered successful at one site, but not sustainable at two, it is worth reviewing and understanding the steps to building collaboration with partners. Participation in this process led to advances in mental health service development (even if not exactly as prescribed through the protocol) and a stronger working relationship between VDH and institutions that led to exploring other funding options and alternative approaches.

Collaborative Learning Model

Collaboration means sharing information and agreeing to work together on a leadership, program and resource level. Collaboration for Virginia was a key method employed for designing, refining, and finalizing each of its four strategies. Under the mental health strategy, collaboration was also operationalized in the context of quick thinking and coordination with VCH to reprogram resources when pilot sites faced challenges and could not carry forward with implementation.

VDH used the Collaborative Learning Model to guide its collaborative process and established a mix of groups to make collaboration and coordination a reality. This model, combined with SPNS outcome evaluation, provided a framework for continuous exploration and improvement. The Collaborative Learning Model is a process whereby systems, organizations and providers implement and measure small-scale interventions, then share their experiences in an effort to accelerate learning and widespread implementation of successful ideas for change.[5] The focus is on continuous refinement of interventions, along with formal process and outcome evaluation. Highlights:

- Each Strategy Group (discussed below) produced a strategy process map in the Plan, Do, Study, Act (PDSA) process, a narrative description of the group's processes, and finally, a list of tools and resources that would be needed to implement the strategy.
- Strategy Groups were also charged with developing the standardized protocol for their intervention during the first 2-3 years of the project.

[5] *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough* Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available at www.IHI.org)

Collaborative Entities

Key Partners

Knowing the key entities is the first step in establishing leadership collaboration: getting the key folks on board. VDH took the time to identify these partners, at the following levels.

- **State Agencies**. Collaboration at the state level involved all units within the Division of Disease Prevention at VDH including HIV Care Services, HIV Prevention Services, HIV Surveillance, and STD Surveillance, Operations and Data Administration.
- **Ryan White and Community Based Entities**. VDH's Ryan White funding crosses multiple programs throughout the state, with Part B service funds and the AIDS Drug Assistance Program (ADAP) intersecting at agencies that also receive HIV Prevention funds, other Ryan White Part funding (Parts A, C, D and F) and state funds. VDH staff report there is a "strong network" among Ryan White Parts in Virginia, with existing collaboration in several large, hospital-based and community center-based Ryan White clinics. Some Ryan White Part B case management services are located in local health departments, and some health departments provide Part B satellite services for university medical centers to be more accessible to rural patients. Ryan White Part B funds have been used to fund mental health services with varying success, although partners have been consistent in identifying increased mental health services as a significant need. Of note, a key partner included a community-based organization that was previously funded with Ryan White Part B for mental health services, but is no longer a recipient. That agency, which continues to develop a mental health program for PLWH and has a strong community presence in the Central health region, provided important input during the protocol and referral process development. This reinforced the lesson that partners may not be current recipients of funding, and it is important to maintain positive relationships with current and former contractors.
- **Mental Health Experts**. VDH contracted mental health experts at two university medical centers, VCUHS and UVA, to provide expertise on developing the screening protocol and identifying appropriate tools. This level of professional expertise was important to ensure the screening tools used were valid for the targeted populations, and to guide VDH on appropriate implementation of the screening protocol.

Collaborative Forums

Throughout the project, VDH convened statewide meetings among all stakeholders, monthly conference calls among a core group of planning representatives, and technical working sessions across the four project strategy areas during the development phase of the initiative. Each is described below.

Planning Group

The Project Planning Group served to guide the overall project design and implementation. Its members included representatives from all four SPNS strategies and focused on overlap and intersection of strategies and opportunities for synergy and efficiencies in linkage and retention strategies. Members were drawn from several units within VDH, community partners at the Virginia Department of Corrections, pilot sites, and other stakeholders in the Central and Southwest regions of the state. They met on a monthly basis during the first two years and shifted to a quarterly basis in Year Three, once full implementation mode was achieved. Note: Each intervention had a Strategy workgroup (see below) that was specific to the intervention, which fed into and reported to the Planning Group.

Community Advisory Committee

The Planning Group recruited several consumers to attend and participate in the initial learning session about the SPNS project. In order to more systematically gather valuable consumer feedback on interventions carried out under the initiative, VDH formed a Community Advisory Committee under the SPNS Learning Collaborative. The objectives of the committee included: providing involved feedback on the interventions particularly during the "Study/Act" part of the PDSA cycle; evaluating whether the interventions are feasible and beneficial to People Living with HIV; providing guidance on involvement of consumers within the collaborative; and being involved in the Collaborative trainings. VDH recruited seven consumers from across the state's five health regions to participate on the committee.

VDH hosted a committee orientation early on to bring the consumer representatives together to learn about the goals of the SPNS initiative and articulate the role and structure of the committee. Members also participated at a subsequent learning session with SPNS sites from other states.

Relatedly, the existing HIV Community Planning Group, which includes patients accessing care from across the Commonwealth, including the various collaborating sites, collaborated on issues such as training, community resources and client needs.

Strategy Groups

Each strategy under Virginia's SPNS project formed a Strategy Group to provide input on the process of development of the strategy's protocol. All groups operated under the direction of the SPNS Planning Group. The Mental Health strategy group's features were as follows:

- **Members**. The group included mental health counselors, medical case managers, program administrators, and HIV clinicians.
- **Purpose**. Develop and pilot the strategy (screening, referral and treatment) in order to retain patients in care to improve both mental health and HIV care outcomes (viral suppression) for patients.
- **Interventions/Activities**. Early on, the planning team determined a need to move the strategy work groups forward by having them focus on "doing" rather than "planning." The sequence of tasks (defined as interventions for the group) included the following, developed as a "process map" with timelines:
  - Establish communication process for sharing information and resources.
  - Review existing referral forms and assessment tools.
  - Work with a team of mental health consultants that developed valid assessment protocols implemented by the pilot sites.
  - Assess efficacy of current referral procedures and improve where needed.
  - Evaluate linkages to other strategy groups.
  - Develop a standardized protocol covering all aspects from assessment to treatment.
- **Process**. The group held bi-weekly conference calls and/or meetings during the first year and then moved to monthly meetings thereafter. Sessions benefited most from having clear agendas and roles for participants, thus avoiding ongoing meetings that only served as information forums. Discussions generally entailed presentation of the issue, group brainstorming, and follow-up tasks to learn more or complete the assignment. Members also met during learning sessions with VDH to both receive training and develop protocols. Strategy groups developed the protocol for their area during years 2-3 of the project, with implementation and evaluation carried out in years 3-4. The groups met formally in three learning sessions with VDH and periodically until completion of the protocols.

- **Monitoring.** Monthly PDSA reports were submitted to document progress for each of the four strategy groups.

Regional Groups

During the Collaborative Learning Model phase of the project, VDH organized regional groups in the two regions where the majority of piloting was occurring: Central and Southwest. The goal of these groups was to create a discussion forum about the intersection of the various linkage strategies being developed and implemented through the SPNS Systems Linkages initiative. In particular, these groups focused on areas where collaboration was most essential, such as referral of newly diagnosed patients from the Active Referral intervention into Patient Navigation and the mechanisms for referring patients from Patient Navigation to Mental Health services. The groups included representatives from all four strategy groups from their respective regions. Regional groups were also useful in creating new referral points, opening up communication channels among partners, and addressing implementation challenges specific to each region.

Staffing

Identify Experienced and Credentialed Professionals

Putting personnel into place for the mental health strategy was very much a matter of building around the existing mental health infrastructure of the initial pilot sites (VCUHS and Carilion) and the replication site (UVA). At each of these sites, personnel procedures (e.g., management, supervision, job descriptions), staffing criteria and processes were already in place for mental health professionals who provided treatment.

There were certain common staff skills that were considered ideal:

- Therapists should be licensed or credentialed in their profession (i.e., Licensed Clinical Social Worker, Licensed Psychologist, Medical Doctor, Licensed Professional Counselor, etc.). This was particularly important if services were to be sustained under Ryan White Part B funding, which requires that services can only be provided by a mental health professional licensed or authorized within the State to render such services. (*http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/HCS/peer_review.htm)*
- Mental health professionals should have experience and training in health conditions and management, preferably HIV
- Qualified individuals needed to be able to administer, score, and triage mental health screenings.

Sites were successful in identifying credentialed providers, but varied in the amount of time those professionals were able to dedicate to the project.

- VCUHS employed two full-time Licensed Clinical Social Workers within the HIV clinic to administer the screenings and provide psychotherapy, secured time from a psychiatrist to see patients during HIV clinic times and a neuropsychologist to review screenings as needed. Having these resources available within the HIV clinic contributed to success during implementation.
- Carilion was able to secure limited time from a Licensed Clinical Social Worker, and hours as needed from a neuropsychologist. Unfortunately, the Social Worker's hours varied due to needing to attend to other priorities within the health center, leading to inconsistent resources available.

Establish Clear Job Roles

UVA took a different approach with staffing when attempting to replicate the strategy, which ultimately led to challenges with sustainability. All medical case managers in the clinic were tasked with administering the mental health screening protocol to all clinic patients, resulting in difficulties attending to their other core job responsibilities. Blending of these roles (medical case manager and mental health screener) led to challenges with prioritizing work and ensuring consistent implementation of the screenings. UVA also experienced challenges with securing adequate psychiatry and psychotherapy services to address the needs identified through the screenings.

In retrospect, staffing the project with dedicated personnel whose primary roles were to screen, refer and provide mental health services, as in VCUHS's case, appeared to support greater success. Blending job roles and relying upon limited and variable professional hours led to an inability to sustain for the long-term.

Training

Design Training to Adjust to Existing Training

Several factors drove the design of a staff training plan for the mental health intervention, which varied in topics depending on the needs of each site's staff. First, staff had existing training requirements within their agencies and according to their professional licensing boards, meaning additional training needed to be limited in scope. Second, a focal point for the training was on implementation of the protocol. Third, training needed to address how best to meld newly hired mental health professionals with the existing medical staff.

