Rec's - 1

• Do not limit to "severely mentally ill"
• GAF administration
  DSM-IV diagnosis
• Recall infor dy.
CARE FUNDED
SHORT AND LONG-TERM MENTAL HEALTH SERVICES

TYPES OF SERVICES PROVIDED
CLIENT DEMOGRAPHICS
AND SEVERITY OF NEED

June 1998
SHORT AND LONG TERM PSYCHOTHERAPY SURVEY
SIGNIFICANT FINDINGS

- The HIV Health Services Planning Council is particularly interested in an "analysis regarding who is using long term (psychotherapy) services." The results of this survey show that the majority (nearly 6 out of 10) of clients seen for long-term care (i.e., more than 24 sessions) are considered chronically and seriously mentally ill. This is viewed by clinicians as a success in terms of keeping high-risk clients in treatment and preventing further deterioration and hospitalization.

- In FY 97-98, about 37% of the hours spent with clients were for longer-term individual and group psychotherapy services.

- No children under 13 years were reported and a very small number (11) of youth aged 13-19 were reported. (Data from 3month sample period. Note that the AIDS Office does not allow an HIV-negative individual to be counted as a UDC but the hours of service may be counted toward UOS. In addition, few providers are currently contracted to provide services to children and youth.)

- Clients are very low income. About 74% are currently living in unstable or potentially unstable situations. Almost all clients (82%) are living on some form of publicly funded income program. 89% of clients have an income of less than $1,200 per month. (Data from 3month sample period.)

- The clients served are fairly disturbed. A summary of Global Assessment of Functioning (GAF) scores for all clients seen shows that about three quarters of clients had a score representing moderate to severe impairment in functioning.

- Multiply diagnosed clients represented 37% of the 3 month sample population.

- 11.5% of all clients had a diagnosis of HIV-related cognitive impairment or AIDS-related dementia. The percentage decreased to 8.9% for long-term clients. (Data from 3month sample period.)

- A large percentages of all clients had a primary diagnosis of depressive, psychotic, sexual, or substance abuse/dependency disorders. The percentage of long-term clients with depressive disorders was 49%, double the percentage for the total sample population.

- With respect to race and ethnicity of clients, a greater percentage of people of color are served by CARE-funded psychotherapy services than the general population of AIDS cases in San Francisco.
SUMMARY OF MAJOR CONCLUSIONS
FROM MEDLINE LITERATURE SEARCH

The following are selected conclusions from a Med-Line literature search on mental health and HIV disease done in April 1998. References are available.

• The knowledge of being infected with human immunodeficiency virus type 1 (HIV-1) brings about psychological distress and social problems including anxiety, depression, and social isolation.

• Severe life event stress is associated with an increased rate of early HIV disease progression.

• Untreated depression hinders treatment compliance and increases risk of suicide.

• Depression is a serious, common, and treatable condition among HIV-infected persons. Increased evaluation and treatment of HIV-infected persons for depression is needed.

• Accumulated clinical experience and a couple of systematic studies suggest that psychotherapy, alone or in combination with antidepressant drug therapy, can be remarkably beneficial. In sum, data support the fact that we have much to offer our depressed HIV-infected patients. Our task is to make sure that we identify their depressions when present and counter their feelings of hopelessness by ensuring that effective antidepressant treatments are provided.

• Rates of psychiatric distress in inner-city adult HIV clinics are much higher than in the general population or than in other outpatient medical clinics. They are also not associated with what most clinicians perceive as traditional risk groups such as psychiatric histories and social disadvantage. These findings support the position that easy access to psychiatric care is essential to HIV clinics.

• Psychiatric treatment of HIV-infected patients is effective when located in the HIV primary-care setting and administered by a multidisciplinary team under the direction of a psychiatrist, using evidence-based interventions.

• The risk of certain psychiatric disorders appears uniquely elevated in HIV+ men. Since other factors also influence risk, interventions designed to minimize psychopathology during HIV infection should attend to both HIV-related and non-HIV-related risk factors.
This report was developed in compliance with the HIV Health Services Planning Council’s directive during the prioritization process for CARE funding in August 1997 to “...do more analysis regarding who is using long term (psychotherapy) services.” A survey instrument (attached) was developed by the Mental Health Work Group, a sub-committee of the Evaluation and Assessment Committee of the HIV Health Services Planning Council. The work group was comprised of Planning Council members, AIDS Office staff, and representatives from short and long-term mental health provider agencies.

The survey was sent to 13 CARE funded Mental Health programs which provided short and long-term psychotherapy services in FY 97-98:

- Family Service Agency of SF
- Instituto Familiar de la Raza
- Iris Center
- Living Well Project
- Native American AIDS Project
- New Leaf
- SFDPH: Community Mental Health Services
- SFDPH: Community Public Health Services
- SFDPH SFGH/Ward 86
- UCSF AIDS Health Project (3 programs)
- UCSF Center on Deafness

One program did not return the questionnaire.

Collectively, these agencies served 1,954 clients in FY 97-98 with 37,133 hours of professional mental health services.

The survey was designed to collect information on the types of services provided by these agencies, demographics of clients served, and information on the severity of clients seen, especially individuals receiving long-term care (over 24 sessions per year). In order to keep data gathering as simple as possible, most of the data is based on a sample of clients seen from January 1, 1998 through the date the survey was completed (beginning of April 1998). The total sample size (described as “All Clients” throughout this document) is 1,429 clients. The following is a brief summary of the survey results.
TYPES OF SERVICES PROVIDED

The following types of services were provided (based on hours of service provided): crisis (3%); assessment and triage (11%); short term individual and group counseling/psychotherapy (26%); long-term individual and group counseling/psychotherapy (37%); Neuropsych evaluations (3%); Psychiatric services (9% including evaluations and medication monitoring); Case Management (12%); and other specialized services for members of the Deaf community.

About 37% of the hours spent with clients were for long-term individual and group psychotherapy services.

At the time the questionnaire was completed, 4 of the 13 programs reported a wait-list for psychotherapy services.

DEMOGRAPHICS

85% of the clients seen were male; 13% female; and 2% transgender.

The great majority (76%) of clients were between the ages of 20 and 44 years with 23% 45 years or older. No children under 13 years were reported and a very small number (11) of youth aged 13-19 were reported. (Please note that the AIDS Office does not allow an HIV-negative individual to be counted as a UDC but the hours of service may be counted toward UOS. In addition, few providers are currently contracted to provide services to children and youth.)

Very few (2.4%) were individuals who had been diagnosed within the past year. About 41% were persons with an AIDS diagnosis.

The racial/ethnic heritage of clients was mixed:

- 61% White
- 15% African American
- 15% Latino
- 2% Asian/PI
- 2% Native American
- 5% Other

About 9% of clients seen preferred to converse in a language other than English, including .5% in American Sign Language.

By and large, clients seen were very low income. About 74% were currently living in unstable or potentially unstable situations including the streets or shelters (11%), friends or family members without paying rent (37%), halfway houses or drug/alcohol programs (3.4%), SRO’s (13%), or in an institutional setting (9%). About 58% of the clients served had an income of less than $660 per month; 89% made less than $1,200 per month.
Only 10% of these clients were employed and most of these were working part-time. Almost all clients (82%) were living on some form of publicly funded income program (GA, SSI, SDI, etc.). About 17% were on either General Assistance or TANF (new AFDC program).

About 25% of these mental health patients were totally uninsured. While many of these uninsured HIV clients (indigent non Medi-Cal) would qualify for CMHS services, the CMHS expanded access program does not currently have the capacity to serve these clients due to limited General Fund dollars. Some 59% of the mental health patients were enrolled in Medi-Cal, Medicaid, or Medicare. Providers who are currently eligible to provide Medi-Cal mental health services are limited by their CMHS contract. There is a set amount of matching State dollars available to San Francisco and therefore a limited number of clients can be served by the Medi-Cal program without additional revenue. In addition, clients often seek out CARE funded programs because of their special expertise in HIV and mental health, including familiarity with drug interactions, and because CARE funded programs have provided more expansive services (not as limited in number of sessions) which have been designed specifically to fit the needs of individuals with HIV disease.

SEVERITY OF NEED

Clients who were seen for long-term care were more disturbed than the overall population of client seen.

<table>
<thead>
<tr>
<th>Severity Indicator</th>
<th>All Clients</th>
<th>Long Term Care Clients</th>
<th>Increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health impairment so severe as to affect ability to access Primary Care or adhere to medical treatment for HIV</td>
<td>28%</td>
<td>35%</td>
<td>+ 7%</td>
</tr>
<tr>
<td>History of suicide</td>
<td>30%</td>
<td>28%</td>
<td>- 2%</td>
</tr>
<tr>
<td>History of violent behavior</td>
<td>17%</td>
<td>25%</td>
<td>+ 8%</td>
</tr>
<tr>
<td>History of physical or sexual abuse</td>
<td>41%</td>
<td>53%</td>
<td>+12%</td>
</tr>
<tr>
<td>Needs day treatment, sub-acute, or residential TX</td>
<td>16%</td>
<td>25%</td>
<td>+ 9%</td>
</tr>
<tr>
<td>Psychiatric hospitalizations within past 12 months</td>
<td>14%</td>
<td>13%</td>
<td>- 1%</td>
</tr>
<tr>
<td>Psychotropic medications</td>
<td>52%</td>
<td>57%</td>
<td>+ 5%</td>
</tr>
<tr>
<td>Considered severely and persistently mentally ill</td>
<td>31%</td>
<td>57%</td>
<td>+26%</td>
</tr>
<tr>
<td>Multi-Diagnosed</td>
<td>37%</td>
<td>45%</td>
<td>+ 8%</td>
</tr>
<tr>
<td>AIDS Dementia or HIV-related cognitive impairment</td>
<td>11.5%</td>
<td>9%</td>
<td>-2.5%</td>
</tr>
</tbody>
</table>
Another indicator of severity of client need is the Global Assessment of Functioning (GAF) score. The GAF is a standard scale in the industry, used by clinicians as part of assessment, that considers psychological, social, and occupational functioning on a continuum of mental health -- illness.

The following is a summary of GAF scores and their interpretation, along with scores for all clients and long-term clients. The percentage increase/decrease shows that long-term care clients are more seriously disturbed and function at a lower level. The following chart shows that, for all clients seen, about three quarters had a score representing moderate to severe impairment in functioning.

<table>
<thead>
<tr>
<th>GAF Score</th>
<th>Interpretation</th>
<th>All Clients</th>
<th>Long Term Care Clients</th>
<th>Increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 10</td>
<td>Persistent danger of severely hurting self or others or persistent inability to maintain minimal personal hygiene or serious suicidal act with clear expectation of death.</td>
<td>0.3%</td>
<td>1.3%</td>
<td>+ 1.0%</td>
</tr>
<tr>
<td>11 - 20</td>
<td>Some danger of hurting self or others or occasionally fails to maintain minimal personal hygiene or gross impairment in communication.</td>
<td>2.8%</td>
<td>5.7%</td>
<td>+ 2.9%</td>
</tr>
<tr>
<td>21 - 30</td>
<td>Behavior is considerably influenced by delusions or hallucinations or serious impairment in communication or judgment or inability to function in almost areas.</td>
<td>5.5%</td>
<td>9.7%</td>
<td>+ 4.2%</td>
</tr>
<tr>
<td>31 - 40</td>
<td>Some impairment in reality testing or communication or major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.</td>
<td>9.9%</td>
<td>18.3%</td>
<td>+ 8.4%</td>
</tr>
<tr>
<td>41 - 50</td>
<td>Serious symptoms or any serious impairment in social, occupational, or school functioning.</td>
<td>23.9%</td>
<td>22.9%</td>
<td>- 1.0%</td>
</tr>
<tr>
<td>51 - 60</td>
<td>Moderate symptoms or moderate difficulty in social, occupational, or school functioning.</td>
<td>34.6%</td>
<td>29.6%</td>
<td>- 5.0%</td>
</tr>
<tr>
<td>61 - 70</td>
<td>Some mild symptoms or some difficulty in social, occupational, or school functioning but generally functioning pretty well, has some meaningful interpersonal relationships</td>
<td>14.7%</td>
<td>10.8%</td>
<td>- 3.9%</td>
</tr>
<tr>
<td>71 - 80</td>
<td>If symptoms are present, they are transient and expectable reactions to psychosocial stressors; no more than slight impairment in social, occupational, or school functioning.</td>
<td>8.1%</td>
<td>1.9%</td>
<td>- 6.2%</td>
</tr>
<tr>
<td>81 - 90</td>
<td>Absent or minimal symptoms; good functioning in all areas; interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns.</td>
<td>0.2%</td>
<td>0.00%</td>
<td>- .2%</td>
</tr>
<tr>
<td>91 - 100</td>
<td>Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0</td>
</tr>
</tbody>
</table>
The chart below shows that large percentages of all clients had a primary diagnosis of depressive, psychotic, sexual, or substance abuse/dependency disorders. The percentage of long-term clients with **depressive disorders** (49%) was double the percentage for the total sample population.

### DIAGNOSTIC INFORMATION

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>All Clients</th>
<th>All Clients</th>
<th>Long-Term</th>
<th>Long-Term</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Primary</td>
<td>% Secondary</td>
<td>% Primary</td>
<td>% Secondary</td>
</tr>
<tr>
<td>ADHD Attention/Hyperactive Disorder</td>
<td>9%</td>
<td>4%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>ADJUSTMENT Disorder</td>
<td>2%</td>
<td>2%</td>
<td>11%</td>
<td>3%</td>
</tr>
<tr>
<td>ANXIETY Disorders</td>
<td>1%</td>
<td>4%</td>
<td>3%</td>
<td>12%</td>
</tr>
<tr>
<td>BIPOLAR Disorders</td>
<td>4%</td>
<td>2%</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>COGNITIVE Disorder or DEMENTIA</td>
<td>1%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>DEPRESSIVE Disorder</td>
<td>27%</td>
<td>2%</td>
<td>49%</td>
<td>20%</td>
</tr>
<tr>
<td>PERSONALITY Disorders</td>
<td>6%</td>
<td>29%</td>
<td>7%</td>
<td>19%</td>
</tr>
<tr>
<td>PSYCHOTIC Disorders</td>
<td>12%</td>
<td>5%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>SCHIZOPHRENIC Disorders</td>
<td>1%</td>
<td>1%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>SEXUAL Problems</td>
<td>11%</td>
<td>15%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>SUBSTANCE ABUSE/Dependency</td>
<td>19%</td>
<td>12%</td>
<td>6%</td>
<td>32%</td>
</tr>
<tr>
<td>OTHER Diagnosis</td>
<td>7%</td>
<td>20%</td>
<td>8%</td>
<td>9%</td>
</tr>
</tbody>
</table>
Client GAF Scores

<table>
<thead>
<tr>
<th>GAF Score</th>
<th>All Clients</th>
<th>Long-Term Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 - 20</td>
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<tr>
<td>81 - 90</td>
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<td></td>
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<tr>
<td>91 - 100</td>
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<td></td>
</tr>
</tbody>
</table>
COST PER UOS
SHORT AND LONG-TERM PSYCHOTHERAPY SERVICES
(FY 97-98)

<table>
<thead>
<tr>
<th>MODALITY</th>
<th>AVERAGE COST/HOUR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psych Consult/Medications</td>
<td>$105.94</td>
</tr>
<tr>
<td>Individual Therapy (Non-M.D.)</td>
<td>$74.25</td>
</tr>
<tr>
<td>Neuropsyc. Evaluation</td>
<td>$84.93</td>
</tr>
<tr>
<td>Group</td>
<td>$106.69</td>
</tr>
<tr>
<td>Case Management</td>
<td>$40.85</td>
</tr>
<tr>
<td>Other</td>
<td>$40.06</td>
</tr>
</tbody>
</table>
CASE VIGNETTES

Names have been changed to protect client confidentiality.