Identify Training Topics/Curricula

Trainings at sites covered a number of core areas, depending on staff need:

- **HIV/AIDS Issues**. HIV/AIDS training was generally provided under a site's existing infrastructure, relying upon training resources already in place and direct training by clinicians on site. HIV training was more crucial for staff with less experience serving HIV-positive individuals. These staff were required to complete an HIV Facts and Fundamentals course (provided through a state-funded training contractor), prior to or as soon as possible after their date of hire.
- **Mental Health Protocol**. One-on-one education was provided to all participating sites about the SPNS mental health protocol.
- **SPNS Orientation**. Staff also got a briefing on the entire SPNS initiative and periodic updates as the SPNS project evolved, focusing on the project's purpose, strategies and outcomes.
- **Screening**. This training covered not only what the screening tools were for but also how to administer them and in what order, as outlined in the protocols (i.e., (MOCA annually; AUDIT/DAST, PCL-C PRN; PHQ9 and GAD7 every 6 months).

Trainings varied depending on the experiences and structure of staff at sites and included:

- **Motivational Interviewing**. Training addressed skills in the principles of Motivational Interviewing as well as practical and experiential application.
- **Cultural and Linguistic Sensitivity.** This training was tailored to populations seen by the particular site.

- **Effective Communication and Negotiation.** The focus was on best methods for integrating services into an existing clinic structure.
- **Legal and Ethical Issues Related to HIV Care.** Given that most professional boards require ongoing training in legal and ethical frameworks and issues, training focused on the unique concerns and approaches related to HIV.

Use Multiple Training Methods

Mental health training took on different shapes and formats, reflecting staff need and the need to fit within pre-existing training at clinic sites. Approaches included the following and focused on both internal staff education and referring staff to external training agencies.

- **Observational Training**. Under this technique, a new staffer observes current mental health staff and additional clinical staff (medical care, nursing, case management) provide services at the HIV clinic. This can be conducted through direct observation, or video and/or audio recordings with patient consent. Departments of psychology at universities can be a good resource for learning appropriate methods for this training approach.
- **Community Education and Training**. Mental health staff conducted educational sessions on the SPNS mental health protocol with internal and external providers, referral sources, and staff. Staff also received trainings in these venues. Training took place during clinic-wide meetings, through individual consultations with staff, and during meetings with external providers. Trainings to a variety of providers can also be provided through performance sites of AIDS Education and Training Centers (AETCs).
- **Written Materials**. Staff provided training to referral sites through distribution of the written protocol, forms, and information sheets on the program and its criteria.

Collaborative Activities

Collaboration cannot be just a series of meetings. To be meaningful requires purpose, structure, and activities to accomplish. The following were essential to Virginia's work.

Secure Buy-In

"I really can't say enough about buy-in." Those words by one VDH staffer sum up the importance of establishing cooperation and participation from potential partners. Outcomes of buy-in include, for example, clinic willingness to give providers time and space in which to perform screenings and deliver subsequent therapy.

VDH staff said it was impossible to introduce a new strategy in a busy clinic atmosphere without buy-in from those involved. This is where VCUHS excelled in marketing the project to providers. Among their strategies:

- **Identify the Message**. SPNS-funded staff explained how integration of the SPNS mental health initiative could potentially assist with efforts to engage and retain patients in treatment and care and improve health outcomes (including viral suppression).
- **Identify Allies**. Identify key supporters within the agency—ideally, individuals from each staff type (e.g., front desk, nursing, physicians) who will understand the project and help you reach your goals.
- **Communicate Outside**. Brief external partner agencies, including satellite clinics and staff in the field.
- **Communicate Inside**. Use internal communications (e.g., emails, staff meeting updates) to educate staff and keep them updated on the program.
- **Educate the Referral System**. Outreach to external providers was conducted to help them identify gaps in service and explain how to refer clients to the VCUHS project. A one-pager on referral criteria was developed to explain how the SPNS project could be a good fit with their work.
- **Secure Buy-In with Patients**. The replication site (UVA) took steps to try and stop the stigma associated with mental health screening by explaining to patients that these screenings were conducted for all patients, normalizing the health screening process. A literacy appropriate tool was developed to explain this to patients.

- **Collaborate with Other Programs.** VCUHS's in-house model did not have every essential service available within the site. Some services needed to be accessed externally, including those not normally found within an in-house model and services that needed to be accessed from external entities and their separate payment sources. They are summarized below.
- **Collaboration with Corrections Serving Agencies**. While the SPNS mental health program did not establish a service component for ex-offenders, as was originally envisioned, relationships were established with other stakeholders working directly with the Department of Corrections and local jails.
- **Collaboration with Substance Abuse Agencies**. The in-house model developed under the SPNS project did not provide substance abuse treatment services but made referrals to 12 step programs and warm handoffs to CSBs.

Collaborate within the Clinic

The mental health protocol involved collaboration from a number of individuals within the VCUHS clinic, including mental health counselors, medical case managers, medical providers, psychiatrists, neuro-psychologists, and administrative staff. Internal collaborative considerations and techniques included the following:

- **Assessments**. As a rule, all referrals to the VCUHS psychiatrist had to first have a mental health assessment conducted by a qualified professional. The model initially allowed a direct referral to a psychiatrist, but that practice was changed at the suggestion of the psychiatrist, who recommended routing referrals through SPNS counselors. Often, there may be treatment needs identified that do not require medication management, or the patient may not be interested in immediately taking psychotropic medications. Conducting a mental health assessment prior to a psychiatric referral can better determine the patient's needs and wants, can help use psychiatry time more effectively, and can also be a cost-savings strategy as psychiatry services are typically more expensive. All staff needed to be aware of this new protocol, particularly in dealing with patients who only wanted psychiatry services and might be resistant to seeing, for example, a psychotherapist, as "patients sometimes just want some medication to fix their problems."
- **Establishing and Monitoring a Treatment Plan**. In follow-up to an assessment and referral to psychiatric services, collaboration took place in setting a mental health treatment plan as the psychiatrist and counselor decided, jointly, on the best course of treatment: counseling, counseling and psychiatric medication follow up, or psychiatry alone. Time did not always allow for formal,

scheduled interdisciplinary team meetings so mental health counselors and the psychiatrist met on a patient-by-patient basis as needed. Additionally, medical records were shared by all professionals, allowing for monitoring progress or identification of additional issues. VCHUS's decision to have the psychiatrist provide services within the HIV clinic setting, where the mental health counselors were also based, allowed for easier treatment coordination and communication. Additionally, as part of a large university medical center, all professionals had 24-hour a day beepers, so they were able to reach each other at any time.

Protocol Development

Identify Key Staff Members

Virginia recommends finding the players in the clinic who will be most affected by the intervention as well as those who would be able to support the project. They are the potential allies and the primary test audience to figure out how to make the protocol work. Virginia worked with at least one representative from each of the following groups throughout the protocol development process: front desk, nursing, infectious disease providers, mental health providers, medical case managers, and administration.

Development of the mental health protocol (Attachment 1) occurred through use of the Collaborative Learning Model, primarily under the direction of mental health strategy group and utilizing time at statewide learning sessions. Elements of the protocol were tested before widespread implementation occurred, using the PDSA (Plan, Do, Study, Act) cycle to test the acceptability and feasibility of potential linkage interventions.

The strategy group focused on developing procedures (and related forms) for referring patients into mental health, as well as referring patients on to other services, ensuring a "feedback loop" to confirm referrals were successful. It was important to differentiate between referrals received from external agencies, and those received from sources internal to the institution to ensure compliance with institutional requirements. The group also developed procedures for discharging patients from treatment, re-engaging clients who may have either dropped out or were previously discharged, and procedures for data collection and reporting. A Process Map was developed to illustrate key points of the process.

Consultants were used to develop the standardized screening protocol and to guide the procedures for administering, scoring, triaging, and re-screening patients. The consultants had professional expertise in the use of screening instruments, and assisted in ensuring the instruments and results would be valid.

As noted previously, one model emerged as dominant, although it was attempted in three settings. The final protocol is based on an in-house model, where a clinic has the internal capacity to screen, refer, and provide mental health counseling, psychiatric and neuropsychiatric services to clients as well as the ability to refer patients out for other specialty services including substance abuse treatment.

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Below are some insights on the process of creating and revising the mental health protocol.

Use What's Already in Place—and Find What's Missing

The final model was successful, in part due to building on the existing infrastructure of mental health services available in the setting. The protocol's referral procedures linked with existing clinic processes for scheduling appointments, referring to other disciplines within the institution, and building upon existing professional relationships (such as with psychiatry and neuropsychology, that had been established under prior clinic programs).

A missing component was the expertise to develop a valid standardized screening protocol. That expertise was found through contacting university Departments of Psychology and identifying psychologists who had both clinical and research backgrounds.

Some of the missing elements were too significant to address during the time of this initiative, and included community-based treatment options for mental health and substance abuse, dedicated professional positions (such as psychiatrists and licensed therapists) available to staff the program, and available space. However, those elements can be addressed over a longer period of time. The first step to solving those types of challenges is to identify them.

Implement Mental Health Strategy

Determine the Fit Within the Primary Care Clinic

Primary care and mental health have different cultures, due to variable payment systems, credentialing requirements, and approaches to non-adherent patients (e.g., type of follow-up to conduct for problems like missed appointments). Below are observations on common adjustments to real world conditions that were made by VDH and its partners.

- **First, Learn the Clinic Culture**. Clinics have existing policies and processes. VDH recognized a need to adjust its mental health strategy to make it work in the clinic setting, such as coordinating referrals with appointment scheduling processes and addressing immediate mental health needs within a larger institution. The most essential step taken was to "learn the culture" of a clinic in conversations with providers, watching and listening.
- **Adjust to Existing Methods**. Clinic structures are very different. This created some real implementation challenges in determining how to fit the mental health strategy within existing operations. Virginia sought out opportunities to implement its protocol around existing clinic operations. For example, the mental health referral form was adjusted to make it easier to enter data into CAREWare software used to record client level data.
- **Integration of Mental Health and Primary Care**.
    - At one site, there were simply not enough staff and the infrastructure to carry out screenings and treatment referrals was not in place.
    - At another site, the foundation was stronger, including buy-in from clinic staff. However, they faced numerous challenges. First, it was not possible to conduct assessments and complete referrals for all of their clients, as was originally envisioned. Medical case managers did not have the time to administer screenings, handle patient referrals and attend to their case management core job functions. While a strategy was developed to make this possible (patients were to come in 30 minutes early to their medical appointments so that screenings could take place), the site quickly determined that screenings could not be carried out in between HIV medical appointments with various providers. The clinic also simply did not have the space: separate rooms to conduct screenings were not available.

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- **Find Space to Meet**. Clinic space to conduct confidential screenings and provide psychotherapy is also crucial. Creativity was used at various Virginia sites, including white noise machines and curtains in a conference room to turn one space into two. Close communication between medical case managers and nursing/front desk staff to determine the best available meeting space at any given appointment was essential.
- **Determine Whom to Screen**. The extent to which mental health screening becomes a routine part of primary care is a matter of time and resources. Some patients have no need for mental health services, while others are in desperate need. Making those distinctions can be challenging. One site (VCUHS) followed carefully designed criteria for mental health referrals (included as an attachment to the mental health protocol). The replication site (UVA) elected to try mental health screening as a routine part of work with all of its Ryan White eligible patients. The time necessary to carry this out proved impossible, given existing operations and demands on staff. Clinics need space to both screen and provide follow-up for those needing mental health services. These challenges suggest that a smaller scale start-up might be advisable for many clinics.
- **Manage Missed Appointments**. The reality for patients with mental health challenges is a high likelihood of missed appointments. Managing missed appointments is an essential part of mental health treatment, as this can indicate problems needing to be addressed. VCUHS providers stress to patients the importance of adherence to medical and mental health appointments and how adherence to these appointments can affect their overall health care outcomes. This is also an area that should continue to be reviewed and updated in any clinical protocol, to ensure appropriate intervention while supporting patient accountability.
- **Establish Staff Responsibilities to Manage Patients**. VDH's experience with the pilot sites was that primary care clinics need to have the capacity to take on mental health services in terms of specific staff to conduct intake, screening, referrals, and subsequent mental health service delivery. One pilot site initially relied upon therapist and psychiatrist hours from other programs that eventually decreased. The replication site assigned medical case managers to conduct initial screening, but this was not manageable as their caseloads were already heavy. The VCUHS site assigned screenings to counselors as an interim step before meeting with the psychiatrist, thus "triaging" patients to appropriate services up front and preserving that physician time for more acute cases.

Manage Referrals

- **Make Sure Patients Understand Referral Services**. Patients benefit when they have a clear understanding of what they will be getting with a referral to mental health care. They may not understand that services can be most effective with a combination of medications and talk therapy. Patients who lack such knowledge may not follow-up and may not touch base with their case managers or therapists. Patients need to understand what they are getting and where their information is going.
- **Identify and Meet Service Challenges**. Patients may not access referred services for varied reasons. Knowing these potential barriers is part of the referral process. Staff report that transportation is one of the bigger barriers. This can be addressed with taxi and other transportation vouchers as clinics often have funding for these services.
- **Know Referral Sources**. Staff need to fully understand the scope of services and other characteristics of the referral locations where they send screened patients. This includes not only services but also location, access, and other practical considerations that can enhance a patient's understanding and willingness to follow-up with a referral.
- **Follow the Protocols—with Flexibility Where Clinically Appropriate**. Certain aspects of the protocol have best results and decrease confusion when followed consistently, such as referral procedures or administering a standardized set of screening tools. However, other protocol elements relate to scoring and triaging/referring patients to mental health services. Staff stress the importance of managing patients based upon these score results, in addition to the clinical assessment of patient needs. For example, a tool may indicate a referral to substance abuse treatment, but clinically, the patient requires other services to help prepare them for benefitting from treatment. Staff appreciate a protocol that allows a clinician to adjust treatment plans when they gain additional insights from interactions with patients, and allowing patients to contribute to their plan. Clinical judgment must be a factor in any treatment.

Focus on Retention and Viral Suppression

What impact does mental health service delivery have on HIV care engagement? Virginia staff report that mental health care is not necessarily a primary tool for initially engaging people in care as "it's hard to get people into mental health care without them [first] being in care." However, Virginia's data on their mental health strategy has documented positive impacts when it comes to improving retention in

care and achieving viral suppression. Below are insights on how retention work is facilitated in the mental health intervention.

- **Continuously Assess Patient Needs**. Staff report that, when doing a "history" on patients, other things come out of the discussion, like family issues and substance abuse challenges. These revelations should be acted upon in order to further support retention of patients in mental health and other needed services.
- **Know the Prevalent Mental Health Issues.** Anecdotally, mental health providers report that depression is a big issue—number one in the estimation of some staff, who see it in most of their patients. It is important to validate information through analyzing screening results and record review, to ensure staff are trained to meet patient needs.
- **Be Ready When Dropouts Return**. People who drop out of care often come back. That says that patients saw value in the services they were getting. Explore those perspectives and build upon them to help further engage patients. Also, review the process for intakes for returning patients, and a more rapid re-entry to mental health services may result in ongoing retention.
- **Use All Available Resources.** Use all available resources to re-engage patients including patient navigators when appropriate. However, there may be some instances where this may not be appropriate given confidentiality concerns. It is important for staff to understand the unique role other services play and how different approaches can work together to support patient retention. Rapport and building of trust among staff across services can also help.
- **Address the relationship between mental and physical health.** Improved psychological functioning and coping help patients benefit from medical treatment by adhering better to appointments and taking medications. Preliminary results showed that both retention in care and viral suppression improved for clients served under the mental health protocol. It is important for both clinicians and patients to understand how getting help with mental health issues can improve physical health and, in the case of HIV, keep communities healthier by reducing transmission risk through viral suppression.

Sustainability and Program Integration

The following are under consideration regarding continuation of the mental health intervention.

Enhance Third Party Billing

Of all the SPNS strategies, the mental health strategy may be most able to benefit from and be sustained through third party (insurance) billing. Mental health services are often covered under insurance plans, Medicare and Medicaid. Many PLWH in Virginia that meet ADAP criteria (at or below 400% of the Federal Poverty Level) can obtain coverage under an insurance plan through the Patient Safety and Affordable Care Act (ACA) and have ADAP pay for premiums and medication costs. Although Virginia did not expand Medicaid under the ACA, those patients are still eligible for ACA insurance through ADAP. There have been some challenges to insurance billing. Mental health providers must be credentialed and paneled under each insurance plan being billed, which requires several steps to be taken by the clinician and the agency (which also varies by insurance company). An added level of complexity at some university medical systems is that there are generally academic and clinical arms of administration, and the ability to bill depends upon which arm employ the staff.

Other factors include determining how to bill for "no-show" appointments and whether providers can bill for group mental health interventions. The mental health programs, VDH, and the fiscal and administrative levels of institutions that house the mental health programs continue to work together toward setting up a third party billing system for services. Even with a functioning insurance billing system, Ryan White and other funding continues to be critical for ensuring full access to mental health services. Some patients will remain uninsurable under the ACA, or if insured, require assistance with mental health visit and medication copayments. Some insurance may restrict the number of visits or types of clinical treatment needed to meet a patient's mental health need. In all these situations, Ryan White funding can be used to assist patients.

Review and Revise Protocol

The mental health protocol is a model that can benefit from ongoing review and updates, including an annual review by a clinic to ensure that the protocol's core components are being carried out. This will be particularly important as referral sources change or hire new staff, or internal agency systems change in response to continuing to implement aspects of the ACA.

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Expand by Linking with Other Partners

Engagement of stakeholders impacted by a mental health network, referral agencies, and other mental health providers in the community is vital to the success of the program. One recommendation is for clinics to continue to work with other stakeholders, who work directly with state corrections and local jails to expand the mental health program to those released from those facilities. The possibility of using telemedicine to reach clients further away from clinical sites was noted by one agency, and continues to be explored. VDH will continue to strategize around recruitment and engagement of mental health providers and agencies to increase capacity for mental health services.

Secure Ongoing Agency Support

Just as buy-in was essential to getting the pilot sites off the ground, ongoing agency support is essential to continuation of the intervention and expansion at other locations. This includes identifying individuals in various professional categories (e.g., front desk, nursing) who will understand the project and help support the project. Said one staffer, "it is impossible to impose a new strategy [and keep it going] in a busy clinic atmosphere without buy-in from those involved."

Use Ryan White HIV/AIDS Program Funding

VDH will be releasing Ryan White Part B funds through a Request for Proposals (RFP) process to reach additional mental health providers across the state. As noted above, insurance billing will be critical to sustaining mental health services, and is legislatively mandated to ensure Ryan White funds remain the payer of last resort. The RFP will require applicants to collect and report accurate and timely data, identify community/agency resources to receive referrals for treatment including substance abuse services and treatment for the seriously mentally ill, provide clinical supervision to mental health providers, and demonstrate the capacity and ability to bill third party payers.

This initiative demonstrated that substantial work must be done to build an initial mental health infrastructure that includes staffing, referral and administrative aspects in many areas throughout the state. Without a basic infrastructure in place, VDH anticipates that sites will be unable to fully implement the protocol as seen in two of the three sites participating in this initiative. Therefore, VDH will also provide non-Ryan White funds to support the RFP for sites that need to invest in building infrastructure during the first year of award.