CASE I:

Peggy is a 37-year-old African-American woman with four children, ages 19, 11, 10, and 5. She was addicted to heroin for 19 years, and worked off and on as a prostitute to support her habit. She has been clean for two years, and is on Methadone maintenance. She is unemployed.

Peggy's former partner, a Caucasian bisexual male and the father of two of her children, died of AIDS four and a half years ago. Peggy was pregnant at the time, and was found to be HIV positive just before he died. The child who was born three months later--four-year-old Lateesha--was diagnosed HIV positive soon after her birth.

Peggy's three younger children were taken away and placed in foster care last year after a domestic violence incident in which the police were called to stop a beating Peggy and Lateesha were receiving from a man with who Peggy described as a "former friend of the family". Peggy attempted suicide soon afterward.

Since her suicide attempt, Peggy has worked hard in therapy on the following goals:

- maintaining her recovery;
- staying free of depression and suicidality;
- visiting her three younger children regularly, and helping them understand her commitment to them;
- helping her 19 year old to find a suitable recovery program for his drug abuse;
- establishing and carrying out a plan to have her three younger children returned;
- seeking ways to get job training so she can become self-supporting.

Without therapy, Peggy and her four children have little hope.

CASE II:

Maria is a 29-year-old lesbian Latina teacher's aide. She has had great difficulty accepting the HIV diagnosis which she received a few months ago. As a non-drug user who relates sexually only to women, she had believed herself to be at low risk for HIV; she now thinks a blood transfusion she had some years ago is the source.

For five years, Maria had lived in a committed partnership with Serena, an unemployed Asian attorney. Serena died six months ago, at the age of 36, of injuries from a car accident. Maria shared Serena's last days, spending long hours at the hospital every day during the weeks doctors hoped Serena would live; she acted as a source of strength for Serena. Immediately after Serena's death, Maria became clinically depressed. She denied suicidality, but felt unable to go to work. For several weeks, she stayed in bed and saw no one. Because she gave no explanation to her employer, she lost her job.

When Maria sought assistance from her parents, they angrily refused, saying she deserved her illness because of her homosexuality. Maria stopped taking her HIV medication during this period. Because she was unable to pay her rent, she was evicted. When she came to us, she was living in a shelter, and had no hope of finding employment.

This client is an example of one who will require more expensive intervention in the future if she is not helped now. Her illness will progress more quickly if she is not helped to restore her belief that she deserves to take her medication and maintain the best health she can. She needs help to recover from her grief and depression and to become employable again.
“CARL”

Carl is a 33 year old gay white man diagnosed with AIDS. When he entered treatment Carl was severely depressed stating that his “death from AIDS is taking too long” and refused to take HIV medications. He had little hope, no relationships, poor quality of life. His problems also included impulsive angry outbursts; for example when angry at a receptionist at Kaiser he stabbed a knife into the reception desk. After a year of individual treatment Carl was referred to our HIV dual diagnosis Art Therapy group. His therapist began managing his anxiety, identifying triggers that led to his depression and anger. He received a psychiatric evaluation at New Leaf which assisted in the diagnosis. Through appropriate medication management, individual and group therapy Carl began to experience an increase in positive feelings. And he no longer wanted to die. After two years of treatment he was willing to take medications for his AIDS. He is currently exploring options to re-train for employment and looks forward to his life rather than his death.

“LONITA”

Lonita is a 36 year old African-American women with a recent HIV diagnosis and cervical cancer. She says she doesn’t know what to do with this information. The client is the mother of four grown children and due to drug abuse her children have been intermittently place in foster homes; presently two are in prison, and one is in jail. Lonita is very angry and blaming of the “system” and mistreatment of her and her family. She is bitter about needing services; feels alone, with no friends. She states that she has heard that AIDS medications turn black people’s skin white and makes them sicker. In therapy the client and therapist explore the feelings and growing attachment in their relationship as a way of understanding her relationships to others including other providers. The therapist also helps client in learning parenting skills. The therapist also enlisted a black educator from Project Inform to come to a session to educate and discuss AIDS medications. Despite several relapses during treatment, she is able to compare the quality of her life on and off of drugs. Currently Lonita is one year clean and sober; she is able to discuss her fears and responsibilities as a person with HIV; she is currently taking an HIV medication cocktail and tolerating it well.
"FRANK"

Frank is a 34 year old gay Latino man who has been HIV+ for over ten years though he has remained asymptomatic until a recent bout of thrush. He has a history of severe alcoholism and major depression which date back to his adolescents, and describes the torment he still feels related to the memories of his sexual abuse by his grandfather. John carries a diagnosis of borderline personality disorder; he exhibits intense internalized homophobia, and a sense of self-loathing; he is often hopeless and helpless and despairing that his life can change. Frank is typically a binge drinker every 1-2 months - at which time he spends days on the streets drinking and usually is admitted to the hospital on a 5150 for suicidal gestures. After long work in therapy around his self-destructive behaviors and establishing a trust in his therapist Frank finally agreed to enter residential substance abuse treatment where he currently lives. He has begun antiviral medication; been prescribed an antidepressant medication by New Leaf’s psychiatrist and is making plans for his graduation from substance abuse treatment having been clean and sober for six months.

"Kathy"

Kathy is a 33 year old white woman who reports being in recovery from Heroin for 2 years and dealing with an AIDS diagnosis. She has neuropathy, extreme fatigue, and thrush. She describes symptoms of ongoing major depression and struggling with issues related to her own adoption and giving up her son due to her drug use. Kathy is angry, defensive, lacks empathy for others and has limited parenting skills to draw on as she has been reunited with her son who is a drug addict and doesn’t know about her AIDS. The client has also recently become pregnant. Issues in therapy included Kathy’s feelings about being a PWA; does she have the “right” to have a baby, possibly transmitting the virus; the risk to her own health; infection of her partner through unsafe sex. The client became obsessive in her fears of being blamed for infecting her baby and her partner. She became more depressed as her partner relapsed. At delivery, the client’s new baby died and Kathy struggles with dealing with this loss, serious financial problems and an emotionally abusive relationship. Through these travails the client has continued to utilize therapy. She has contracted to attend 12 step meetings and has been able to maintain her own recovery and she and her partner entered couples counseling at New Leaf. She also reluctantly agreed to a referral to our psychiatrist for assessment for antidepressant medication. Through therapy she has decreased her impulsive behaviors and her obsessive thought processes have also diminished. We continue to work with this client through the multiplicity of needs which she has.
Don

Don is a 33 year old African American gay man with AIDS. He has a history of growing up with a mentally ill and periodically suicidal mother, of experiencing long-term underlying depressive symptoms, of alcohol and drug abuse since adolescence, of self-mutilation (cutting) and a suicide attempt as a teenager.

Initially he was referred to the Multi-Diagnosis Project (MDP) for individual psychotherapy several years ago by his primary care physician at the Castro-Mission Health Center. At that time he was in early recovery from amphetamine dependence, and was experiencing vegetative symptoms of depression, along with suicidal ideation, enormous anger, and difficulty getting along with people. For extended periods he would not leave his apartment, and he refused to speak to his friends. Soon after starting therapy, he relapsed, using amphetamines, and left to go to a residential drug treatment program for several months. After he completed that program, he returned to therapy through the MDP. Despite his significant symptoms, Don declined a medication evaluation with the MDP psychiatrist, because, as a recovering addict, he did not want to depend on any medications. Over the course of long-term therapy through the MDP, with simultaneous active involvement in recovery and 12-step programs in the community, Don’s depressive symptoms resolved, he managed anger appropriately, he had strong relationships with friends and his boyfriend, he had maintained sobriety for 18 months, and he was functioning well in all areas of his life, and his treatment in therapy was concluded.

Five months ago, over a year since he was last seen in therapy, Don saw his primary care physician here at the Castro-Mission Health Center for a medical visit. He was tearful, sad, and withdrawn, so his physician screened him for substance use and for suicidality, and Don acknowledged both that he had used amphetamines a few weeks before, and that he was feeling very suicidal. His physician immediately contacted his former therapist on the MDP team, who was able to meet with Don right away to provide further clinical assessment and a supportive intervention. Don had been experiencing a growing depression over some time, and was feeling alone and unsupported, which led to his relapse with amphetamines. Don again entered individual psychotherapy through the Multi-Diagnosis Project. He also met with the MDP psychiatrist, who recommended antidepressant medications and this time Don agreed to try this. His suicidal thoughts persisted for about a month, but Don readily agreed to verbal no harm contracts, met regularly with his MDP therapist and psychiatrist, and abstained from any substance use. Gradually his suicidal feelings disappeared, his depressive symptoms were alleviated, and he has now resumed a high level of functioning.
ROBERT

ROBERT IS A 45 YEAR OLD GAY, WHITE MALE WITH AN AIDS DIAGNOSIS. HE WAS REFERRED TO THE MULTI-DIAGNOSIS PROJECT BY HIS PRIMARY CARE PHYSICIAN HERE AT CASTRO-MISSION HEALTH CENTER IN JANUARY OF 1995 BECAUSE THE CLIENT HAD RECENTLY BEEN RELEASED FROM AN INVOLUNTARY HOLD AT THE INPATIENT PSYCHIATRIC WARD AT SAN FRANCISCO GENERAL HOSPITAL DUE TO AN AMPHETAMINE INDUCED PSYCHOSIS. HIS M.D. WAS PARTICULARLY CONCERNED ABOUT ROBERT'S RECURRING AND SEVERE OUTBREAKS OF GENITAL HERPES AND STAPH INFECTIONS DUE TO COMPULSIVE MASTURBATION, SPEED ABUSE AND HIS UNRELIABILITY IN TAKING HIV MEDICATIONS.

ROBERT PRESENTED WITH OBSESSIVE DELUSIONAL THOUGHTS THAT HE IS UNABLE TO FUNCTION SEXUALLY AND REPORTED THAT HE COMPULSIVELY MASTURBATES WITH A VACUUM PUMP TO COMPENSATE FOR HIS SEXUAL "PROBLEM". HE REPORTED THAT HE HAD CONTINUED TO ENGAGE IN IV SPEED USE ON A REGULAR BASIS AND WAS NOT MOTIVATED TO STOP. HOWEVER, HE DID NOT WANT TO BE HOSPITALIZED AGAIN. HE WAS ALSO FEARFUL THAT HIS HERPES AND STAPH INFECTION COULD BECOME LIFE THREATENING. SOON AFTER ROBERT BEGAN TREATMENT WITH US HE HAD TO HAVE HIS LEFT TESTICLE REMOVED DUE TO SEVERE INFECTION.

AS OF 3/27/98 ROBERT CONTINUES IN WEEKLY PSYCHOTHERAPY. TREATMENT CONSISTS OF HARM REDUCTION FOR HIS IV SPEED ABUSE, PSYCHIATRIC MEDICATIONS AND IN-DEPTH THERAPY TO DEAL WITH ISSUES OF MULTIPLE LOSS, DISABILITY, MORTALITY AND SELF HATE.

AS A RESULT OF LONG TERM TREATMENT AND ONGOING CONSULTATION WITH THE PRIMARY CARE PHYSICIAN, ROBERT HAS SIGNIFICANTLY IMPROVED. HE HAS NOT EXPERIENCED PSYCHOTIC SYMPTOMS AGAIN, ELIMINATED COMPULSIVE BEHAVIOR, HAS NOT BEEN HOSPITALIZED AGAIN AND IS FREE OF RECURRING EPISODES OF HERPES AND STAPH INFECTION. HE HAS BEEN COMPLIANT IN TAKING HIS HIV MEDICATION, RESULTING IN REDUCTION OF VIRAL LOAD AND AN INCREASE IN HIS CD4 COUNT.

ROBERT CONTINUES TO NEED TREATMENT BECAUSE HE IS STILL AT RISK, AS HE USES SPEED NASALLY AND ORALLY.
EDWARD

EDWARD IS A 34 YEAR OLD GAY, WHITE MALE, CURRENTLY LIVING IN AN INDEPENDENT, CLEAN AND SOBER RESIDENCE WITH THREE OTHER CLEAN AND SOBER ROOMMATES. PREVIOUSLY, EDWARD HAD ATTEMPTED TO ENGAGE IN THERAPY ON FOUR SEPARATE OCCASIONS, BETWEEN NOVEMBER OF 1995 AND FEBRUARY OF 1997. ON THE THREE PREVIOUS ASSESSMENTS, EDWARD WAS UNABLE TO FOLLOW UP WITH THERAPY BECAUSE OF HIS SEVERE METHAMPHETAMINE ABUSE.

WHEN FIRST SEEN IN THERAPY, EDWARD WAS EMOTIONALLY LABILE, WITH ANGRY OUTBURSTS, IMPULSIVE SPEED USE, INCREASING INTERPERSONAL CONFLICTS AND IMPULSIVE SEXUAL BEHAVIORS. THE PATIENT SUBSEQUENTLY LOST HIS JOB, HIS RELATIONSHIP ENDED AND HE LOST HIS APARTMENT. EDWARD WAS EXTREMELY HOPELESS, UNABLE AND UNWILLING TO FOLLOW UP WITH HIS PRIMARY CARE APPOINTMENTS AND UNRELIABLE IN TAKING HIS HIV MEDICATIONS. EDWARD EXPRESSED A SEVERE SENSE OF BEING DISSOCIATED AND EXPRESSED "PASSIVE" SUICIDAL THOUGHTS, (I.E. "I'M NOT GOING TO TAKE MY MEDS., HOPEFULLY I'LL GET SICK SOONER.")