Measuring Program Effectiveness

Data collection and the evaluation of processes and outcomes were critical to ensuring program effectiveness. Below is the basic framework for collecting data and conducting basic evaluation of the Mental Health strategy and reporting data to VDH for program evaluation and reporting purposes.

Outcome Goals

The main goal of the Mental Health strategy was to address mental health barriers that may impede continuous engagement in HIV care and to ultimately facilitate an increase the percentage of persons who retain in HIV care over time and increase the percentage of persons who are virally suppressed.

Variables for Data Collection

VDH collected primary data for evaluation of this strategy in a secure database. Data were entered locally by Mental Health programs either via CAREWare or the Virginia Client Reporting System (VACRS). In addition to other key demographic and patient information routinely collected by each agency or clinic, the following data were collected for all patients enrolled in Mental Health Services:

- Patient's Full Name (Last, First, Middle Initial)
- Patient Date of Birth
- Patient's Current Gender
- Patient's Race
- Patient's Ethnicity
- Patient's Insurance Status/Type
- Date Client Enrolled in Mental Health Services
- Date of Intake Screening
- Scores for all Screeners Conducted with dates for any re-screening
- (PHQ-9, AUDIT-DAST, GAD-7, Rx screener, PTSD, MOCA)
- Date of Mental Health Service Visit(s)

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- Type of Mental Health Service Provided at each Mental Health Visit
- Duration of Service Encounter/Mental Health Visit
- Referrals to other Mental Health services (internal and external)
- Date of Mental Health Program Service Closure

* If the Mental Health Program is not co-located within the medical facility where patients are receiving HIV care, programs should consider collecting other HIV-care related data in order to monitor HIV care outcomes in conjunction with their mental health treatment to meet program outcomes. At the state level, VDH accesses HIV care markers, discussed later in this section, to monitor HIV care outcomes for clients enrolled in the Mental Health intervention. However, the local Mental Health program has access to client EMRs and HIV care information.

Outcome Measures

The following outcomes were used to measure effectiveness of the Mental Health strategy:

Hypothesis	Key Independent Variables	Dependent Variables
Retention	1) Received SPNS MH Services (yes, no) 2) Date of first MH service	1) 12 month retention measure 2) 24 month retention measure
Viral Suppression	1) Received SPNS MH Services (yes, no) 2) Date of first MH service	1) Viral load measure six months after services start 2) Viral load at 12 months

* An HIV care marker includes evidence of a CD4 or viral load lab draw, HIV medical care visit, or antiretroviral prescription

** Retention in Care over 12 months: An individual is considered "retained in care" over a 12 month period, if he or she has two or more care markers in the 12-month period that are at least three months apart.

*** Retention in Care over 24 months: An individual is considered "retained" in care over a 24 month period if he or she has at least one care marker in each 6-month period, with a minimum of 60 days between each care marker.

Data Sources

The variables listed above were captured in the referral and screening forms contained in this manual as well as from encounter-level field data and case notes that were entered into CAREWare. In addition to data received from Mental Health programs, VDH utilized data from the Care Markers Database (CMDB) which houses HIV data from multiple statewide data systems, including the statewide electronic HIV/AIDS Reporting System (eHARS), the Virginia Client Reporting System (VACRS), the AIDS Drug Assistance Program (ADAP) and available Medicaid data to determine whether a patient was linked and retained in HIV medical care.

Data Entry and Data Quality

Data entry and data quality are critical considerations for programs implementing a Mental Health program. Data entry errors may affect process and outcome measures as well as the ability to match information into other data sources as described above. VDH worked closely with sites to ensure complete and accurate data collection of all necessary process and outcome data measures. It is important to ensure adequate staffing of a data manager or data entry specialist at each of the mental health sites to ensure quality assurance processes are occurring on all submitted client-level data.

Data Analysis

For the VA SPNS Systems Linkages Initiative, linkage and retention outcomes were assessed using separate logistic regression models in which the individual likelihood of being retained in care and virally suppressed was estimated. Basic frequencies and means of demographic variables were produced to describe the population receiving Mental Health services. Process measure data analysis was particularly useful for program planning purposes at the agency level.

Mental Health Data Collection & Evaluation Lessons

Sites must ensure adequate data manager/data analyst/data entry specialist time to support data management activities at the site level including ensuring necessary variables are programmed into the database and conducting data quality assurance activities on a routine basis. This will be contractually mandated at Ryan White Part B-funded sites.

Data should be entered no more than a week after a client encounter occurs and overall data should be monitored on at least a monthly basis.

It may be useful for programs to track referrals to specialty mental health services, such as substance abuse, particularly if they are external to the program.

It may be useful to track/record all mental health diagnoses in the program's data system, not only the primary diagnosis. This information will assist agencies in ensuring appropriate training and resources for staff to treat prevalent and emerging mental health needs.

It may be useful for programs to consider administration of and recording of a Quality of Life Scale to periodically assess patients in conjunction with the other screeners. Furthermore, it may be useful to database and analyze all screening and re-screening results to identify issues being presented by patients, and tie them to mental health outcomes. This initiative focused on HIV-related outcomes, which is important. The additional information about impact on the mental health diagnoses will assist in improving treatment and revising the screening protocol as needed.

Preliminary outcomes from the SPNS Mental Health intervention indicate improvements in 12-month retention in care and viral suppression rates for those served by the Mental Health program at one large university medical site. Tracking the impact of mental health services on HIV-related outcomes will be required through the RFP being released, and will continue to be contractually required by Ryan White Part B-funded sites.

Methodology for Preparing this Manual

Implementation insights were identified through a series of interviews with project staff along with a comprehensive review of project progress reports, presentations, and products developed. The methodology was as follows.

- **Project Materials**. Virginia's SPNS project generated lots of materials on the intervention project. Among these resources: presentations on project goals and activities; agendas; action plans; and tools used in planning, staffing, and other essentials of putting a project like this into place.
- **Interviews**. Few of the above resources captured the experience and thoughts of the interventionists themselves: the program managers at the state level and the people in the field working with patients. To gain their perspectives, a series of group discussions on each strategy were held over a two-month time frame. Discussions were guided by a series of broad questions and follow-up prompts. The protocol covered: Staffing/Training; Collaboration and Coordination; Protocols and Processes; Working with Clients; and Sustainability. The protocol that was used was based upon SPNS sites interview tools used by three other SPNS sites. The draft underwent a few "test drives" and was subsequently modified by the project team.
- **Review of Implementation Manuals**. A review was conducted of a select set of implementation manual drafts from prior SPNS initiatives, as well as more recent manuals from other Linkages projects. This review was undertaken to identify optimal ways to present information, especially lessons learned from project implementation. As a result, an initial outline was developed, using other SPNS manuals as well as the HRSA/HAB template.
- **Analysis and Presentation**. The above information and outline was used to write the implementation manuals. The emphasis was on lessons learned, "aha moments," and other insights that could be readily adopted and adapted by others. As such, the manual maximizes use of bulleted lists that are intended to present information in an easy-to-grasp format.

Mental Health Strategy Protocol

Special Projects of National Significance (SPNS)

Systems Linkages & Access to Care in Virginia

Virginia Department of Health

Madison Building

HIV Care Services

109 Governor Street

Richmond, Virginia 23219

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I. Purpose

The Special Projects of National Significance (SPNS) Mental Health protocol is an intervention designed to deliver comprehensive screening, referral, and treatment services to address the mental health needs of HIV-positive clients. HIV-positive individuals are at an increased risk for developing mental health conditions, and these conditions can impede an individual's ability to connect with or stay in HIV care. Mental health is also an important aspect of an HIV-positive individual's overall well-being.

The mental health protocol aims to increase retention in HIV care and improve the mental health care outcomes of persons living with HIV/AIDS (PLWHA) through the increased referral to and utilization of mental health services by PLWHA. Mental health professionals, medical case managers (MCMs), and HIV health care providers work together to increase access to mental health services by screening clients for mental health issues and referring them to specialty mental health services such as therapy, counseling, neuropsychological testing, and substance abuse treatment.

This protocol is based on an in-house model, where a clinic has the internal capacity to screen, refer, and provide mental health counseling and/or therapy, psychiatric and neuropsychological services to clients as well as the ability to refer patients out for other specialty services including substance abuse treatment.

II. Scope

The objectives of the SPNS mental health protocol are to increase retention in HIV care and improve mental health outcomes of HIV-positive clients coping with mental health issues by:

I. Using standardized and validated standardized depression, anxiety, cognitive functioning, alcohol, and substance abuse screeners to screen clients for mental health issues.

II. Using a standardized referral process to refer HIV-positive clients to specialized mental health, psychiatry, and neuropsychological services from both internal and external clinic settings as well as community agencies.

III. Developing and using client-centered treatment and counseling plans aimed at improving both mental health and HIV care outcomes.

IV. Referring clients to and providing psychiatry, neuropsychological services, and other specialty services when applicable.

V. Reviewing clients for transition from specialized mental health services to community or other services based on mental health and medical care outcomes.

VI. Building relationships with HIV care and mental health providers to facilitate use of mental health resources to support HIV-positive clients.

Target Populations

The SPNS mental health protocol targets persons who meet one or more of the following criteria:

- Persons newly diagnosed with HIV/AIDS;
- Persons new to HIV care;
- Persons who are non-adherent to HIV care due to symptoms of mental health, substance abuse or psychosocial stressors;
- Persons who are adherent to HIV care but have mental health, substance abuse or psychosocial stressors that may cause the person to become non-adherent or lost-to-care (LTC);
- Persons transitioning or released from correctional facilities within the past six months

III. Responsibility

The mental health protocol involves collaboration from a number of individuals within the clinic including mental health counselors, medical case managers, medical providers, psychiatrists, neuropsychologists, and administrative staff. In addition, community-based organizations (CBOs) and other clinics that may refer patients to receive SPNS screening through the mental health program are involved in assessing clients based on the above criteria and making referrals accordingly.