BY ENGAGING EDWARD IN A COGNITIVE/BEHAVIORAL THERAPY MODEL, IN CONJUNCTION WITH TREATMENT FROM THE PSYCHIATRIST WITH ANTI-DEPRESSIVE MEDICATIONS THE PATIENT BEGAN TO MAKE DRAMATIC CHANGES IN HIS FUNCTIONING AND MOOD. EDWARD IS CURRENTLY 8 MONTHS CLEAN AND SOBER, PLANNING ON MOVING INTO HIS OWN APARTMENT ON MAY 1ST. EDWARD WAS NOT ONLY ABLE TO REGAIN HIS PREVIOUS JOB, BUT WAS PROMOTED TO A MANAGERIAL POSITION. EDWARD'S SYMPTOMS OF DEPRESSION, ANXIETY AND EMOTIONAL LABILITY HAVE ALL RESOLVED TO NORMAL LIMITS. EDWARD IS PRO-ACTIVE IN HIS TREATMENT AND ACCESSING OF PRIMARY CARE SERVICES. HE IS NOW VERY FOCUSED ON MAINTAINING HIS HEALTH, AS WELL AS, A STRONG DESIRE TO HELP OTHERS. EDWARD CONTINUES TO WORK TO MAINTAIN HIS SOBRIETY FROM DRUGS AND ALCOHOL BY INCREASING HIS INSIGHT AND AWARENESS OF HIS DYSFUNCTIONAL PATTERNS OF BEHAVIOR AND BY GAINING CONFIDENCE THAT HE CAN COPE WITH ALL HE IS FACED WITH. EDWARD VERBALIZES THAT HE WAS NEVER ABLE TO OBTAIN THAT THROUGH TRADITIONAL DRUG TREATMENT AND 12 STEP PROGRAMS.

AS OF 4/1/98 EDWARD CONTINUES IN ONGOING PSYCHOTHERAPY AT LEAST THROUGH HIS FIRST YEAR OF SOBRIETY TO INSURE CONTINUED SOBRIETY, GROWTH OF SELF ESTEEM, THE HOPE OF LONG TERM STABILITY AND COPING.
Psychiatry Vignette

Ernesto

Ernesto is a 47 year-old gay, Latino male whose mother was a schizophrenic who had been repeatedly hospitalized against her will. As a child, Ernesto experienced frequent trauma from seeing his mother frequently confused, disorganized and vulnerable when in the hospital, and he had since avoided all contact with health-care and mental health-care professionals. Over the last six months, Ernesto has noticed a white, filmy substance on his tongue and palate. In addition he had significant fatigue and worsening backache exacerbated by his work as a massage therapist. Ernesto avoided getting help for these problems because of his fear of doctors and therapists and because of a fear of public places and crowds. If he went outside he would have a panic attack. He rarely saw anyone but a few friends and a few clients who came to his home. He was too anxious to leave the house and go places where he might meet other gay men and for this reason avoided dating and sex. Only occasionally, he would impulsively force himself out into a public cruising ground at night. Because he would not allow himself to think about meeting other gay men or about sex, he did not have condoms with him and had unsafe sex, including unprotected anal intercourse.

Ernesto's fatigue and pain worsened, and he began to cancel his clients and have trouble paying his rent. He began to face eviction and became more depressed and isolated, staying in bed all day. He began to feel hopeless and contemplate suicide. He feared he had AIDS and would die but did not want to face the shame of telling anyone about his gay identity and possible HIV+ identity. He also dreaded a lifetime of seeing physicians as his mother had done.

In crisis, he came to the Castro-Mission Health Center and had a nursing intake. The nurse responded to his distress by referring him for a psychiatric evaluation. Although his HIV-status was unknown, given his symptoms of thrush and fatigue, it seemed likely that he was indeed HIV+. General funds allow for a small number of clinic patients to see the staff psychiatrist for consultation, even if a patient's serostatus is unknown. After meeting with the psychiatrist, he began anti-anxiety and antidepressant medications. In about a month he began to feel more energetic and less hopeless. In discussions with the psychiatrist he expressed his fears about doctors and of ostracism if people discovered he had HIV. Feeling comfortable in his contacts with a psychiatrist and nursing staff at the clinic so far, he began to feel he could risk the possibility that his own experience might be less traumatic than his mother's. He went to get an anonymous HIV-test, tested positive, and found physician in our clinic he felt relaxed with. The psychiatrist consulted with his physician and taught the primary-care MD about treatment for Ernesto's anxiety and depressive disorders and about the impact Ernesto's developmental history was having on his willingness to make use of health-care services.
Ernesto began prophylactic treatment for opportunistic infections and after a period of discomfort on protease inhibitors, he began to adjust to them almost without side-effects. He also began a course of brief therapy, attended a support group and began to adjust to challenges of living with HIV.

Ultimately, Ernesto has attended all his monthly primary-care clinic appointments and recovered from a serious major depressive episode. He continues on anti-depressant medications and is able to go out more and overcome his social phobia. He has stopped having unsafe sex and come out as an openly gay man comfortably to several friends. He also had back surgery and is now pain-free. He has begun working again as a masseur and got a part-time job that gives him a reliable income for food and rent. The patient’s treatment made a crucial difference to his ability to function and live productively with HIV.
To further elucidate our current population, several vignettes are offered describing individual clients and the type of services provided.

M.I. a Native American, congenitally Deaf, was living in a SRO hotel in the Tenderloin. His primary communication mode is “limited” American Sign Language. With lower level writing and reading skills, his comprehension in English was always a struggle. He did not have any usable residual hearing and both his speaking and speech-reading skills were poorly developed. Though he went to a state school for the Deaf, he did not socialize with Deaf peers. Referral to our program was made when his health care providers noted his difficulty following through with appointments and treatments. Though he had certified American Sign Language interpreting services at his medical appointments, it was noted that, he did not appear to grasp much of what was going on due to his limited language skills.

The client reported having frequent blackout episodes from binge drinking. He reported feeling confined in his own living quarters as he did not feel safe in his Tenderloin community. His intermittent lover was a non-deaf person with a history of domestic violence and domineering behaviors.

Through DASS services, he was able to relocate to a residential facility specifically for individuals with HIV/AIDS. He was able to take advantage of in-house medication monitoring as well as assistance with money management services. In addition, he could join facility sponsored group activities which contributed to reducing his drinking episodes. Our program provided regular consultation to the house case manager as well as provided interpreting services for meetings between client and case manager. Other interpreting services at the facility were also provided through a subcontract. This new living situation also resolved his risk of domestic violence and his partner was able to offer limited support.

A second case scenario describes M.C., a mid-30's profoundly Deaf, Central American immigrant who is now a U.S. citizen. MC, as a deaf child received very little formal education in his country of origin. Since immigrating he has adopted American Sign Language as his preferred method of communication. A friend brought him to our program when he was feeling very agitated by his newly discovered diagnosis of seropositive status.

He had been experiencing significant anxiety attacks and phobic reactions to crowds. He was, at the time of referral, undergoing hormone treatments for becoming a transgender. He reported being very active sexually working as a prostitute in his neighborhood.

MC's living situation consists of a one-bedroom rental apartment partly subsidized by his brother in another state. MC himself is supported on SSI (as are a significant portion of profoundly deaf persons). Although he has his own apartment, MC invites a stream of long-term guests into his apartment which creates frequent interpersonal conflicts. Malso has difficulty with money management and complains of always being short of funds for everyday personal needs. Our mental health and client-advocacy services focus on developing firmer boundaries among his circle of friends. He has received resource linkages to ABC, A.F., Project Open Hand, VNA to name a few. This network of services have helped him achieve a more stable financial situation.
Compliance with medical treatment was of great concern initially; MC was often confused regarding the specifics of his medical condition and his treatment. He is considered to have HIV-related cognitive impairment. However his compliance has increased after receiving direct client advocacy services to assist him in understanding his current medical situation. He has sought and been provided a staff member, fluent in American Sign Language to accompany him to his medical appointments.

ST is another client who has been “falling through the cracks.” He has a long history as a triple diagnosed individual in the mental health system as well as in HIV-related agencies. However he also now has HIV related hearing loss and found many difficulties in receiving services that were sensitive to his special needs. Since he is a native English speaker, he found that providers often assumed that he had only a very mild impairment and could just “read lips. Yet he has acquired ASL skills and depends on ASL interpreting for receptive language. Through DASS, he eventually made use of an array of assistive listening devices as well as alerting devices (doorbell, telephone) for his apartment. He received individual therapy as well as brief couple work for himself and a partner.

He was referred for psychiatric medication monitoring to UCCD where his hearing loss needs were well attended to. He has recently experienced a significant relapse in his polysubstance abuse but DASS was able to assist him in accepting residential substance abuse treatment. Although he is now in a 21 day residential program, he has made use of extensive DASS consultation to the treatment center regarding his special needs, including advocacy under Americans with Disabilities Act (ADA) for his rights to access while in treatment.
MENTAL HEALTH QUESTIONNAIRE
SERVICES PROVIDED

**IVIDER:**
__________________________________________________________

**HBIT:**
__________________________________________________________

**IVIDUAL COMPLETING THIS QUESTIONNAIRE:**
__________________________________________________________

**NE:**
__________________________________________________________

### PES OF SERVICE PROVIDED

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Number of Clients Who Received:</th>
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<tbody>
<tr>
<td>Crisis</td>
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<tr>
<td>Assessment and Triage</td>
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<tr>
<td>Short term individual counseling/psychotherapy (&lt; 24 hours per year for a single client) (non-M.D.)</td>
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<tr>
<td>Long-term individual counseling/psychotherapy (&gt; 24 hours per year for a single client) (non-M.D.)</td>
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<tr>
<td>Short term group (&lt; 24 hours per year for a single client)</td>
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<tr>
<td>Long-term group (&gt; 24 hours per year for a single client)</td>
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<tr>
<td>Neuropsych Evaluations</td>
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<tr>
<td>Psychiatric services (evaluations, medication monitoring, etc.)</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
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<tr>
<td>Other (please specify: ________________)</td>
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### Total Hours Spent Providing:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Total Hours Spent Providing:</th>
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<tbody>
<tr>
<td>Crisis (non-M.D.)</td>
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<tr>
<td>Assessment and Triage (non-M.D.)</td>
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<tr>
<td>Case Management</td>
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<tr>
<td>Other (please specify: ________________)</td>
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### WAIT LIST

As of today, does your program have a wait list for non-Psychiatric services?  
_____ Yes  _____ No

If yes, how many people are on the wait list?  ____

As of today, does your program have a wait list for Psychiatric services?  
_____ Yes  _____ No

If yes, how many people are on the wait list?  ____

Entire FY 97-98 Period

DEMOGRAPHICS

WIDER:

II BIT:

AL NUMBER OF CURRENT CLIENTS REPORTED: __________________________

ASE NOTE THAT, UNLESS OTHERWISE SPECIFIED, THE NUMBER OF ENTS FOR EACH QUESTION BELOW SHOULD EQUAL THE NUMBER OF ENTS ABOVE.

Mnder  
(int each client only once)

____ Male
____ Female
____ Transgender
____ Unknown

E  
13 Years or Under
13-19 Years
20-44 Years
45 Years or Older
Unknown

LDREN  

umber of clients with dependent children (under the age 18 living with the client): ______

V DIAGNOSIS  
(int each client only once)

____ HIV negative
____ HIV positive (not AIDS) Dg within past year
____ HIV positive (not AIDS) Dg over 1 year
____ AIDS
____ Unknown

CIAL/ETHNIC HERITAGE  
(int each client only once)

____ White (non-Hispanic)
____ Black (non-Hispanic)
____ Hispanic
____ Asian/Pacific Islander (including Filipino/a)
____ Native American/Aleutian/Na Alaskan/Eskimo
____ Other
____ Unknown

NGUAGE PREFERENCE  
(int each client only once)

____ English
____ Spanish
____ Tagalog/Ilocano
____ Mandarin
____ Other (please specify: __________________________)

CURRENT LIVING SITUATION (REQUIRED)  
(count each client only once)

If the client has had several different living situations recently, choose the most recent.

____ street, park, car or abandoned building shelter
____ emergency housing, not shelter
____ living with friend or family member and not paying rent
____ halfway house or drug/alcohol program
____ single room occupancy hotel room
____ hospital/institution
____ jail/incarcerated
____ renting or own house, apartment or flat other
____ unknown

LIVING SITUATION LAST 12 MONTHS (OPTIONAL)  
(specify all that apply)

____ street, park, car or abandoned building shelter
____ emergency housing, not shelter
____ living with friend or family member and not paying rent
____ halfway house or drug/alcohol program
____ single room occupancy hotel room
____ hospital/institution
____ jail/incarcerated
____ renting or own house, apartment or flat other
____ unknown
MONTHLY INCOME FOR INDIVIDUAL CLIENTS
(Or Household) (Put each client only once)

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Code</th>
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<tbody>
<tr>
<td>$350 or Below</td>
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<td>$350 - $660</td>
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<td>$661 - $1,200</td>
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<td>$1,201 - $2,630</td>
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<td>Above $2,630</td>
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<td>Unknown</td>
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SOURCE OF INCOME
(City all that apply)

- GA
- TANF
- Food Stamps
- Salary
- Unemployment Benefits
- Veteran’s Benefits
- SSI
- SSDI
- State Disability Insur.
- SSA Retirement
- Long-term Disability
- Other

EMPLOYMENT STATUS
(Put each client only once)

- Full Time (30 or more hours per week)
- Part Time (< 30 hours per week)
- Not Employed
- Unknown
- Disabled

HEALTH INSURANCE FOR MENTAL HEALTH SERVICES

- No coverage
- Emergency or short-term only (24 or fewer sessions per year)
- Over 24 sessions per year
- Unknown

MEDI-CAL ELIGIBILITY
What is your current case load for this contract exhibit? _______
How many of these clients are enrolled in Medi-Cal _______

PRIVATE INSURANCE

- Private Insurance (include HMO’s)
- Kaiser
- Medi-Cal/Medicaid
  Count clients who have applied and are awaiting administrative approval as well as clients who have Medi-Cal through a private insurance company.
- Medicare
- Other Public Insurance
  Includes CARE funded primary care clinics, Champus, VA, Wker’s Comp and IHS
- Uninsured
- Unknown

HEALTH CARE COVERAGE
(Not only primary coverage)
TYPES OF CLIENTS SERVED 
AND SEVERITY OF NEED 
(ALL CLIENTS)

Please provide information here on all clients seen as of January 1, 1998.

M-IV DIAGNOSES
Using the DSM-IV categories, please list the types of diagnoses served by this contract exhibit. (Please do not diagnostic numbering codes.) Show the number of clients with primary and secondary diagnosis for each diagnostic category listed.

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>PRIMARY</th>
<th>SECONDARY</th>
<th>DIAGNOSIS</th>
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SEVERITY INDICATORS
Specify the number of clients with:

- Mental health impairment so severe as to affect ability to access Primary Care services or adhere to medical care for HIV: __________
- Suicide attempts during the preceding year: __________
- Self inflicted behavior within the last year: __________
- History of violent behavior prior to the preceding year: __________
- Suicidal ideation within the last year: __________
- History of physical or sexual abuse: __________

INTENSITY OF SERVICES REQUIRED
Specify the number of clients who:

- Need day treatment, sub-acute, or residential mental health treatment to maintain stability and avoid acute care: __________
- Have had one or more psychiatric hospitalizations within the last 12 months: __________
- Have taken psychotropic medications since beginning treatment: __________
- Are considered severely and persistently mentally ill: __________

GLOBAL ASSESSMENT OF FUNCTIONING (GAF)
Using the GAF Scale, please indicate the number of clients within each range.

- 1 - 10 __________
- 11 - 20 __________
- 21 - 30 __________
- 31 - 40 __________
- 41 - 50 __________
- 51 - 60 __________
- 61 - 70 __________
- 71 - 80 __________
- 81 - 90 __________
- 91 - 100 __________

MULTI-DIAGNOSED
Number of current clients who have an active substance abuse/dependency problem that warrants treatment or will affect client's ability to access care along with an active psychiatric illness that warrants treatment or will affect client's ability to access care: __________

AIDS DEMENTIA
Number of clients with diagnosis of:

- HIV-Related Cognitive Impairment __________
- AIDS Dementia __________
## TYPES OF CLIENTS SERVED
### AND SEVERITY OF NEED
#### (LONG-TERM CLIENTS)

Use provide information here only on clients who have received over 24 sessions per year (Long-term clients).

### DSM-IV DIAGNOSES

Using the DSM-IV categories, please list the types of diagnoses served by this contract exhibit. (Please do not use diagnostic numbering codes.) Show the number of clients with primary and secondary diagnosis for each diagnostic category listed.

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### INTENSITY OF SERVICES REQUIRED

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- Have had one or more psychiatric hospitalizations within the last 12 months: 
- Have taken psychotropic medications since beginning treatment: 
- Are considered severely and persistently mentally ill: 

### GLOBAL ASSESSMENT OF FUNCTIONING (GAF)

Using the GAF Scale, please indicate the number of clients within each range.

- 1 - 10
- 11 - 20
- 21 - 30
- 31 - 40
- 41 - 50
- 51 - 60
- 61 - 70
- 71 - 80
- 81 - 90
- 91 - 100

### MULTI-DIAGNOSED

Number of current clients who have an active substance abuse/dependency problem that warrants treatment or will affect client’s ability to access care along with an active psychiatric illness that warrants treatment or will affect client’s ability to access care:

### AIDS DEMENTIA

Number of clients with diagnosis of:

- HIV-Related Cognitive Impairment
- AIDS Dementia
I. Introduction

The Ryan White CARE Act, Title I, provides emergency assistance to EMAs most severely affected by the HIV/AIDS epidemic. As it applies to San Francisco, the CARE Act stipulates that Title I funds should be used to provide access to integrated health services for persons living with HIV/AIDS (PLWHA) who:

- Reside within the San Francisco EMA;
- Have no third party payment source (uninsured);
- Have limited third party coverage (underinsured); or
- Have been denied coverage by a third party payer (uninsured or underinsured).

In addition, enrollment priorities are as follows:

- First priority: Residents of the San Francisco EMA who have low or no income and are uninsured
- Second priority: Residents of the San Francisco EMA who have low or no income and are underinsured

Finally, CARE funds will be used only for services that are not reimbursed by any other source of revenue.

In addition to these federal guidelines, the San Francisco EMA has developed standards of care for all Title I-funded HIV health services in the San Francisco EMA. This document defines the minimally acceptable standards for service delivery and provides measures that will be used to determine whether service standards are being met. In addition, the standards described in this document are in line with CMHS policies and procedures.
II. Overview

Mental Health Standards of Care are designed to ensure consistency among the Title I mental health services provided as part of San Francisco's continuum of care for PLWHAs.1,2 These minimal acceptable standards for service delivery provide guidance to programs so that they are best equipped to:

- Assist HIV-positive clients and their families, friends, and/or partners to deal with the psychological and emotional aspects of living with HIV by helping them develop healthy coping strategies for everyday living as well as for traumatic, life-threatening situations. Mental health services may involve a variety of cognitive, emotional, spiritual, and practical skills, as well as clinical treatments and interventions, linkages to primary care, and medications adherence.
- Meet the specific and unique needs of HIV-positive clients.
- Promote integration and access to mental health services that sustain a healthy life.
- Minimize barriers to services.
- Implement coordinated, client-centered, and effective service delivery.
- Appropriately address issues of consent, confidentiality, and other client rights, for clients enrolled in services.
- Deliver mental health services in as culturally and linguistically appropriate manner as possible, within individual programs or through referral, while in compliance with all federal, state and local laws, regulations, ordinances and codes.

III. Description of Service

Psychosocial and psychiatric treatment and counseling services, including individual and group counseling, provided by a mental health professional, including psychiatrists, psychologists, clinical nurse specialists, social workers, counselors, and peers.

IV. Unit of Service

A mental health Unit of Service (UOS) is one hour of face-to-face or telephone contact between a client and a provider or one hour of face-to-face or telephone case conferencing with another provider. A psychiatric consultation UOS is one hour of mental health consultation (face-to-face, telephone, or email) with another provider about an individual client.

V. Standards of Care

1 These standards do not apply to telephone crisis counseling.
2 Because there are multiple types of services included in the mental health service category, these standards may not fully apply to some programs (e.g., treatment planning standards may be different for private service providers, staff training requirements may be different for certain types of services). In these cases, this issue must be resolved during contract negotiations.
A. Administration

Administrative standards ensure that all professionals providing mental health services are properly trained and licensed in accordance with CMHS standards, have an understanding of the scope of their job responsibilities, and that all programs funded are adequately staffed.

Standard 1: License, credentials, and experience.

Participating staff will possess licenses, credentials, and/or experience appropriate to the services they provide, in accordance with CMHS standards.

- Individual, group, couples, and family therapy and counseling must be provided by a licensed and/or board certified psychiatrist, psychologist, social worker, marriage and family therapist, or psychiatric nurse. License-eligible professionals, life-experienced individuals, individuals with credentials other than a U.S.-based license, and volunteers may also provide these services only with clinical supervision by a licensed professional. Services provided are commensurate with the experience of the staff persons used.

Staff experience:

Regardless of credentials, all staff members providing services to Title I clients must receive ongoing HIV/AIDS training as appropriate for employee job function. It is recommended that staff members have:

- HIV-related experience
- A sense of commitment and ethical concern for those being served

Measure: Completed paperwork on file for all participating providers.

Standard 2: Staffing levels.

Agencies will make every effort to ensure appropriate staffing levels are reached and maintained to provide contracted services.

Measure: Full and part-time FTE positions funded under contract are filled; OR appropriate actions being taken to fill positions.

Standard 3: Job descriptions.

Staff members will have a clear understanding of their job definition and responsibilities.

Measure: Written job description on file for each position signed by the staff/staff supervisor.

Standard 4: Policies and procedures.

Each funded agency will adhere to the CMHS Policy and Procedure Manual. In
addition, Title I programs will have written policies and procedures covering the following areas:

- Eligibility and admission requirements for PLWHA that are sensitive to their unique needs
- Referral resources and procedures
- Reggie consent form
- Data collection procedures and forms, including data reporting, for Title I-required data
- Quality assurance/quality improvement for services for PLWHA
- Health education and primary and secondary prevention education
- Guidelines for language accessibility
- Grievance procedures that comply with local AIDS Office/health department requirements
- Ensuring safety of clients and staff
- Drug use for clients and staff
- Nondiscrimination policies for clients with children

Measure: Written policies and procedures manual.
Standard 5: Staff training.

Staff are trained and knowledgeable regarding:

- HIV/AIDS issues and the delivery of mental health services in that context (see Standard 13 for details)
- Culturally and linguistically appropriate service delivery
- Harm reduction principles
- Primary and secondary prevention education principles
- Agency's written policies and procedures (including confidentiality, client rights, and human resources)
- Data requirements of the local jurisdiction
- All local, state, and federal standards of service delivery for mental health services
- Decision-making related to client eligibility for Title I services, including how to access other sources of funding for clients (e.g., Medi-Cal, GA)
- Referral resources
- Reducing barriers to access for clients, including streamlining paperwork

Measure: Documentation of all completed trainings on file.
B. Facility Standards

Facility standards are intended to ensure program safety and accessibility for both clients and staff.

Standard 6: Standard safety requirements.

The program is located in a physical facility that:

- Meets fire safety requirements
- Meets criteria for Americans with Disabilities Act (ADA) compliance
- Is clean and comfortable
- Complies with Occupational Safety and Health Administration (OSHA) infection control practices
- Has emergency protocols for health- and safety-related incidents posted
- Is free from anticipated hazards
- Is equipped for safe, legal, and appropriate storage of pharmaceuticals

Measure: **Compliance with all appropriate regulatory agencies, including ADA compliance; written policy describing plan for accommodating individuals with disabilities.**

Standard 7: Program specific requirements.

All mental health programs must include:

- Options for a private, confidential space for clients to meet with program staff
- Access to clean, accessible bathrooms
- A comfortable, accessible environment for people with HIV/AIDS
- Residential treatment sites that meet appropriate housing quality standards

Measure: **Client satisfaction surveys conducted at least annually.**
C. Service Delivery

Standards related to service delivery define the minimum set of activities to be performed.

Standard 8: The full continuum of services described below is provided on site or through referral.

Services on-site:

- Intake and follow-up assessment
- Treatment planning
- Crisis intervention
- Psychotherapeutic services
- Coordination and referral
- Discharge planning (this may include medical, psychiatric, or housing planning or other kinds of planning)

Services on-site or through referral:

- Access to HIV health services continuum of care (i.e., the mental health program must either provide other Title I services or assist clients in accessing, as necessary, other non-mental health Title I services outside the agency)
- Primary and secondary prevention education
- Psychiatric consultation and medication monitoring
- Psychological testing
- Case management
- Psychiatric rehabilitation
- Inpatient services

Measure: Description of on-site and referral services available (e.g., MOUs, brochures of other agencies).

Standard 9: Intake/Assessment.

All clients referred to the program will receive an intake assessment by a mental health professional in accordance with CMHS requirements. In addition, Title I programs shall also collect the following on intake, during subsequent assessments, or as part of ongoing assessment associated with treatment planning, where relevant:

- Assessment of STD/HIV risk and prevention education needs
- HIV/AIDS-related medical history, including medications
- Assessment of how client’s HIV disease will affect client’s ability to participate in program
- Ethnic, gender, cultural, and spiritual identifications
- Grief/loss inventory
- Client strengths

Measure: All client charts include completed intakes within 30 days of first visit.
Standard 10: Treatment planning.

Each client has a comprehensive, individualized, client-driven plan prepared, reviewed, and modified in accordance with CMHS requirements. In addition, Title I programs shall include the following in treatment plans for HIV-positive clients where relevant:

- Primary and secondary prevention education and behavior change plan
- Substance abuse treatment/harm reduction plan
- A plan for adherence to HIV/AIDS medication regimen

Treatment planning shall also ensure that:

- Services include clients and families (not necessarily including minor children) as partners in determining needs and appropriate services, as appropriate given the reality of funding restrictions/limitations
- Approaches offered to clients include a wide range of options both within and outside the agency (e.g., primary and secondary prevention education, harm reduction services)
- Clients feel that services are effective and make a positive difference for them

Completed treatment plan and acceptance of treatment plan in client file, signed by client and attending provider. (If provider is unable to obtain client signature, provider must indicate the reason in client’s chart.)


Services offered minimize or eliminate barriers to access and utilization. Access to services should be made equal for all individuals using the following strategies:

- A plan for addressing cognitive, social, economic, and other barriers to access for clients should be in place.
- All patients should have access to a provider of their choice and should be given other options if they are dissatisfied with their provider
- Crisis centers should provide access to services on demand
- Services should adhere to the CMHS policy “Access to Services for Individuals with Dual Diagnosis Disorders of Substance Abuse and Mental Illness”
- Services are located where people can and will go
- Where financially possible, support services, such as child care, translation, and transportation, are provided
- Services are offered in a timely fashion, both in terms of hours when contact with agency is available and in terms of reasonable length of time between application and service start-up
- Clients must be made aware of what to do/who to call in case of crisis or emergency
- Services offered are as culturally and linguistically appropriate as possible (see Standard 12)

Frequently updated inventory of services provided in house as well as referral resources. (MOUs submitted with monitoring reports constitute a fulfillment of this requirement.)
Standard 12: Cultural sensitivity and relevance.

Service providers are as culturally sensitive and relevant as possible with regard to language, culture, spirituality, sexual orientation, age, gender, race, PLWHA issues, harm reduction principles, etc. At a minimum, providers should have an awareness and understanding of the cultures of the populations they serve.

- Outreach is targeted to specific communities in need in a manner consistent with community culture
- Services are provided using language and methods sensitive to the communities served
- Services provide opportunities for clients to assist in identifying issues related to culture that may affect how they respond to services (e.g., primary language, spirituality needs, sexual orientation, community identification, family needs, and customs)
- Staff should be ethnically, culturally, and linguistically diverse
- Service providers should have referral relationships that can address gaps in culturally relevant services (e.g., if agency does not have internal capacity for translation, non-English-speaking clients can be referred)

Measure: Adherence to the San Francisco DPH cultural competency plan or relevant local county/city cultural competency plan.

Standard 13: Appropriateness of services to PLWHAs.

Services provided are appropriate for, and consider the unique needs of, PLWHAs, including:

- Absence from sessions/missed appointments due to illness
- Effects of HIV/AIDS and HIV/AIDS medications on mental health and functioning
- Access to HIV/AIDS medications, primary care/specialty care appointments, primary and secondary prevention education, and other medical and social HIV-related services
- Counseling that addresses the unique mental health issues of PLWHAs (e.g., living with chronic life-threatening illnesses, death and dying issues)
- Counseling that addresses current life issues, and not just past issues/history

Measure: Policies and procedures in place that address the unique needs of PLWHAs.
D. Coordination and Referral

The objective of coordination and referral is to address the client's spectrum of needs in a comprehensive way, while minimizing duplication of services.

Standard 14: Coordination and referral.