IV. Procedures

Procedures for Referring Clients to the SPNS MH Intervention
Referral Agencies:

SPNS mental health programs may receive referrals of PLWHA from a variety of partners within the local system of HIV care. These providers may include:

Internal clinic providers

- Health care providers (physicians, nurse practitioners, physician assistants, nurses)
- Medical case managers
- Adherence counselors
- Mental health and substance abuse treatment counselors/practitioners

External/Community agencies/partners

- Health care providers
- Correctional facilities
- Case managers/social workers
- Adherence counselors

Clients may be referred to the SPNS mental health intervention in several ways. Referral options include:

A medical provider (internal or external) identifies mental health symptoms that may impact adherence to care and discusses referral to SPNS mental health program to receive additional screening. The referring provider completes an internal or external referral form (Attachments 2 and 3) and faxes it to the client's medical case manager (MCM). The MCM sends the referral to the SPNS mental health program.

A social worker/case manager or adherence counselor identifies mental health symptoms that may impact adherence to care and discusses referral to the SPNS mental health program to receive additional screening with the client. The referring provider completes an internal or external referral form (Attachments 2 and 3) and faxes it to the client's SPNS mental health program.

Procedures for Making Referrals to the SPNS Mental Health Intervention from External Organizations:

A medical provider, case manager, adherence counselor, or mental health provider outside of the clinic who identifies a need for mental health counseling for a client takes the following steps to link the client to the SPNS mental health program:

Discuss the SPNS program and the impact mental health counseling can play in improving overall health care outcomes with the client.

If the client accepts and agrees with the referral, the referring provider completes a SPNS mental health External Referral form (Attachment 3) and faxes it to the SPNS mental health program.

Upon receipt of the External Referral form, the mental health counselor (MHC) reviews the referral to determine if the client meets referral criteria.

If additional information is needed to determine if the client meets referral criteria, the MHC will contact the referral source to further discuss the pending referral.

If the client does not meet SPNS referral criteria, the MHC will contact the external referral source and refer the client to other community mental health resources.

If, upon further evaluation, the client meets any of the referral criteria, the MHC will attempt to contact the client within **seven days** of receipt of the referral to schedule an initial intake/assessment.

Initial Client Contact/Feedback Loop to Referring Provider:

The MHC engages in the following steps to initiate SPNS mental health services:

The MHC makes three (3) separate attempts to reach the client, documenting the dates of the calls on the referral form.

If the MHC is unable to reach the client, the MHC will send a letter to the client, requesting that the client call the clinic to schedule an appointment.

If the client does not respond within ten (10) days after the MHC sends the letter, the MHC will notify the referring provider that the client has not responded to contact attempts.

When contact is made with the client, the MHC will explain the reason for the call, referencing the conversation the client had with the referring provider to receive further screening related to their mental health and to help them address barriers to staying in care.

The MHC will then schedule an initial evaluation/assessment with the client, documenting the date of the appointment on the referral form.

For the first appointment, the MHC should request that the client arrive 15 minutes early to complete some initial screening questionnaires. This will include the Mental Health Screening Packet Cover sheet (Attachment 11) and the Generalized Anxiety Disorder 7-Item Scale (GAD-7), Patient Health Questionnaire 9-Item Screener (PHQ-9), and the Post Traumatic Stress Disorder (PTSD) Checklist Civilian Version (PCL-C) screening instruments (Attachments 5, 6, and 7).

The MHC should have a clipboard with these forms ready for the client upon check-in with the client services representative at the reception desk.

The MHC will make a reminder call to the client one (1) business day before their first appointment.

If the client fails to show for their initial evaluation/assessment, the MHC will call the client and attempt to reschedule the appointment.

If unable to reach the client, the MHC will send a letter to the client requesting a return call within ten (10) days.

If the client does not respond within 10 days of the MHC sending the letter, the MHC will notify the referring provider that the client did not engage in mental health counseling.

Procedures for Making Internal Referrals to the SPNS Mental Health Intervention:

If a medical provider, case manager, adherence counselor, or psychiatrist in the clinic where the SPNS initiative is housed identifies a need for mental health screening and counseling services and believes that a client meets SPNS criteria, the referring provider will:

Discuss the SPNS program and the impact mental health counseling can play in improving overall health care outcomes.

If the client accepts and agrees with the referral, the referring provider will complete a SPNS mental health Internal Referral Form (Attachment 2) and send it to the client's medical case manager. The MCM will send the form to the SPNS mental health program.

Upon receipt of the SPNS mental health Internal Referral Form, the MCM will:

Review all referrals to determine if the client meets SPNS mental health referral criteria.

If the client does not meet the referral criteria, the MCM will provide the client with other community mental health resources.

If the client meets SPNS mental health referral criteria, the MCM will send the referral form to a SPNS MHC.

The MHC contacts the client to schedule an initial assessment/intake.

The MHC will attempt to contact the client within **seven (7) days** of receipt of the referral to schedule an initial intake/assessment.

The MHC will make three (3) separate attempts to reach the client, documenting the dates of the calls on the referral form.

If unable to reach the client, the MHC will send a letter to the client, requesting that the client call to schedule an appointment.

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> If unable to reach the client, the MHC will send a letter to the client requesting a return call within ten (10) days.
>
> If the client does not respond within 10 days of the MHC sending the letter, the MHC will notify the referring provider that the client did not engage in mental health counseling.

Procedures to Screen Clients Using the SPNS Screening Instruments

When the client arrives for their initial intake appointment, the MHC should have a clipboard with the demographic forms, the PHQ-9, GAD-7, and PCL-C screeners ready for the client upon check-in with the client services representatives at the reception desk.

> If a referring provider makes the MHC aware of a potential literacy issue, the MHC will leave only a data sheet on the clipboard for the patient to complete upon arrival. When the client comes into the counseling office, the MHC will facilitate completion of the forms and screeners with the client.

The mental health assessment begins upon first face-to-face contact between the mental health provider and the client. The MHC completes a Mental Health Clinical Assessment Form (Attachment 12) within the first two sessions. Face-to-face time with the client for the purpose of completing the assessment is approximately two hours.

Session #1: As outlined above, just prior to the first session, the client will complete the PHQ-9, GAD-7, and PCL-C screeners to assess the client for symptoms of depression, anxiety, and post-traumatic stress. During the first session, the mental health provider completes the initial assessment/evaluation including the Drug Abuse Screening Test with RX Abuse (DAST) and the Alcohol Use Disorders Identification Test (AUDIT) (Attachments 8 and 9) with the client.

Session #2: During the second session, the mental health provider administers the Montreal Cognitive Assessment (MOCA) (Attachment 10) with the client and jointly identifies appropriate treatment goals. The MOCA screener assesses the client for cognitive functioning. At the end of this session, the MHC enters a DSM-5 (*The Diagnostic and Statistical Manual of Mental Disorders,* 5th ed.; *DSM-5;* American Psychiatric Association, 2013) diagnosis and the client-centered treatment plan in the client's electronic medical record (EMR) or a paper chart.

Procedures for Scoring and Triage/Referring Clients to MH services based on score results

DAST

If the client's DAST score is between 3 and 5, which suggests moderate drug abuse, the MHC will recommend that the client seek substance abuse treatment and provide referral information.

If the client's score is greater than 5, which suggests substantial/severe drug abuse, the MHC will provide the client with referrals for substance abuse treatment.

The MHC will ask the client to sign a release of information form (Attachment 4) so that the mental health provider and provider of substance abuse treatment can openly communicate with and on the client's behalf.

AUDIT

If the client's score on the AUDIT is greater than 8, the MHC will recommend treatment for alcohol abuse and provide referral information.

If the scores on the AUDIT are ≥13 for women or ≥15 for men, the MHC will provide referral information for alcohol treatment.

The MHC will ask the client to sign a release of information form (Attachment 4) so the mental health and substance abuse providers can communicate with and on the client's behalf.

If the MHC determines that the client could benefit from a psychiatric medication evaluation, the MHC schedules an appointment with the psychiatrist providing SPNS mental health oversight to the program.

The MHC provides a letter of psychiatric referral (Attachment 13) to the client.

The MHC asks the client to sign the letter, scans it into the client's record, and offers a copy to the client.

If the MHC believes that the client's need for medication seems more imminent:

The MHC will talk with the HIV medical provider to determine if they are willing to write a prescription for a psychiatric medication.

The MHC will consult with the SPNS mental health psychiatrist electronically at the request of the HIV/AIDS medical provider.

If the screening indicates that a client is at risk for harm to self/others, the MHC will direct the client to the emergency department for further evaluation or implement other crisis intervention protocols.

MOCA

If the client scores ≤25 on the MOCA, the MHC will notify the referring provider that the score suggests possible cognitive impairment and that further neuropsychological testing may be necessary.

Procedures for Re-screening Clients

The MHC will re-administer the PHQ-9, GAD-7, AUDIT, and DAST every six (6) months and/or at the conclusion of treatment.

The MHC will re-administer the MOCA annually.

Procedures for Discharging Patients from Mental Health Program or Services

The mental health provider sets criteria for discharge from mental health services. Reasons for discharge include, but are not limited to:

- Completion of treatment goals,
- Client's self-assessment that they can manage without further mental health intervention,
- Three failed attempts made by the mental health provider to reconnect with a client who has failed to keep or reschedule an appointment.

Procedures for Re-Engaging Clients in Mental Health Program

If a client wants to return to mental health services, the client should call their mental health provider within six months of discharge from counseling. If the client wants to return after six months, a medical provider or MCM must initiate a new referral for determination that the client continues to meet SPNS referral criteria.

Procedures for Data Collection and Reporting

A SPNS MHC and a data coordinator enter and monitor data related to the program in CAREWare or another central client data repository.