Coordination and referral includes identification of other service providers or staff members with whom the client may be working and identification of other services that the client may need or want. The agency will:

- Adhere to CMHS requirements for referral/consultation
- Identify and communicate with primary care providers and other collateral caregivers to support coordination and delivery of high quality care to clients (case conferences and/or communication about client plans, including changes in treatment, should be documented)
- Provide appropriate referrals to any necessary specialty care in accordance with client's treatment plan
- Ensure that the needs of clients with dual and triple diagnosis (HIV, mental health, substance abuse) are addressed
- Document when a client is referred to the agency by another provider and from where they were referred
- Document and, to the extent possible, follow-up on referrals to other services

Measure: Documentation in client record of referrals made; up-to-date treatment plan in client’s chart documenting necessity for specialty referral, follow-up required, and outcome. (Follow-up not required when case is closed.)
E. Quality Improvement, Monitoring, and Evaluation

The objective of quality improvement, monitoring, and evaluation is to continually improve services based on assessments of the process and outcomes of the program, as well as client satisfaction with service provision.

Standard 15: Quality improvement, monitoring, and evaluation.

A process for quality improvement, monitoring, and evaluation is in place that adheres to the CMHS quality management plans and addresses:

- Collection and monitoring of adverse outcomes (incident reports)
- Utilization management
- Clinical and/or medication monitoring or peer review
- Evaluation and monitoring of linkages with primary care
- Staff performance evaluations
- Responsibility and accountability for implementation of quality improvement strategies
- Staff training on quality improvement
- Client involvement and active participation in the quality development/improvement of the Title I mental health program
- Annual implementation of client satisfaction surveys and use of findings to improve programs
- Client grievance procedures

Measure: Quality improvement plan in place; ongoing documentation and reporting of program and provider performance; client satisfaction surveys conducted at least annually.
<table>
<thead>
<tr>
<th>Standard</th>
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</table>
The other side of the healthy relationships intervention: mental health outcomes and correlates of sexual risk behavior change.
Kalichman SC. Department of Psychology, University of Connecticut, Storrs 06269, USA.
seth.k@uconn.edu

Healthy Relationships is a small-group, social cognitive theory-based HIV prevention intervention designed for people living with HIV/AIDS. The Healthy Relationships intervention was demonstrated effective in a controlled randomized clinical trial. The intervention also integrated stress reduction with sexual risk reduction techniques, but the mental health outcomes from the intervention have not yet been reported. This study examined the 6-month follow-up mental health outcomes of the Healthy Relationships intervention among 81 HIV-positive study participants (45 in the Healthy Relationships condition and 36 in the health maintenance control condition) who reported sexual relationships with HIV-negative or unknown HIV status (nonconcordant) partners. Compared with the time-matched control condition, the Healthy Relationships intervention demonstrated significant reductions in perceived HIV-related stress. There was also evidence that reductions in perceived HIV-related stress mediated the intervention effects on sexual risk behaviors with nonconcordant partners.
Results have implications for designing the next generation of HIV prevention interventions targeted to people living with HIV/AIDS.
Publication Types: Clinical Trial Multicenter Study Randomized Controlled Trial

Substance use and mental health correlates of nonadherence to antiretroviral medications in a sample of patients with human immunodeficiency virus infection.
Tucker JS, Burnam MA, Sherbourne CD, Kung FY, Gifford AL. RAND Health, Santa Monica, California 90407-2138, USA. joan_tucker@rand.org

PURPOSE: Mental health and substance use problems are common among patients infected with human immunodeficiency virus (HIV) and may impede adherence to antiretroviral regimens. This study investigated associations of antiretroviral medication nonadherence with specific types of psychiatric disorders and drug use, and varying levels of alcohol use. METHODS: Data were drawn from a survey of a national probability sample of 2267 (representing 181,557) adults enrolled in the HIV Cost and Services Utilization Study. This study focused on 1910 patients who reported their antiretroviral medication adherence during the past week. RESULTS: Patients with depression (odds ratio [OR] = 1.7; 95% confidence interval [CI]: 1.3 to 2.3), generalized anxiety disorder (OR = 2.4; 95% CI: 1.2 to 5.0), or panic disorder (OR = 2.0; 95% CI: 1.4 to 3.0) were more likely to be nonadherent than those without a psychiatric disorder. Nonadherence was also associated with use of cocaine (OR = 2.2; 95% CI: 1.2 to 3.8), marijuana (OR = 1.7; 95% CI: 1.2 to 2.3), amphetamines (OR = 2.3; 95% CI: 1.2 to 4.2), or sedatives (OR = 1.6; 95% CI: 1.0 to 2.4) in the previous month. Compared with patients who did not drink, those who were moderate (OR = 1.6; 95% CI: 1.3 to 2.0), heavy (OR = 1.7; 95% CI: 1.3 to 2.3), or frequent heavy (OR = 2.7; 95% CI: 1.7 to 4.5) drinkers were more likely to be nonadherent. These associations could not be explained by demographic, clinical, and treatment factors. CONCLUSION: These findings suggest the need for screening and treatment for mental health and substance use problems among HIV-positive patients to improve adherence to antiretroviral medications.

Cox LE. The Richard Stockton College of New Jersey, Division of Social and Behavioral Sciences, Pomona 08240-0195, USA. Lisa.Cox@Stockton.edu
Social work practitioners and researchers have greatly understudied the idea of how social support correlates with combination therapy medication compliance, in people living with HIV disease. Meanwhile, such data could help health social workers better assist HIV-infected people who want to cope well, live long, and avoid drug resistance. Therefore, this article presents findings from a three-stage empirical secondary data analysis that examined seven specific types of social support, psychological history and stage of illness variables, and sociodemographics and their connection to medication compliance ratings. A sub-sample of 179 HIV-infected clinical trial study participants enrolled in a federally funded combination therapy treatment study and a nested compliance study were analyzed. Analysis of 14 bivariate hypotheses and 20 predictor variables at the multivariate level revealed that **having emotional support and being employed seemed to be predictive of being a "Good Complier."** Also, having higher levels of HIV symptoms appeared to be associated with being a "Poor Complier."

Effect of individual cognitive behaviour intervention on adherence to antiretroviral therapy: prospective randomized trial.
Weber R, Christen L, Christen S, Tschopp S, Znoj H, Schneider C, Schmitt J, Opravil M, Gunthard HF, Ledergerber B; Swiss HIV Cohort Study. Division of Infectious Diseases and Hospital Epidemiology, University Hospital, Zurich, Switzerland. infweb@usz.unizh.ch

**OBJECTIVE:** A high level of adherence to antiretroviral therapy is required for complete suppression of HIV replication, immunological and clinical effectiveness. We investigated whether cognitive behaviour therapy can improve medication adherence. **DESIGN:** Prospective randomized 1-year trial. **SETTING:** Collaboration of HIV university outpatient clinic and psychotherapists in private practice. **PARTICIPANTS:** 60 HIV-infected persons on stable antiretroviral combination therapy and viral load below 50 copies/ml. **INTERVENTION:** Cognitive behaviour intervention in individual patients, in addition to standard of care. **MAIN OUTCOME MEASURES:** Feasibility and acceptance of intervention; adherence to therapy assessed using medication event monitoring system (MEMS) and self-report questionnaire; virological failure; psychosocial measures. **RESULTS:** The median number of sessions for cognitive behaviour intervention per patient during the 1-year trial was 11 (range 2-25). At months 10-12, mean adherence to therapy as assessed using MEMS was 92.8% in the intervention and 88.9% in the control group (P=0.2); the proportion of patients with adherence > or = 95% was 70 and 50.0% (P=0.014), respectively. While there was no significant deterioration of adherence during the study in the intervention arm, adherence decreased by 8.7% per year (P=0.006) in the control arm. No differences between the intervention group and standard of care group were found regarding virological outcome. **Compared with the control group, participants in the intervention group perceived a significant improvement of their mental health during the study period. **CONCLUSIONS:** Cognitive behavioural support in addition to standard of care of HIV-infected persons is feasible in routine practice, and can improve medication adherence and mental health.

Uptake and adherence to highly active antiretroviral therapy among HIV-infected people with alcohol and other substance use problems: the impact of substance abuse treatment.
Palepu A, Horton NJ, Tibbetts N, Meli S, Samet JH. Centre for Health Evaluation and Outcome Sciences, St Paul's Hospital, Department of Medicine, University of British Columbia, Vancouver, British Columbia, Canada. anita@hivnet.ubc.ca

**AIM:** We examined the association of substance abuse treatment with uptake, adherence and virological response to highly active antiretroviral therapy (HAART) among HIV-infected people with a history of alcohol problems. **DESIGN:** Prospective cohort study. **METHODS:** A standardized questionnaire was administered to 349 HIV-infected participants with a history of alcohol problems regarding demographics, substance use, use of substance abuse treatment and uptake of and adherence to HAART.
These subjects were followed every 6 months for up to seven occasions. We defined substance abuse treatment services as any of the following in the past 6 months: 12 weeks in a half-way house or residential facility; 12 visits to a substance abuse counselor or mental health professional; or participation in any methadone maintenance program. Our outcome variables were uptake of antiretroviral therapy, 30-day self-reported adherence and HIV viral load suppression.

FINDINGS: At baseline, 59% (205/349) of subjects were receiving HAART. Engagement in substance abuse treatment was independently associated with receiving antiretroviral therapy (adjusted OR; 95% CI: 1.70; 1.03-2.83). Substance abuse treatment was not associated with 30-day adherence or HIV viral load suppression. More depressive symptoms (0.48; 0.32-0.78) and use of drugs or alcohol in the previous 30 days (0.17; 0.11-0.28) were associated with worse 30-day adherence. HIV viral load suppression was positively associated with higher doses of antiretroviral medication (1.29; 1.15-1.45) and older age (1.04; 1.00-1.07) and negatively associated with use of drugs or alcohol in the previous 30 days (0.51; 0.33-0.78).

CONCLUSION: Substance abuse treatment was associated with receipt of HAART; however, it was not associated with adherence or HIV viral load suppression. Substance abuse treatment programs may provide an opportunity for HIV-infected people with alcohol or drug problems to openly address issues of HIV care including enhancing adherence to HAART.


Relationship of gender, depression, and health care delivery with antiretroviral adherence in HIV-infected drug users.

Turner BJ, Laine C, Cosler L, Hauck WW. Received from the Division of General Internal Medicine, University of Pennsylvania School of Medicine, Philadelphia, PA 19104, USA.
bturner@mail.med.upenn.edu

BACKGROUND: Antiretroviral adherence is worse in women than in men, and depression can influence medication adherence. OBJECTIVE: To evaluate the relationship of gender, depression, medical care, and mental health care to adherence in HIV-infected drug users. DESIGN: Retrospective cohort study.

SETTING: New York State Medicaid program. PARTICIPANTS: One thousand eight hundred twenty-seven female and 3,246 male drug users on combination antiretroviral therapy for more than 2 months in 1997. MAIN MEASURES: A pharmacy-based measure of adherence was defined as > or =95% days covered by at least 2 prescribed antiretroviral drugs. Independent variables were: depression, regular drug treatment (> or =6 months), regular medical care (2+ and >35% of visits), HIV-focused care (2+ visits), psychiatric care (2+ visits), and antidepressant therapy. RESULTS: Women were less adherent than men (18% vs 25%, respectively, P < .001) and more likely to be diagnosed with depression (34% vs 29%). In persons with depression, the adjusted odds ratio (AOR) for adherence was greater for those with psychiatric care alone (AOR 1.52; 95% confidence interval [95% CI], 1.03 to 2.26) or combined with antidepressants (AOR 1.49; 95% CI, 1.04 to 2.15). In separate models by gender in persons with depression, psychiatric care plus antidepressants had a slightly stronger association with adherence in women (AOR 1.92; 95% CI, 1.00 to 3.68) than men (AOR, 1.26; 95% CI, 0.81 to 1.98). In drug users without depression, antidepressants alone were associated with greater adherence (AOR, 1.23; 95% CI, 1.02 to 1.49) with no difference by gender. Regular drug treatment was positively associated with adherence only in men.

CONCLUSIONS: In this drug-using cohort, women had worse pharmacy-measured antiretroviral adherence than men. Mental health care was significantly associated with adherence in women, while regular drug treatment was positively associated with adherence in men.

Nearly half of HCSUS participants reported recent severe drug abuse, and 9 percent reported drug dependence. Drug problems clearly affected the likelihood that HIV-positive people would take life-prolonging antiretroviral therapy (ART), according to this study. Drug-dependent men and women and those with HIV exposure related to injection drug use were less likely to receive ART than those without these problems. The researchers examined self-reported ART use among 2,267 HCSUS participants in 1997. About 90 percent of participants reported use of any ART, and 61 percent reported use of the more advanced, currently recommended HAART (highly active ART: three or more drugs, including at least one protease inhibitor or non-nucleoside reverse transcriptase inhibitor). After adjustment for drug abuse, mental disorders had no significant effects on use of ART, perhaps due to the high prevalence of these problems in drug users. **On a positive note, patients who had recently received mental health care were more likely than those who had not to report taking HAART, even after adjusting for other factors.** Among drug users on ART, only mental health treatment was associated with HAART. **Thus, drug abuse seemed to be a greater barrier to ART use than mental disorders.** Problem drinking was not associated with ART use or type of ART treatment among users. The researchers call for more studies to distinguish provider- from patient-related reasons for the failure of 10 percent of patients to receive ART.
MENTAL HEALTH
SUMMARY

Service Provider: SFDPH Community Mental Health Services
Fiscal Agent: SFDPH Community Mental Health Services
Total Contract Amount: $610,524

Program Name: Mental Health Case Management
Exhibit: A-1
Amount: $610,524
Term: March 1, 1998 - February 28, 1999
Funding Source: Federal CARE Title I / General Fund
Service Category (CARE): Mental Health/Counseling
Service Subcategory (CARE): Long/Short Term Mental Health Treatment
Units of Service: 9531
UDC: 224
Target Population: Individuals of all ages with HIV decease and a spectrum of mental illness ranging from transient mental health issues to severe and chronic conditions.

Description of Service: Mental Health Case Management at the Center for Special Problems provides four service components:
Non-physician services including psychological assessment, individual, family and couple therapy and consultation.
Physician services including evaluation, treatment and monitoring of psychiatric medication.
Group services that include psychotherapy facilitated by non physician clinicians.
Case management services including peer support, linkage and coordination, client advocacy, and referrals to community providers.
SUMMARY

Service Provider: Family Service Agency of San Francisco
Fiscal Agent: Family Service Agency of San Francisco
Total Contract Amount: $216,324

Program Name: HIV Mental Health Services
Exhibit: A-1
Amount: $216,324
Term: March 1, 1998 - February 28, 1999
Funding Source: Federal CARE Title I
Service Category (CARE): Mental Health/Counseling
Service Subcategory (CARE): Long/Short Term Mental Health Treatment
Units of Service: 2684
UOS Definition: One hour of professional service to a client
UDC: 182
Target Population: HIV infected individuals who need mental health services including adult, youth women, homeless, multiply diagnosed, and geriatric clients.

Description of Service: Psychiatric services including medication evaluation and monitoring, individual/couple/group therapy and crisis intervention; Neuropsychiatric Assessment services; Non-psychiatric mental health services which include individual/couple/group therapy and home visits.
SUMMARY

Service Provider: Instituto Familiar de la Raza, Inc.
Fiscal Agent: Instituto Familiar de la Raza, Inc.
Total Contract Amount: $119,019

Program Name: Psychotherapeutic Support Services
Exhibit: A-1
Amount: $119,019
Term: September 1, 1998 - February 28, 1999
Funding Source: Federal CARE Title I
Service Category (CARE): Mental Health/Counseling
Service Subcategory (CARE): Long/Short Term Mental Health Treatment
Units of Service: 1488
UOS Definition: One hour of professional service to a client
UDC: 63
Target Population: Chicano(a)s/Latino(a)s who are HIV+ or who have AIDS, reside in San Francisco mostly uninsured and indigent.

Description of Service: Bilingual, bicultural short and long term psychotherapeutic services for Chicano(a)/Latino(a) clients within the context of a comprehensive mental health advocacy program.
SUMMARY

Service Provider: UCSF Center on Deafness
Fiscal Agent: UCSF Center on Deafness
Total Contract Amount: $78,432

Program Name: Mental Health Services/Psychosocial Support
Exhibit: A-1
Amount: $78,432
Term: March 1, 1998 - February 28, 1999
Funding Source: Federal CARE Title I
Service Category (CARE): Mental Health/Counseling
Service Subcategory (CARE): Long/Short Term Mental Health Treatment
Units of Service: 1485
UOS Definition: One hour of professional service to a client
UDC: 23
Target Population: San Francisco residents with a hearing loss who are HIV+. Clients may be deaf, hard of hearing, late-deafened or have an HIV-related hearing lost.

Description of Service: Mental Health--Individual, couple and family psychotherapy, psychological or neuropsychological testing.
Peer Advocacy--Assessment and referrals, advocacy on individual accessibility issues, accompanying clients to appointments, and related efforts
ASL Translation/Communication Support--Sign language interpreting and real time captioning.
Educational Workshops--Topical presentations followed by discussion.
Competency Training--Competency training designed to enhance provider ability to serve Deaf persons with HIV, consultation regarding delivery of services, and general technical assistance to other HIV service organizations.
SUMMARY

Service Provider: New Leaf
Fiscal Agent: None
Total Contract Amount: $407,274

Program Name: Outpatient Mental Health Services
Exhibit: A-1
Amount: $245,348
Term: 3/1/98 - 2/28/98
Funding Source: CARE Title I
Service Category (CARE): Mental Health
Service Subcategory (CARE): Short and Long Term Mental Health Services
Units of Service: 2,678 as shown:
2,411 Non-Physician Mental Health UOS
192 Mental Health groups UOS
75 Psychiatric (M.D.) Consultation UOS

UOS Definition: Hours
UDC: 222
Target Population: Dually and/or tri-diagnosed lesbians, gay, bisexual, and transgender persons with HIV disease.
Description of Service:
Individual, family or couples mental health assessment, therapy and consultation by a Non-M.D. provider; Mental Health groups (recovery group for HIV+ women and creative arts therapy group for HIV+ gay/bisexual men); Psychiatric consultation and evaluation and medication monitoring.

Program Name: Outpatient Substance Abuse Services
Exhibit: A-2
Amount: $161,926
Term: 3/1/98 - 2/28/98
Funding Source: CARE Title I
Service Category (CARE): Substance Abuse
Service Subcategory (CARE): Outpatient Substance Abuse Services
Units of Service: 2,892 as shown:
1,644 Individual UOS
1,248 Group UOS

UOS Definition: One hour of individual or group counseling services
UDC: 200
Target Population: HIV+ persons, who are low income and uninsured residents of San Francisco.
Description of Service:
Outreach activities include community and organizational presentations who have contact with the target population regarding program services. Program services include substance abuse individual and/or group sessions.
SUMMARY

Program Name: Counseling Services for HIV Positive Women
Exhibit: A-2
Amount: $150,000
Term: March 1, 1998 - February 28, 1999
Funding Source: Federal CARE Title I
Service Category (CARE): Mental Health
Service Subcategory (CARE): Short/Long Term Psychotherapy
Unit of Service: 1,728 Counseling Hours
UOS Definition: One hour of counseling services
UDC: 36
Target Population: HIV-infected adult women, who are low income and uninsured residents of San Francisco. Special emphasis on African American women, Latinas and lesbians.

Description of Service
Program services include psychological assessment, individual, couple, group and/or family counseling sessions.
SUMMARY

Service Provider: UCSF AIDS Health Project
Fiscal Agent: None
Total Contract Amount: $632,352

Program Name: Psychotherapy Services Program
Exhibit: A-1
Amount: $101,422
Term: July 1, 1998 - February 28, 1999
Funding Source: Federal CARE Title I
Service Category (CARE): Mental Health
Service Subcategory (CARE): Short/Long Term Psychotherapy
Unit of Service: 3,520
UOS Definition: One hour of professional psychotherapy provided to a client.
UDC: 150
Target Population: Low income or underinsured residents of San Francisco with HIV disease.
Description of Service: Individual Psychotherapy Counseling.

Program Name: Ward 86 Mental Health Services
Exhibit: A-2
Amount: $101,805
Term: July 1, 1998 - February 28, 1999
Service Category (CARE): Mental Health
Service Subcategory (CARE): Short/Long Term Psychotherapy
Funding Source: Federal CARE Title I
Unit of Service: 826
UOS Definition: One hour of counseling or one hour in consultation with an agency or other professional on behalf of a client.
UDC: 176
Target Population: Patients at SFGH's Ward 86.
Description of Service: Comprehensive mental health assessments and treatment recommendations.
<table>
<thead>
<tr>
<th>Program Name:</th>
<th>HIV Neuropsychological Assessment and Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exhibit:</td>
<td>A-3</td>
</tr>
<tr>
<td>Amount:</td>
<td>$210,045</td>
</tr>
<tr>
<td>Term:</td>
<td>July 1, 1998 - February 28, 1999</td>
</tr>
<tr>
<td>Funding Source:</td>
<td>Federal CARE Title I</td>
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<tr>
<td>Service Category (CARE):</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Service Subcategory (CARE):</td>
<td>Short/Long Term Psychotherapy</td>
</tr>
<tr>
<td>Unit of Service:</td>
<td>2,132</td>
</tr>
<tr>
<td>UOS Definition:</td>
<td>One hour of client-centered consultation with a service provider or one hour with a client.</td>
</tr>
<tr>
<td>UDC:</td>
<td>73</td>
</tr>
<tr>
<td>Target Population:</td>
<td>Medically indigent or underinsured residents of San Francisco with HIV disease who have mental health problems.</td>
</tr>
<tr>
<td>Description of Service</td>
<td>Neuropsychological testing and assessment; Individual, family, couples and group mental health therapy sessions; and Psychiatric consultation, evaluation and medication monitoring.</td>
</tr>
</tbody>
</table>
SUMMARY

Service Provider: Native American AIDS Project
Fiscal Agent: Urban Indian Health Board, Inc.
Total Contract Amount: $156,057

Program Name: Mental Health
Exhibit: A-1
Amount: $30,325
Term: October 1, 1998 - February 28, 1999
Funding Source: Federal - CARE Title I
Service Category (CARE): Mental Health/Counseling
Service Subcategory (CARE): Long/Short Term Psychotherapy
Unit of Service: 380
UOS Definition: One hour of mental health services provided by a licensed professional with or on behalf of a client.
UDC: 50
Target Population: This program targets HIV+ Native Americans and Alaska Natives in any stage of HIV disease who reside in San Francisco.
Description of Service: This program provides long and short-term psychotherapy (including intake, assessment, crisis intervention, follow-up and monitoring, and case consultations).
Program Name: Multi-Diagnosis Program
Exhibit: A-3
Amount: $276,900
Funding Source: Federal CARE Title I
CARE Service Category: Mental Health
CARE Service Sub-category: Long/Short Term Psychotherapy
Number of Units of Service: 2,390
UOS Definition: a) Hours (FTF/NFTF) b) Encounters (FTF)
Number of UDC: 158
Target Population: indigent, low income, uninsured, underinsured residents of SF with HIV who are dual or triple diagnosed and receiving primary care at CMHC
Description of Service: assessment or re-assessment; individual therapy, case management and patient triage, neuropsychology testing and report writing, case conferences, face to face Psychiatry encounters, psychiatric medication evaluation and monitoring.
SUMMARY

Service Provider: Asian & Pacific Islander Wellness Center
Fiscal Agent: Asian & Pacific Islander Wellness Center
Total Contract Amount: $14,327

Program Name: Mental Health Case Management
Exhibit: A-1
Amount: $14,327
Term: July 1, 1998 - February 28, 1999
Funding Source: CARE Title I
Service Category (CARE): Mental Health/Counseling
Service Subcategory (CARE): Long/Short Term Psychotherapy
Unit of Service: 186
UOS Definition: one hour of service proved to or on behalf of a client by a licensed or license-eligible mental health professional.
UDC: 8
Target Population: This program targets HIV+ Asian Pacific Islanders with mental health issues who are residents of San Francisco.
Description of Service
This program provides mental health counseling and on-going therapy, including screening and assessment, provisional diagnosis, service plan coordination and referrals.
### Proposal for Revised Service Categories for FY 2003-4

<table>
<thead>
<tr>
<th>New Priority Rank</th>
<th>FY 2003 Priority</th>
<th>NEW SUB-CATEGORY</th>
<th>HRSA CATEGORY</th>
<th>NOTES</th>
<th>HHS CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Ambulatory/Outpatient Medical Care</td>
<td>AMBULATORY/OUTPATIENT MEDICAL CARE</td>
<td></td>
<td>A1</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Emergency Housing</td>
<td>HOUSING ASSISTANCE</td>
<td>Now includes &quot;Congregate Meals&quot;</td>
<td>B1</td>
</tr>
<tr>
<td>3</td>
<td>3 / 30</td>
<td>Food Bank/Home Delivered Meals</td>
<td>FOOD BANK/HOME DELIVERED MEALS</td>
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<td>C1</td>
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<tr>
<td>4</td>
<td>4</td>
<td>Integrated Service Programs</td>
<td>AMBULATORY/OUTPATIENT MEDICAL CARE</td>
<td></td>
<td>A7</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>Residential Programs and Subsidies</td>
<td>HOUSING ASSISTANCE</td>
<td></td>
<td>B2</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>Benefits Counseling</td>
<td>CLIENT ADVOCACY</td>
<td></td>
<td>N3</td>
</tr>
<tr>
<td>7</td>
<td>7 / 13 / 26</td>
<td>Outpatient Mental Health</td>
<td>MENTAL HEALTH SERVICES</td>
<td>Now includes &quot;Psychiatric Consultation&quot; and &quot;Crisis Mental Health Services&quot;</td>
<td>D1</td>
</tr>
<tr>
<td>8</td>
<td>8</td>
<td>Direct Emergency Financial Assistance</td>
<td>DIRECT EMERGENCY FINANCIAL ASSISTANCE</td>
<td>HRSA requires funds spent in this category to be reported under primary use of money; will be reported to HRSA as &quot;Emergency Housing&quot;.</td>
<td>A2</td>
</tr>
<tr>
<td>9</td>
<td>9 / 28</td>
<td>Oral Health Care</td>
<td>ORAL HEALTH CARE</td>
<td>Now includes &quot;Centralized&quot; and &quot;De-centralized Dental Care&quot;</td>
<td>A2</td>
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<tr>
<td>10</td>
<td>10</td>
<td>Money Management</td>
<td>CLIENT ADVOCACY</td>
<td></td>
<td>N5</td>
</tr>
<tr>
<td>11</td>
<td>11</td>
<td>Transitional Housing</td>
<td>HOUSING ASSISTANCE</td>
<td></td>
<td>B3</td>
</tr>
<tr>
<td>12</td>
<td>12 / 22</td>
<td>Case Management</td>
<td>CASE MANAGEMENT</td>
<td>Now includes &quot;Integrated Case Management&quot;</td>
<td>I1</td>
</tr>
<tr>
<td>13</td>
<td>14 / 16</td>
<td>Residential Substance Abuse Services</td>
<td>SUBSTANCE ABUSE SERVICES -- RESIDENTIAL</td>
<td>Now includes &quot;Residential Detox&quot;</td>
<td>E1</td>
</tr>
<tr>
<td>14</td>
<td>15</td>
<td>Residential Mental Health Services</td>
<td>MENTAL HEALTH SERVICES</td>
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<td>D4</td>
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<tr>
<td>15</td>
<td>17 / 18</td>
<td>Home Health Care</td>
<td>HOME HEALTH CARE</td>
<td>Includes all types of home care (professional, paraprofessional, and specialized). Includes old categories of both &quot;Home-based&quot; and &quot;Facility-based.&quot;</td>
<td>A5</td>
</tr>
<tr>
<td>16</td>
<td>19 / 27 / 16</td>
<td>Outpatient Substance Services</td>
<td>SUBSTANCE ABUSE SERVICES -- OUTPATIENT</td>
<td>All outpatient services. Now includes &quot;Outpatient Detox&quot; and &quot;Methadone Maintenance&quot; Includes immigration services and permanency planning</td>
<td>E3</td>
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<tr>
<td>17</td>
<td>20</td>
<td>Legal Services</td>
<td>LEGAL SERVICES</td>
<td></td>
<td>N4</td>
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<tr>
<td>18</td>
<td>21</td>
<td>Complementary Therapies</td>
<td>OTHER SUPPORT SERVICES</td>
<td></td>
<td>A4</td>
</tr>
<tr>
<td>19</td>
<td>23</td>
<td>Adult Day Health Care</td>
<td>OTHER SUPPORT SERVICES</td>
<td></td>
<td>A10</td>
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<tr>
<td>20</td>
<td>24</td>
<td>Treatment Adherence</td>
<td>TREATMENT ADHERENCE</td>
<td></td>
<td>A9</td>
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<tr>
<td>21</td>
<td>25</td>
<td>Childcare</td>
<td>CHILDCARE</td>
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<td>J2</td>
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<td>22</td>
<td>29</td>
<td>Transportation Services</td>
<td>TRANSPORTATION SERVICES</td>
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<td>L1</td>
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<tr>
<td>Outreach</td>
<td></td>
<td>OUTREACH</td>
<td></td>
<td>When outreach is conducted as part of Case Management/Tx Advocacy, it is considered part of &quot;Peer Advocacy.&quot;</td>
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<tr>
<td>not ranked</td>
<td>Planning Council Support</td>
<td>PLANNING COUNCIL SUPPORT</td>
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<td>Quality Management</td>
<td>QUALITY MANAGEMENT</td>
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<td></td>
<td>Q1</td>
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<tr>
<td>New Priority Rank</td>
<td>FY 2003 Priority</td>
<td>NEW SUB-CATEGORY</td>
<td>HRSA CATEGORY</td>
<td>NOTES</td>
<td>HHS CODE</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>-------</td>
<td>----------</td>
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<tr>
<td>not ranked</td>
<td>Marin County</td>
<td></td>
<td></td>
<td>County line items only appear in Planning Council budgets; services are included in HRSA budgets under appropriate service categories.</td>
<td>S1</td>
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<tr>
<td>not ranked</td>
<td>San Mateo County</td>
<td></td>
<td></td>
<td></td>
<td>S2</td>
</tr>
</tbody>
</table>