Data sources include Internal and External referral forms, CAREWare, client charts, and/or an Electronic Medical Record system (EMR).

To determine how the mental health protocol is being implemented, a number of data elements can be tracked including the following:

- Date referral to mental health services was sent/made
- Mental Health Referral receipt date
- Date of contact attempts to schedule intake appointment
- Date of scheduled appointment
- Confirmation of intake appointment
- Length of intake visit
- Dates of HIV medical care visits
- Dates of mental health visits
- Mental health diagnosis and severity (all types)
- Substance Abuse diagnosis and severity
- Referrals to mental health /substance abuse resources outside of the clinic (e.g., for acute substance abuse issues)
- Length of time of each contact with client
- Role of the person meeting with client at each session (counselor, psychologist, case manager, etc.)

Procedures for SPNS Mental Health Intervention Training

Required Credentials for staff implementing the SPNS mental health protocol:

Therapists should be licensed or credentialed in their profession (i.e., Licensed Clinical Social Worker, Licensed Psychologist, Medical Doctor, Licensed Professional Counselor, etc.). This is particularly important if services are to be sustained under Ryan White Part B funding, which requires that services

can only be provided by a mental health professional licensed or authorized within the State to render such services. (http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/HCS/peer_review.htm)

Mental health professionals should have experience and training in health conditions and management, preferably HIV

Qualified individuals needed to be able to administer, score, and triage mental health screenings.

SPNS MH Intervention Training Requirements:

HIV-Related Training: If SPNS MHCs do not have experience serving HIV-positive individuals, they are required to complete an HIV Facts and Fundamentals course (prior to or as soon as possible after their date of hire).

Observational Training: A new MHC observes current MHC and additional clinical staff (medical care, nursing, case management) providing services at the HIV clinic. This can be conducted through direct observation, or video and/or audio recordings with patient consent according to agency requirements.

Community Education and Training: The MHCs conduct education regarding SPNS criteria with internal and external providers, referral sources, and staff. Training may occur at clinic-wide meetings, through individual consultations with staff, and through meetings with external providers.

New providers receive one-on-one education about the SPNS mental health protocol as part of their orientation to the clinic.

In addition, the MHCs include information sheets regarding SPNS criteria when they distribute the internal and external referral forms to potential referral sites.

V. Review and Revision

The implementing site should review the protocol annually with the agency funding the program to ensure that the protocol's core components are being carried out.

VI. Definitions

- At-risk of becoming non-adherent: Individuals who are at-risk of not attending medical appointments on a regular basis due to barriers that affect their ability to stay in care.
- AUDIT: Alcohol Use Disorders Identification Test: questionnaire that screens for hazardous or harmful alcohol consumption.
- CAREWare: A client reporting data base used by clinics for data entry and tracking.

MENTAL HEALTH

- DAST: Drug Abuse Screening Test: questionnaire that screens for drug abuse.
- DSM-5: *The Diagnostic and Statistical Manual of Mental Disorders* (5th edition) is the most widely accepted classification of mental disorders used by mental health professionals and researchers. (American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.)
- GAD-7: Generalized Anxiety Disorder 7-Item Scale: questionnaire for screening and severity measuring of generalized anxiety disorder.
- LTC: Lost-to-care: Individuals who have not attended a medical appointment in six months or longer
- MCM: Medical Case Manager
- Mental Health Counselor (MHC): A licensed or certified mental health provider
- MOCA: Montreal Cognitive Assessment (MOCA) screening instrument: a cognitive screening test designed to assist health professionals for detection of mild cognitive impairment.
- Newly diagnosed: Individuals who have been diagnosed with HIV within the last 90 days.
- New-to-care: Individuals who have never been engaged in HIV care or who are new to care at a clinic.
- Non-adherent: Individuals who attend medical appointments sporadically
- PCL-C: Post Traumatic Stress Disorder (PTSD) Checklist Civilian Version
- PHQ-9: Patient Health Questionnaire 9-Item Screener: a multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression.
- VACRS: The Virginia Client Reporting System; The clinic's designated SPNS coordinator and/or data base manager enters required data into the VACRS database. VDH uses this data to assess and analyze service delivery and progress in meeting objectives/outcomes.

Attachments

1. SPNS Mental Health Referral Criteria
2. Internal Referral Form
3. External Referral Form
4. Mental Health Consent Form
5. GAD-7 (Generalized Anxiety Disorder 7-Item Scale)
6. PHQ-9 (Patient Health Questionnaire)
7. PCL-C (PTSD Checklist)
8. DAST-10 (Drug Abuse Screening Test)
9. AUDIT (Alcohol Use Disorders Identification Test)
10. MOCA-7 (Montreal Cognitive Assessment)
11. Mental Health Screening Packet Cover
12. Mental Health Clinical Assessment Form
13. Psychiatric Referral Letter
14. Process Intervention Map

Attachment 1. SPNS Mental Health Referral Criteria

I. Non-Adherent to Care *due to symptoms of mental illness*

- Indicate adherence profile and social history of mental illness
- Briefly note current psychosocial stressors

II. Adherent to Care *but psychosocial Stressors may cause client to become Non-Adherent*

- Acknowledge adherence
- Indicate known symptoms of mental illness
- Briefly state/list psychosocial stressors

III. Non-Adherent / Risk for Becoming Non-Adherent to Care *due to Substance Abuse*

- Participation in SPNS Mental Health Counseling is contingent upon client actively engaging in primary substance abuse treatment which will be monitored by mental health counselor via contact with provider of substance abuse treatment
- Indicate on referral document that client is seeking substance abuse treatment
- Indicate problem with adherence to HIV care and the mental health symptoms that may be contributing factors

IV. New to Care / New Diagnosis

- If client has social work intake, case managers will assess for mental health issues that may impact adherence to care and refer to mental health counselors
- If client enters care without an initial social work intake, medical providers can assess for mental health symptoms that may impact adherence to care and discuss with referring case managers for possible referral to mental health counselors.

Referral Criteria is Subject to Change

Attachment 2. Internal Referral Form

VCUHS: Special Projects of National Significance (SPNS)
Mental Health Referral Form - Internal

MRN:

Please Note
SPNS is Tasked to Provided Mental Health Services to Persons Diagnosed with HIV who have Psychiatric Symptoms that put them at an Increased Risk for Non-Adherence to Medical Care. SPNS Counselors **DO NOT** Provide Treatment for Substance Abuse or Treatment for Patients with Serious, Unmanaged Symptoms of Chronic Mental Illness, Such as Psychosis.

Date: Referral Source & Phone Number:

Patient's Full Name:

Date of Birth: Age: Gender:

Race: HISPANIC NOT HISPANIC

RISK FACTORS (Check ALL that may apply)

Men Who Have Sex With Men | Injecting Drug User | Heterosexual | Hemophilia / Coagulation Disorder
Perinatal Transmission | Receipt of Transfusion of Blood, Blood Components, or Tissue | Unknown

STOP

ASSESS FOR SUICIDAL / HOMICIDAL THOUGHTS:
If patient is having suicidal and/or homicidal thoughts, emergency intervention is needed. Please complete form at a later time.

STOP

Referred to: ☐ Mental Health Counseling ☐ Neuropyschological Evaluation (check *ONE* or *BOTH*)

Reason for Referral: (Indicate history of/current psychiatric symptoms as they relate to non-adherence and/or potential risk for non-adherence to medical care and/or being lost.)

STOP AND PLEASE RETURN COMPLETED REFERRAL TO ASSIGNED CASE MANAGER/SOCIAL WORKER

Form Revised: 06/16/2015

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VCUHS: Special Projects of National Significance (SPNS)
Mental Health Referral Form - Internal

Referral Date: _____ MRN: _____

Patient's Full Name: _____ Date of Birth: _____

Telephone Number (Primary): _____

Telephone Number (Other): _____

Patient Linkage Status:

☐ New to Care ☐ Lost to Care ☐ At Risk of Dropping out of Care ☐ Incarcerated / Recently Released

Patient HIV/AIDS Status:

☐ HIV-Positive, *not AIDS*
☐ HIV-Positive, *AIDS Status Unknown*
☐ CDC-Defined AIDS

Year of HIV Diagnosis: _____

Year of AIDS Diagnosis: _____

Patient Insurance:
(Please Check ALL That Apply)

☐ Private ☐ Medicare ☐ Medicaid ☐ Other Public ☐ No Insurance ☐ Other

Date Referral Received: _____

Date of Collaboration: _____ ☐ Does Not Meet SPNS Criteria

Date of 1st Attempt: _____

Date of 2nd Attempt: _____

Date of 3rd Attempt: _____

Date of Initial Appointment: _____ ☐ Appointment Kept

Referral Received By: ☐ Paula Connolly, LCSW ☐ Barbara Sherwood-Kelly, LCSW

Form Revised: 06/16/2015

Attachment 3. External Referral Form

VCUHS: Special Projects of National Significance (SPNS)
Mental Health Referral Form - External

MRN:

Please Note
SPNS is Tasked to Provided Mental Health Services to Persons Diagnosed with HIV who have Psychiatric Symptoms that put them at an Increased Risk for Non-Adherence to Medical Care. SPNS Counselors **DO NOT** Provide Treatment for Substance Abuse or Treatment for Patients with Serious, Unmanaged Symptoms of Chronic Mental Illness, Such as Psychosis.

Date: Referral Source & Phone Number:

Full Name:

Address:

City, State: Date of Birth:

Gender: Race: ○ HISPANIC ○ NOT HISPANIC

ASSESS FOR SUICIDAL / HOMICIDAL THOUGHTS:

STOP Is patient currently having suicidal and/or homicidal thoughts? STOP

If YES, emergency intervention is needed and form should not be completed at this time.