**NOT USED BY SAN FRANCISCO COUNTY:**

| Client Advocacy  | CLIENT ADVOCACY  | Sub-category used by SM County only |
NEW LEAF

FEE SCHEDULE

FOR: HIV Mental Health Services (CARE, Not-private pay)
and Substance Abuse Services
(Not to be used for the Stage IV Group in Substance Abuse)

<table>
<thead>
<tr>
<th>MONTHLY NET INCOME</th>
<th>INDIVIDUAL/FAMILY/ COUPLES/PSYCHIATRY SERVICE FEE</th>
<th>GROUP FEE</th>
<th>MAXIMUM MONTHLY FEE (for 1 Individual and 2 groups/week in S.A.S.)</th>
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<tbody>
<tr>
<td>&lt; 200</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>$200-299</td>
<td>$2</td>
<td>0</td>
<td>$8</td>
</tr>
<tr>
<td>$300-399</td>
<td>$4</td>
<td>$2</td>
<td>$28</td>
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<tr>
<td>$400-499</td>
<td>$6</td>
<td>$4</td>
<td>$56</td>
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<tr>
<td>$500-599</td>
<td>$9</td>
<td>$6</td>
<td>$84</td>
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<tr>
<td>$600-699</td>
<td>$11</td>
<td>$9</td>
<td>$116</td>
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<td>$700-799</td>
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<td>$140</td>
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<td>$800-899</td>
<td>$16</td>
<td>$13</td>
<td>$168</td>
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<tr>
<td>$900-999</td>
<td>$18</td>
<td>$16</td>
<td>$200</td>
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<tr>
<td>$1,000-1,099</td>
<td>$21</td>
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<td>$228</td>
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<tr>
<td>$1,100-1,199</td>
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<td>$21</td>
<td>$260</td>
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<tr>
<td>$1,200-1,299</td>
<td>$25</td>
<td>$23</td>
<td>$284</td>
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<tr>
<td>$1,300-1,399</td>
<td>$28</td>
<td>$25</td>
<td>$312</td>
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<tr>
<td>$1,400-1,499</td>
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<td>$28</td>
<td>$344</td>
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<tr>
<td>$1,500-1,599</td>
<td>$33</td>
<td>$30</td>
<td>$372</td>
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<tr>
<td>$1,600-1,699</td>
<td>$35</td>
<td>$33</td>
<td>$404</td>
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<td>$1,700-1,799</td>
<td>$37</td>
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<td>$428</td>
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<tr>
<td>$1,800-1,899</td>
<td>$40</td>
<td>$37</td>
<td>$456</td>
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<tr>
<td>$1,900-1,999</td>
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<td>$40</td>
<td>$488</td>
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<td>$2,000-2,099</td>
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<td>$42</td>
<td>$516</td>
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<tr>
<td>$2,100-2,199</td>
<td>$47</td>
<td>$45</td>
<td>$548</td>
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<tr>
<td>$2,200-2,299</td>
<td>$49</td>
<td>$47</td>
<td>$572</td>
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<tr>
<td>$2,300-2,399</td>
<td>$52</td>
<td>$49</td>
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<tr>
<td>$2,400-2,499</td>
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<td>$52</td>
<td>$632</td>
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<tr>
<td>$2,500+</td>
<td>$57</td>
<td>$54</td>
<td>$660</td>
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Net Income = Take home pay after taxes
### UDC/UOS Reporting by Programs

Close this popup window and use the main one when you are finished.

#### Analysis

<table>
<thead>
<tr>
<th>Analysis Start Date:</th>
<th>01/01/2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Start Date:</td>
<td>01/01/2000</td>
</tr>
<tr>
<td>Report End Date:</td>
<td>12/31/2000</td>
</tr>
</tbody>
</table>

#### Programs:
- All Programs
- 86-1-da
- AIDS & Substance Abuse (ASAP)
- ASAP Case Management (CM)
- ASAP CSAS Assess&Groups

#### UOS Types:
- Adult Day
- Childcare hr
- Day
- Day, bed

#### Selected: All Programs

- UDC Count
- Gender
- Current Living Situation
- CIS Monthly Income
- Residence ZIP
- Agency Psych Illness
- UOS Total

#### Total UDC: 1496

#### GENDER

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td>Intersex</td>
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<tr>
<td>Male</td>
<td>88.8%</td>
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</tr>
<tr>
<td>Transgender</td>
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</tr>
<tr>
<td>Female</td>
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</tr>
<tr>
<td>Unknown</td>
<td>0.1%</td>
<td>2</td>
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</table>

#### Total: 1496

Show detail Analyze Results

### MAJOR ETHNICITY

<table>
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<tr>
<th>Ethnicity</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>European-American/White</td>
<td>972</td>
</tr>
<tr>
<td>Other</td>
<td>29</td>
</tr>
<tr>
<td>Native American</td>
<td>20</td>
</tr>
<tr>
<td>African-American</td>
<td>252</td>
</tr>
<tr>
<td>Latino/a</td>
<td>157</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
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</tr>
<tr>
<td>Unknown</td>
<td>6</td>
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<td>(blank)</td>
<td>17</td>
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<tr>
<td><strong>Total</strong></td>
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</tr>
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</table>

### HIV DISEASE STAGE

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<thead>
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<th>Stage</th>
<th>Count</th>
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<tbody>
<tr>
<td>HIV+, disease stage unkn</td>
<td>165</td>
</tr>
<tr>
<td>HIV negative</td>
<td>1</td>
</tr>
<tr>
<td>HIV+, sympt. not AIDS</td>
<td>153</td>
</tr>
<tr>
<td>HIV+, asymptomatic</td>
<td>122</td>
</tr>
<tr>
<td>AIDS</td>
<td>525</td>
</tr>
<tr>
<td>HIV+, disabling</td>
<td>255</td>
</tr>
<tr>
<td>Unknown</td>
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</tr>
<tr>
<td>Disabling AIDS</td>
<td>235</td>
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<td>(blank)</td>
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### AGE CATEGORY

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<td>50 To 59</td>
<td>216</td>
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<tr>
<td>60 Plus</td>
<td>23</td>
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<tr>
<td>20 To 24</td>
<td>13</td>
</tr>
<tr>
<td>30 To 39</td>
<td>574</td>
</tr>
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<td>0 to 19</td>
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<td>25 To 29</td>
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### CIS MONTHLY INCOME

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<th>Income Range</th>
<th>Percentage</th>
<th>Count</th>
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<tbody>
<tr>
<td>&gt; $1350.99</td>
<td>23.7%</td>
<td>355</td>
</tr>
<tr>
<td>$751.00 - $1350.99</td>
<td>3.5%</td>
<td>351</td>
</tr>
<tr>
<td>Unknown</td>
<td>13.3%</td>
<td>199</td>
</tr>
<tr>
<td>$461.00 - $750.99</td>
<td>30.7%</td>
<td>459</td>
</tr>
<tr>
<td>$301.00 - $450.99</td>
<td>5.3%</td>
<td>80</td>
</tr>
<tr>
<td>$1.00 - $300.99</td>
<td>0.8%</td>
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<tr>
<td>No Income</td>
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<tr>
<td>&gt; $1350.99</td>
<td>71.0%</td>
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**Total:** 1496

### SEXUAL ORIENTATION

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<tbody>
<tr>
<td>Lesbian</td>
<td>8</td>
</tr>
<tr>
<td>Bisexual</td>
<td>123</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>218</td>
</tr>
<tr>
<td>Gay/Homosexual</td>
<td>1062</td>
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<tr>
<td>Unknown</td>
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<td>(blank)</td>
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<tr>
<td>Unsure</td>
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</tr>
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**Total:** 1496

*UOS Total was not requested.*
UDC/UOS Reporting by Programs

Close this popup window and use the main one when you are finished.

Analysis
Start Date: 01/01/2000
Report Start Date: 01/01/2000
Programs: All Programs

Report End Date: 12/31/2000

UDC/UOS Reporting by Programs

Output Preferences:
- UDC Count
- Gender
- Current Living Situation
- CIS Monthly Income
- Residence ZIP
- Agency Psych Illness
- UOS Total

Selected: All Programs

UDC/UOS Types:
- All UOS Types
- Adult Day
- Childcare Day hr
- Day
- Day, bed

Selected: All UOS Types

Output Preferences:
- Show UDC Names
- Major Ethnicity
- HIV Disease Stage
- Private Insurance
- Sexual Orientation
- Show UDC Services
- Minor Ethnicity
- Age
- Unemployment History
- Agency Substance Abuse

Total UDC: 1496

Show detail Analyze Results

PRIVATE INSURANCE COVERAGE

<table>
<thead>
<tr>
<th>Coverage Type</th>
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<th>Count</th>
</tr>
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<tbody>
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<tr>
<td>Cvrg with deductible/ffs</td>
<td>7.1%</td>
<td>106</td>
</tr>
<tr>
<td>Cvrg with copay/capitated</td>
<td>26.3%</td>
<td>394</td>
</tr>
<tr>
<td>Unknown</td>
<td>4.2%</td>
<td>63</td>
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Total 1496

Show detail Analyze Results
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<tr>
<th>Unemployment History</th>
<th>Count</th>
<th>% Total</th>
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<tr>
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<td>31.3%</td>
</tr>
<tr>
<td>Never employed</td>
<td>22</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>490</strong></td>
<td><strong>32.8%</strong></td>
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**UOS Total** was not requested.
FAX Transmittal

Date: 2/4

To: Jim Dille

Agency: _______________

Fax #: _______________

Phone: _______________

Notes: _______________

Transmitted by: _______________

For: _______________

Transmission: 3 pages, including cover

Mailing Address
AHP Services Center
Box 1312
San Francisco, CA 94143-1312

Street Address
1930 Market Street
San Francisco, CA 94102

Tel: (415) 476-3902
Fax: (415) 476-3655
UDC/UOS Reporting by Programs

Close this popup window and use the main one when you are finished.

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Selected: All Programs

Output Preferences:
- [X] UDC Count
- [X] Show UDC Names
- [X] Major Ethnicity
- [X] HIV Disease Stage
- [X] Private Insurance
- [X] Sexual Orientation
- [X] Agency Psych Illness
- [X] UOS Total

Total UDC: 1496

PRIVATE INSURANCE COVERAGE

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<th>Percentage</th>
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<td>4.2%</td>
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<tr>
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<td>2.0%</td>
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Total: 1496

Show detail Analyze Results

## Unemployment History

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<th>Category Name</th>
<th>Count</th>
<th>% Total</th>
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<tr>
<td>Never employed</td>
<td>22</td>
<td>1.5%</td>
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<tr>
<td><strong>Total</strong></td>
<td>490</td>
<td>32.8%</td>
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</tbody>
</table>

UOS Total was not requested.

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PROCESS

A total of 51 CIS client records and 49 Clinical Assessments were reviewed utilizing the HSP Chart Review Tool and the AHP QI Form, respectively. Records were selected randomly through two reports: Records Needing Chart Review and Clients Served by Staff and by review of the Clinical Assessment Appointment Log. All records had current services (Client Profile, Profile Update or Clinical Assessment) in the last quarter (July 1, 2000 - September 30, 2000). Records were reviewed over a 10 week period and were examined for both technical accuracy and clinical content.

RESULTS

Of the records reviewed, a total of 25 had their initial intake completed at AHP. (SFAF had completed 19 and Shanti had completed seven.)

1. Registration: Core Data

A total of 18 records (35%) had issues noted regarding completion of required Reggie registration data fields, Reggie/CIS eligibility documentation or Annual Verification screens. Two paper charts could not be located for review.

Answers recorded in all the required Reggie fields

Four records were missing Reggie client information:

- 215-92-0522  Reggie eligibility documentation not entered
- 430-21-9983  Reggie eligibility documentation not entered
- 498-64-2265  Reggie eligibility documentation not entered
- 496-76-5070  Reggie eligibility documentation not entered

430-21-9983  Reggie data fields not completed

Reggie Share/Non-share Form and HSP Consent for Services

HSP consent not initialed:

- 039-44-1519

HSP consent not in paper chart:

- 572-67-2672
Missing Paper Charts (unable to review):
550-86-6944  430-21-9983

Reggie Annual Verification

(A total of six charts had missing or past due dates.)

Missing core dates:
430-21-9983

Missing CM dates:
430-21-9983  561-49-1979

Missing CIS dates:
430-21-9983  561-49-1979  545-75-8189

2. Service Line Items

For purposes of this review, SLIs were matched to profile, update, assessments and progress/psychotherapy note entries. Four records (8%) had issues noted regarding services entry.