RISK FACTORS (Check ALL that may apply)

○ Men Who Have Sex With Men ○ Injecting Drug User ○ Heterosexual ○ Hemophilia / Coagulation Disorder
○ Perinatal Transmission ○ Receipt of Transfusion of Blood, Blood Components, or Tissue ○ Unknown

Reason for Referral: (Indicate history of/current psychiatric symptoms as they relate to non-adherence and/or potential risk for non-adherence to medical care and/or being lost.)

Form Revised: 06/16/2015

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VCUHS: Special Projects of National Significance (SPNS)
Mental Health Referral Form - External

Referral Date: _____ MRN: _____

Patient's Full Name: _____ Date of Birth: _____

Telephone Number (Primary): _____

Telephone Number (Other): _____

Patient Linkage Status:

☐ New to Care ☐ Lost to Care ☐ At Risk of Dropping out of Care ☐ Incarcerated / Recently Released

Patient HIV/AIDS Status:

☐ HIV-Positive, *not AIDS*
☐ HIV-Positive, *AIDS Status Unknown*
☐ CDC-Defined AIDS

Year of HIV Diagnosis: _____

Year of AIDS Diagnosis: _____

Patient Insurance:
(Please Check ALL That Apply)

☐ Private ☐ Medicare ☐ Medicaid ☐ Other Public ☐ No Insurance ☐ Other

Form Completed By: _____

STOP HERE AND PLEASE FAX COMPLETED REFERRAL TO "SPNS MH" AT 804-828-2444

Date Referral Received: _____

Date of Collaboration: _____ ☐ Does Not Meet SPNS Criteria

Date of 1st Attempt: _____

Date of 2nd Attempt: _____

Date of 3rd Attempt: _____

Date of Initial Appointment: _____ ☐ Appointment Kept

Referral Received By: ☐ Paula Connolly, LCSW ☐ Barbara Sherwood-Kelly, LCSW

Form Revised: 06/16/2015

Attachment 4. Mental Health Consent Form

VCUHS: Special Projects of National Significance (SPNS)
Mental Health Consent Form
Reporting Year: 2014

Referral Date: _____ Today's Date: _____

Patient's Full Name: _____ Date of Birth: _____

CONSENT TO SHARE INFORMATION

I understand that the following confidential information may be exchanged with other providers:

1. Referral Information
2. Assessment Information
3. Financial Information
4. Benefits/Services Needed, Planned &/or Received
5. Household Information
6. Medical Diagnosis
7. Mental Health Diagnosis
8. Medical Records
9. Psychological Records
10. Family
11. Education Records
12. Psychiatric Records
13. Criminal Justice Records
14. Employment Records
15. Other _____

I understand that this information will be exchanged only for the following purposes

1. Service coordination and treatment planning
2. Eligibility Determination
3. Federal & State Reporting Requirements

I understand that this information may be shared via:

1. Written Information
2. In meeting or by phone
3. Secure Centralized Database

I can withdraw this consent at *any* time by telling the referring medical site. This will stop the funded medical site from sharing information after they know my consent has been withdrawn.

I want all medical sites related to my health care to accept a copy of this form as a valid consent to share information.

If I do not sign this form, information will not be shared and I will have to contact each medical site individually to give them information about myself.

Patient's Signature: _____ Date: _____/_____/_____

Initials of SPNS Representative/Provider: _____ (Expires ONE YEAR from referral date)

Attachment 5. GAD-7 (Generalized Anxiety Disorder 7-Item Scale)

VCUHS: Special Projects of National Significance (SPNS)
GAD-7

MRN:

Patient's Full Name: Today's Date:

Date of Birth:

Over the last two weeks, how often have you been bothered by any of the following problems? *(Please circle to indicate your answer)*		**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1.	Feeling nervous, anxious or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it is hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3

FOR OFFICE CODING: _____ + _____ + _____ + _____

= Total Score: _____

Form Revised: 06/16/2015

Attachment 6. PHQ-9 (Patient Health Questionnaire)

VCUHS: Special Projects of National Significance (SPNS)
Patient Health Questionnaire-9 (PHQ-9)

MRN:

Patient's Full Name: Today's Date:

Date of Birth:

Over the last two weeks, how often have you been bothered by any of the following problems? *(Please circle to indicate your answer)*		**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself - or that you are a failure or havlet yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING: _____ + _____ + _____ + _____

= Total Score: _____

If you check off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
Please circle to indicate answer

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

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Form Revised: 06/16/2015

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Attachment 7. PCL-C (PTSD Checklist)

VCUHS: Special Projects of National Significance (SPNS)
PCL-C (PTSD Checklist)

MRN:

Patient's Full Name: Today's Date:

Date of Birth:

Have you experienced or witnessed:

a) A life threatening situation?	Yes	No
b) A situation where actual or threatened serious harm occurred?	Yes	No
c) A situation where there was actual or threatened sexual violence?	Yes	No

If you answers NO to all of the above questions, STOP and DO NOT COMPLETE ASSESSMENT

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

		Not at all (1)	*A little bit (2)*	*Moderately (3)*	*Quite a bit (4)*	*Extremely (5)*
1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?					
2	Repeated disturbing dreams of a stressful experience from the past?					
3	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it?)					
4	Feeling very upset when something reminded you of a stressful experience from the past?					
5	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?					
6	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?					
7	Avoid activities or situations because they remind you of a stressful experience from the past?					
8	Trouble remembering important parts of a stressful experience from the past?					
9	Loss of interest in things that you used to enjoy?					
10	Feeling distant or cut off from other people?					
11	Feeling emotionally numb or being unable to have loving feelings for those close to you?					
12	Feeling as if your future will somehow be cut short?					
13	Trouble falling asleep or staying asleep?					
14	Feeling irritable or having angry outbursts?					
15	Having difficulty concentrating?					
16	Being "super alert" or watchful on guard?					
17	Feeling jumpy or easily startled?					

Total Score: _____

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Attachment 8. DAST-10 (Drug Abuse Screening Test)

VCUHS: Special Projects of National Significance (SPNS)
DAST- 10 & Rx Misuse Screenings

MRN:

First Name: _____ **Today's Date:** _____/_____/_____

Last Name: _____ **Date of Birth:** _____/_____/_____

DAST - 10

These questions refer to the past 12 months	Circle Your Response	
1. Have you used drugs other than those required for medical reasons?	**YES**	**NO**
2. Do you abuse more than one drug at a time?	**YES**	**NO**
3. Are you always able to stop using drugs when you want to?	**YES**	**NO**
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	**YES**	**NO**
5. Do you ever feel bad or guilty about your drug use?	**YES**	**NO**
6. Does your spouse (or parents) ever complain about your involvement with drugs?	**YES**	**NO**
7. Have you neglected your family because of your use of drugs?	**YES**	**NO**
8. Have you engaged in illegal activities in order to obtain drugs?	**YES**	**NO**
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	**YES**	**NO**
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	**YES**	**NO**

SCORE: _____

Rx Misuse

These questions refer to the past 12 months	Circle Your Response	
1. Have you ever used prescription medicine not prescribed for you?	**YES**	**NO**
2. Have you ever taken a prescription drug (yours or someone else's) only for the experience or feeling it caused?	**YES**	**NO**
3. Have you ever used prescription medicine in a way other than prescribed by your doctor (e.g. taken more than you should have taken, taken it more often than prescribed, or got the same kind of medicine from more than one doctor)?	**YES**	**NO**

SCORE: _____

Form Revised: 06/16/2015

Attachment 9. AUDIT (Alcohol Use Disorders Identification Test)

VCUHS: Special Projects of National Significance (SPNS)
AUDIT - Self-Report Version

Today's Date: MRN:

Patient's Full Name: Date of Birth:

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.
Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. 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 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

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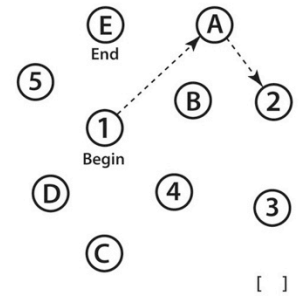
Attachment 10. MOCA-7 (Montreal Cognitive Assessment)

MONTREAL COGNITIVE ASSESSMENT (MOCA)
Version 7.1 Original Version

NAME :
Education :
Sex :
Date of birth :
DATE :

VISUOSPATIAL / EXECUTIVE — POINTS



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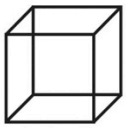


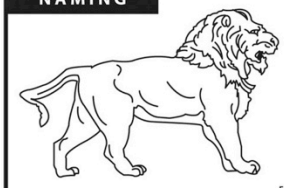
[ ] [ ]

Draw CLOCK (Ten past eleven)
(3 points)

[ ] Contour [ ] Numbers [ ] Hands

__/5

NAMING



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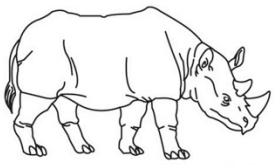
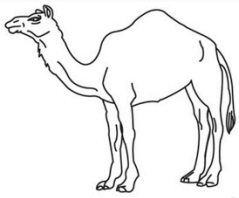


[ ]



[ ]

__/3

MEMORY Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order [ ] 2 1 8 5 4
Subject has to repeat them in the backward order [ ] 7 4 2

__/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

__/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

__/3

LANGUAGE Repeat : I only know that John is the one to help today. [ ]
The cat always hid under the couch when dogs were in the room. [ ]

__/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words)

__/1

ABSTRACTION Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler

__/2

DELAYED RECALL

	Has to recall words **WITH NO CUE**	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

__/5

ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

__/6

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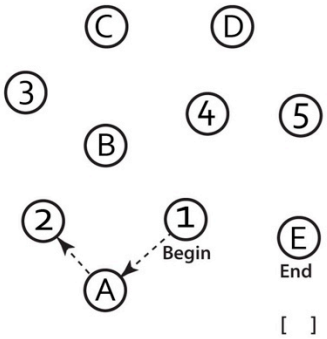
TOTAL __/30
Add 1 point if ≤ 12 yr edu

Administered by: _____

MONTREAL COGNITIVE ASSESSMENT (MOCA)
Version 7.2 Alternative Version

NAME :
Education : Date of birth :
Sex : DATE :

VISUOSPATIAL / EXECUTIVE



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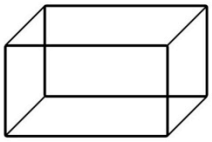


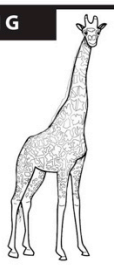
[ ] [ ]

Draw CLOCK (Five past four)
(3 points)

[ ] Contour [ ] Numbers [ ] Hands

POINTS ___/5

NAMING



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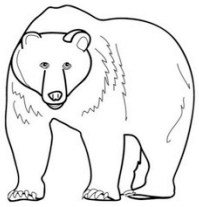

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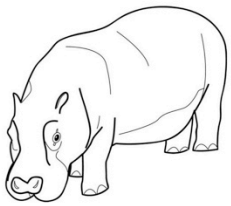


[ ] ___/3

MEMORY Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	TRUCK	BANANA	VIOLIN	DESK	GREEN
1st trial					
2nd trial					

No points

ATTENTION Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order [ ] 3 2 9 6 5
Subject has to repeat them in the backward order [ ] 8 5 2 ___/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B ___/1

Serial 7 subtraction starting at 90 [ ] 83 [ ] 76 [ ] 69 [ ] 62 [ ] 55
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt** ___/3

LANGUAGE Repeat : A bird can fly into closed windows when it's dark and windy. [ ]
The caring grandmother sent groceries over a week ago. [ ] ___/2

Fluency / Name maximum number of words in one minute that begin with the letter S [ ] _____ (N ≥ 11 words) ___/1

ABSTRACTION Similarity between e.g. carrot - potato = vegetable. [ ] diamond - ruby [ ] cannon - rifle ___/2

DELAYED RECALL

	Has to recall words **WITH NO CUE**	TRUCK [ ]	BANANA [ ]	VIOLIN [ ]	DESK [ ]	GREEN [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

___/5

ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City ___/6

Adapted by : Z. Nasreddine MD, N. Phillips PhD, H. Chertkow MD
 www.mocatest.org

Normal ≥ 26 / 30

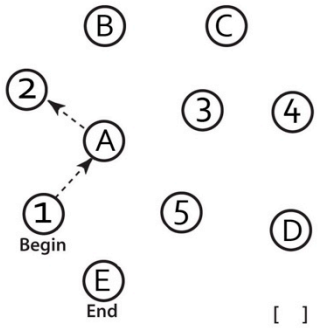
TOTAL ___/30
Add 1 point if ≤ 12 yr edu

Administered by: _____

MONTREAL COGNITIVE ASSESSMENT (MOCA)
Version 7.3 Alternative Version

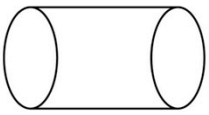
NAME :
Education : Date of birth :
Sex : DATE :

VISUOSPATIAL / EXECUTIVE POINTS



[ ] [ ]

Copy cylinder

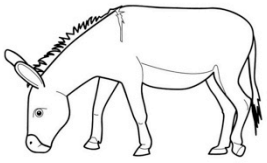


Draw CLOCK (Ten past nine)
(3 points)

[ ] Contour [ ] Numbers [ ] Hands

__/5

NAMING



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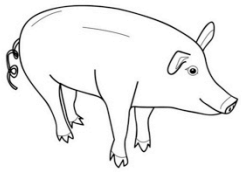

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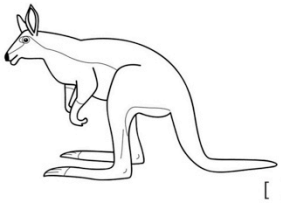

[ ]

__/3

MEMORY Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	TRAIN	EGG	HAT	CHAIR	BLUE
1st trial					
2nd trial					

No points

ATTENTION Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order [ ] 5 4 1 8 7
Subject has to repeat them in the backward order [ ] 1 7 4

__/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

__/1

Serial 7 subtraction starting at 80 [ ] 73 [ ] 66 [ ] 59 [ ] 52 [ ] 45

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

__/3

LANGUAGE Repeat : She heard his lawyer was the one to sue after the accident. [ ]
The little girls who were given too much candy got stomach aches. [ ]

__/2

Fluency / Name maximum number of words in one minute that begin with the letter B [ ] _____ (N ≥ 11 words)

__/1

ABSTRACTION Similarity between e.g. banana - orange = fruit [ ] eye – ear [ ] trumpet – piano

__/2

DELAYED RECALL

	Has to recall words WITH NO CUE	TRAIN [ ]	EGG [ ]	HAT [ ]	CHAIR [ ]	BLUE [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

__/5

ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

__/6

Adapted by : Z. Nasreddine MD, N. Phillips PhD, H. Chertkow MD
 www.mocatest.org

Normal ≥ 26 / 30

TOTAL __/30
Add 1 point if ≤ 12 yr edu

Administered by: _____

Attachment 11. Mental Health Screening Packet Cover

VCUHS: Special Projects of National Significance (SPNS)
Mental Health Screening Packet Cover
Reporting Year: 2014

MRN: _____ **Today's Date:** _____/_____/_____

_____
First Name *Middle Initial* *Last Name*

Date of Birth: _____/_____/_____

PLEASE COMPLETE THE BOTTOM PORTION OF THIS FORM AND THE TWO SCREENINGS ATTACHED.

AFTER YOU HAVE FINISHED, HOLD ON TO THIS PACKET AND YOUR COUNSELOR WILL BE OUT TO GET YOU SHORTLY.

Contact Information:

Home Address: APT/UNIT:

City: State: Zip Code:

Home Telephone Number: Ok To Leave Message?

Cell Phone Number: Ok To Leave Message?

Emergency Contact: Relationship to Patient:

Emergency Contact #: Ok To Leave Message?

Form Revised: 02/18/2014

Page 1 of 1

Attachment 12: Mental Health Clinical Assessment Form

VCUHS: Special Projects of National Significance (SPNS)
Mental Health Clinical Assessment

Patient's Name_____Date of Birth_____

Referral Source_____Date of Assessment_____

1) Reason for Referral:

2) Patient's Perception of Problem: Patient narrative

3) Family and Social History:

☐ Domestic violence victim ☐ Witnessed domestic violence ☐ Traumatic Event(s)

☐ Divorce ☐ Death of significant family member

☐ Abuse: (☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect) ☐ Victim of crime

1

4) Previous Psychiatric History (include family history as well as pt's current meds)

5) Substance Abuse History (include family history of substance abuse)

6) Legal History

7) Medical History (include current meds)

8) Educational/Work History

9) Current Support System/Coping Strategies

10) Mental Status Profile

Appearance:

Stated Age ___ Younger____Older____

Attire: Appropriate___ Inappropriate

Hygiene: Well-groomed_____Disheveled____

Eye Contact: Appropriate____ Fair____Poor___ Variable____

Manner of Relating: Guarded____Angry___Attentive___
Cooperative____Aloof_____

Motor Activity:

Purposeful____Agitated_____ Slowed_____Tics___Posturing___

Affect:

Full Range___Expansive____Blunted___Flat___Congruent___
Incongruent____Labile____Constricted_____

Mood:

Euthymic_____Depressed_____Anxious_____Angry____Manic___

Speech:

Normal___Rapid____Slowed____Coherent____Incoherent_____

Thought Process:

Goal Directed_____Circumstantial____Tangential_____
Disorganized_____Logical_____

Perceptions:

Appropriate_____Hallucinations____Depersonalization

Thought Content:

Appropriate___Ruminations_____Obsessions____Delusions____
Distortions_____Somatic Complaints_____Self Deprication____
Deprication of Others_____Phobias_____

Impulse Control:

Adequate_____ Inadequate____

Judgment:

Good____ Fair_____ Poor-but-intact____ Not intact ___

Insight:

Good____Fair____Poor___

Orientation: Person_____Place_____Time_____Oriented x3____

Memory: Intact_____Impaired_____

Suicide Risk:

Ideation Past____Present_____

Current Intent No___ Yes____ Plan? No____Yes____ (Describe:

Prior Attempts: No_____ Yes_____ Circumstances:

Harm to Others:

Ideation Past___ Present____

Current Intent: No____ Yes_____

Plan: No____ Yes_____ Describe:

Prior Attempts: No_____ Yes____ Circumstances:

Diagnostic Summary:

Multiaxis Assessment	DSM-IV TR Code	Disorder or Description
Axis I		
Axis II		
Axis IIII		
Axis IV		
Axis V	Current GAF	

Diagnostic Screening Tools:

Date of Screen (scanned) PHQ9_____GAD_____DAST_____AUDIT_____
MOCA_____ PCL-C _____

Clinical Summary

Attachment 13. Psychiatric Referral Letter

VIRGINIA COMMONWEALTH UNIVERSITY
VCU Medical Center

Date: _____/_____/_____

Dear: _____

The VCU SPNS program is a program in the ID Clinic at the VCU Health System that is in place to help patients work through mental health concerns that might affect their adherence with their medical care.

Your SPNS Mental Health Counselor is _____

After completing a thorough assessment, _____ has referred you to the SPNS Psychiatrist, Dr. (Insert Name) for a psychiatric evaluation.

In order to see Dr. (Insert Name) **for the initial appointment as well as follow-up appointments, you must continue to see your Mental Health Counselor until you both decide that you have met your counseling treatment goals.**

In the event that you drop out of counseling or miss several appointments with you counselor, you will no longer be able to see Dr. (Insert Name) for medication management. If you continue to need psychiatric care, a list of community providers will be provided to you.

Referring Counselor	Date
Client	Date

Attachment 14. Process Intervention Map