Missing service entry for progress notes/profile update:
469-90-0733 (8/31/00 note)
445-54-0610 (profile update)

Service entered/no psychotherapy note:
249-29-8124 (9/15/00 and 9/22/00)

Missing services entry for clinical assessment/update:
546-13-8166

3. Specialty:  Case Management and Medical

Nineteen charts (37%) were missing responses in the Specialty Case Management fields:
HSP consent not in Reggie/CIS system:
215-92-0522  498-64-2265
430-21-9983  496-76-5070

HSP consent Agency Use section not complete:
568-39-7407  530-42-4585

Income Statement:
Income Statement not in Reggie/CIS system:
498-64-2265  496-76-5070  430-9983

Client Rights and Responsibilities:
Rights and Responsibilities not in Reggie/CIS system:
215-92-0522  498-64-2265
430-9983-496-76-5070

Rights and Responsibilities not in paper chart:
572-67-2672

Letter of Diagnosis
LOD not in paper chart:
572-67-2672

LOD not in Reggie/CIS system:
430-21-9983

LOD not verified by staff:
566-58-6841

All Eligibility Forms Missing from Chart:
215-92-0522  529-11-6231  032-28-4915
Missing psych/substance fields: (17)
- 558-06-1182
- 529-11-6231
- 571-39-4519
- 550-76-1356
- 545-98-6776
- 518-82-5225

- 249-29-8124
- 459-96-5020
- 561-49-1977
- 571-80-9174
- 430-21-9983
- 548-17-1555

- 028-54-8366
- 545-75-8189
- 563-53-7450
- 498-64-2265
- 496-76-5070

558-06-1182 249-29-8124 028-54-8366
529-11-6231 459-96-5020 545-75-8189
550-76-1356 571-80-9174 498-64-2265
545-98-6776 430-21-9983 496-76-5070
518-82-5225 548-17-1555

Missing ART fields: (3)
- 215-92-0522
- 516-50-3280
- 518-82-5225

4. Client Profile

21 of the 51 charts reviewed had current client profiles. Of the 21 profiles reviewed, seven (33%) were complete. Fourteen (67%) had some issues noted. Twelve (57%) were lacking documentation of a discussion with the client regarding Collaboration services. (See recommendations section for further discussion of this topic.) Two records were missing Client Profiles.

Lacking Collaboration documentation:
- 568-39-7407
- 547-17-9036
- 572-67-2672
- 364-66-8282

- 264-69-8382
- 382-44-9953
- 266-39-0418
- 457-21-2317

- 469-90-0733
- 042-56-0476
- 511-62-5610
- 000-11-1059

Missing profile:
- 529-11-6231
- 430-21-9983

5. Profile Update

A total of 30 records had profile updates. Of those records, nine (30%) had past-due updates and one record had an incomplete profile update.

Past-due updates:
- 496-76-5070
- 571-39-4519
- 498-64-2265

- 558-06-1182
- 561-49-1977
- 545-75-8189

- 463-85-6521
- 585-98-8164
- 028-54-8366

Incomplete update:
- 215-92-0522
6. Progress Notes

Of the records reviewed, six records (12%) had issues noted. Five records had problems regarding timeliness of entry and one had problems regarding charting of psychotherapy notes/continuity of content:

Timeliness of entry:
- 249-29-8124 (up to 25 days lag time)
- 546-13-8166 (up to eight months lag time)
- 445-54-0610 (up to two months lag time)
- 264-69-8382
- 548-17-1555

Psychotherapy notes not being charted/lacking continuity of content:
- 566-58-6841

7. Care Plan

A total of 32 records (63%) had issues concerning their care plans. Of those, 22 needed updating, 5 records had no care plans and 5 had no current entries during the review period. (See recommendation section.)

Need updating:
- 461-29-3019
- 015-44-9077
- 000-07-0962
- 364-66-8282
- 545-98-6776
- 042-56-0476
- 547-17-9036
- 568-39-7407
- 241-98-2866
- 585-98-8164
- 550-76-1356
- 530-42-4585
- 570-96-8738
- 032-28-4915
- 264-69-8382
- 546-59-6354
- 038-44-9479
- 563-53-7450
- 511-62-5610
- 550-86-6944
- 382-44-9953
- 516-50-3280

No care plan:
- 571-39-4519
- 215-92-0522
- 545-75-8189
- 430-21-9983
- 498-64-2265

No current entries:
- 571-80-9174
- 445-54-0610
- 039-44-1519
- 028-54-8366
- 566-58-6841
8. Clinical Assessment/Diagnosis Screen

Clinical Assessment

A total of 49 clinical assessments were reviewed, including two neuropsychology assessments. Of the assessments reviewed, seven (14%) had clinical issues noted.

No diagnosis:
DOB 4/28/55

No Plan:
DOB 5/22/59

No clear clinical evidence to support diagnosis:
DOB 10/23/68
DOB 9/2/59

Needed to address client's diagnosis in disposition:
DOB 4/8/50

Incomplete HPI, psych and substance histories:
DOB 3/26/56

Assessment illegible:
DOB 9/7/57

Diagnosis Screen

Of the 49 assessments reviewed, five (10%) had incomplete Diagnosis Screens:
430-21-9983 000-07-0962 516-50-3280
459-96-5020 000-10-0156

RECOMMENDATIONS

1. Quality Improvement Process

Through the HSP Quality Improvement Committee, work is underway to develop a comprehensive quality improvement process. This chart review was an important step in that process.
For AHP, a formal, on-going chart review for both CIS records and clinical assessments is recommended. Though all new client registration/profiles completed by clinical interns are reviewed by the Intake Coordinator, which is an important part of a QI process, not all profiles are conducted by interns nor are profile updates, service line items, annual verification, on-going progress notes or clinical assessments routinely reviewed.

Part of formalizing a QI process should include frequency and number of CIS records and clinical assessments reviewed as well as establishing threshold standards. For example, of 50 clinical assessments reviewed no more than 5% will have clinical issues noted. Additionally, standards for legibility and documentation (e.g. not using red ink on client consents and forms) and timeliness of charting should be included. Standards for CIS should involve the HSP Quality Improvement Committee since this is a shared responsibility.

The chart review also revealed that 57% of the completed profiles did not document a discussion of Collaboration services. It is recommended that a consistent approach be implemented across the Collaboration as part of the charting process, for example in the impressions section staff would be required to note that a discussion of Collaboration services had taken place and whether referrals were made. In the event that the discussion does not take place, that should be indicated, along with the reason for not doing so.

Through the course of this chart review, feedback was given to supervisors about areas needing improvement in documentation, profiles and clinical assessments. Some incomplete screens, recording of eligibility documentation and clinical assessment issues have been corrected. A process should be implemented to follow-up on any needed corrections to ensure that they have been accomplished.

2. Clinical Concerns

During the course of the review, several clinical concerns surfaced that warrant discussions:

**Formal Treatment Plans for ASAP Case Management Clients**

No formal, written case management treatment plans detailing both short and long-term goals are established for case management clients. In reviewing the ASAP charting notes, it was difficult to determine a course of treatment. In one particular example, the client had a long-standing history of alcoholism and had been drinking throughout his treatment with is previous ASAP case manager and now with his current case manager. After
an extensive time with ASAP case management, it did not appear that the 
client had ever made a minimal commitment to harm reduction. It would 
seem that having a treatment plan with the client and reviewing that plan 
with the client would be in the best interest of both the client and the ASAP 
case manager. Additionally, criteria should be established for discharging 
clients that includes clients who are not ready for case management. In this 
particular case, it seems the client was not able to make the best use of case 
management and should either commit to some type of harm reduction or be 
discharged from the program.

Clarification of the Return to Work Program

Some clarification of the RTW clinician’s role should be established. In one 
record reviewed, the psychotherapy notes, as they were charted, revealed that 
the client was currently in treatment with a therapist. (The client had been 
seeing this therapist for seven years.) The RTW psychotherapy notes did not 
seem limited to work related issues and, in fact, the RTW clinician had 
referred the client for both a psychiatric medication evaluation and for 
neuropsychological testing -- both of which seem the role of the primary 
therapist.

In another case, a client was attending the RTW group though there was no 
decrease in his substance use and an increase in his manic symptoms. (The 
client had taken himself off his medication.) Under the circumstances, it was 
unclear why the client was being encouraged to return to work.

Fee for Psychotherapy Services

It is recommended that AHP consider establishing a sliding scale fee for 
psychotherapy services, perhaps using HUD low income guidelines for 
setting fees. Two charts reviewed indicated clients who could reasonably 
afford to pay for psychotherapy. One client’s annual income was $84,000 and 
the other client’s annual income was $60,000 and he had just purchased a 
home in Oakland.

Timeliness of Clinical Notes and Assessments

There was a significant lag time in entering some clinical notes into the 
system. For example, up to two months for psychotherapy notes, up to seven 
weeks for a clinical assessment and up to eight months for psychiatrists notes. 
Though these were exceptions, some standard (timeline) should be 
established for entering clinical work into CIS.
3. Case Management Screens

There appeared to be some confusion around data entry for the psychiatric and substance use screens in Reggie/CIS. Even with share clients in the Reggie system, this information is not shared across agencies. Individual agencies need to complete these fields for their clients. The Collaboration Program Committee is meeting to discuss the best approach for ensuring these fields are entered.

4. Care Plan

The care plan is difficult to assess because of current discussion of its utility and staff's willingness to complete. As decisions are reached by the Collaboration regarding the future of the care plan, that should be reflected in the chart review tool and QI process.

5. AHP QI Form

Lastly, the AHP QI Form for reviewing clinical assessments should be updated to better reflect the CIS QI process.
AIDS Health Project Community Meeting
August 30, 2001

When I make a referral for mental health services:

1. The most common mental health problem clients have that I refer for mental health services is:

2. The kind of service I most commonly need for my clients with a mental health problem is: (rank order the following by placing a 1 by the first, 2 by the second, etc).

   Individual Psychotherapy
   Group therapy
   Psychiatry evaluation (meds) and follow up
   Neuropsychiatry evaluation
   Help with SSI or other disability eval
   Support group (peer)
   Other __________________________

2. The mental health service I have the most difficulty in obtaining (from the list in #2) is:_________________.
The second most difficult is: ___________________
3. Of the clients I refer for mental health problems, the proportion that I think (---the client, of course may not agree) also have a substance abuse problem is: __________

4. How often would you say the client(s) you refer are homeless, or marginally housed?

   10% or less   10-20%   30-40%   50% plus

5. How often would you say the client(s) you refer have had a history of psychiatric hospitalization?

   10% or less   10-20%   30-40%   50% plus

6. When I think a client is in need of residential treatment services for a combination of mental health/substance abuse problems, I would refer to the following:

   a. ________________________________

   b. ________________________________

   c. ________________________________
From: Joanna Rinaldi (4/4/01)  
To: James Dilley  

FWD: Fw: Update on Excel inquiry

We ran all of the initials and dates of birth through my best CA public record resource and with just the initials; there was not enough data to return any results. The initials only are too "wild", as wild card searches go. This was with the MIS databases. MIS is the best resource for CA specific information.

When we selected initials and dates of birth, as well as initials and zip code; I did not receive positive results via DBT; but it is POSSIBLE that an inquiry could return a positive result. With enough time and expense; it could be possible to return at least a suspect list of possible matches with public records information. It would take us at least 16 billable hours to develop this list, from the spread sheet provided. The results would still require verification via an independent source. I would proably order an off-line search of date of birth matches from the ZIP codes identified and then filter on the initials, to determine a suspect list. An additional filter would be SSN prefix matches to the State of Births for each subject (i.e., California SSN issue prefix is 545-573 and 602-626). This would really narrow the pool.

No sources that we currently use has any search filters based on ethnicity, but gender would be a common-sense guide to filtering any positive returns from the DBT search. The only time that I see enthnicity as a filter is National Wants and Warrants using NCIC for outstanding criminal warrants. Update: We spoke to a programmer at DBT this morning and to run a custom batch search using the parameters from the Spreadsheet, would require a minimum population of 500 individuals in order for DBT to process. LEOs run similar types of searches when they go fishing for suspects.

As I said earlier, it is POSSIBLE to develop a suspect list using this batch search method. This is probably the most cost-effective means to reach your desired results. The 16-hours that you authorized would proably pay for a lot of "hunt-n-peck" work that would not be as productive as using a batch search method.

Please advise me of your desire and I will get a cost estimate from DBT. We need to have a sense of your commitment to this type of batch search prior to negotiating a price with DBT.

Kenn
MENTAL HEALTH QUESTIONNAIRE
SERVICES PROVIDED

AIDER: _______________________________________

BIT: __________________________________________

INDIVIDUAL COMPLETING THIS QUESTIONNAIRE:
___________________________________________

ONE: _________________________________________

**PES OF SERVICE PROVIDED**

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<th>Number of Clients Who Received</th>
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<tr>
<td>Assessment and Triage</td>
<td>360</td>
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<tr>
<td>Short term individual counseling/psychotherapy (&lt;24 hours per year for a single client)</td>
<td>417</td>
</tr>
<tr>
<td>Long-term individual counseling/psychotherapy (&gt;24 hours per year for a single client)</td>
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</tr>
<tr>
<td>Short term group (&lt;24 hours per year for a single client)</td>
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<tr>
<td>Long-term group (&gt;24 hours per year for a single client)</td>
<td>260</td>
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<tr>
<td>Neuropsych Evaluations</td>
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<tr>
<td>Psychiatric services (evaluations, medication monitoring, etc.)</td>
<td>195</td>
</tr>
<tr>
<td>Case Management</td>
<td>78</td>
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<tr>
<td>Other (please specify:)</td>
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</tr>
</tbody>
</table>

**WAIT LIST**

As of today, does your program have a wait list for non-Psychiatric services? _____ Yes _____ No

If yes, how many people are on the wait list? ______

As of today, does your program have a wait list for Psychiatric services? _____ Yes _____ No

If yes, how many people are on the wait list? ______

**Total Hours Spent Providing:**

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<th>Hours</th>
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<tr>
<td>Crisis (non-M.D.)</td>
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<td>511</td>
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<tr>
<td>Long-term individual counseling/psychotherapy (&gt;24 hours per year for a single client) (non-M.D.)</td>
<td>94.35</td>
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<tr>
<td>Short term group (&lt;24 hours per year for a single client) (non-M.D.)</td>
<td>85</td>
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<tr>
<td>Long-term group (&gt;24 hours per year for a single client) (non-M.D.)</td>
<td>520</td>
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<tr>
<td>Neuropsych Evaluations (non-M.D.)</td>
<td>38.5</td>
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<tr>
<td>Psychiatric services (evaluations, medication monitoring, etc.)</td>
<td>67.6</td>
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<tr>
<td>Case Management</td>
<td>466.75</td>
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<tr>
<td>Other (please specify:)</td>
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</tbody>
</table>

GAF score: 65

May 1, 1998
DEMOGRAPHICS

CURRENT LIVING SITUATION (REQUIRED)
(count each client only once)
If the client has had several different living situations recently, choose the most recent.

- street, park, car or abandoned building
- emergency housing, not shelter
- living with friend or family member and not paying rent
- halfway house or drug/alcohol program
- single room occupancy hotel room
- hospital/institution
- jail/incarcerated
- renting or own house, apartment or flat
- other
- unknown

LIVING SITUATION LAST 12 MONTHS
(specify all that apply)

- street, park, car or abandoned building
- shelter
- emergency housing, not shelter
- living with friend or family member and not paying rent
- halfway house or drug/alcohol program
- single room occupancy hotel room
- hospital/institution
- jail/incarcerated
- renting or own house, apartment or flat
- other
- unknown

CURRENT NUMBER OF CURRENT CLIENTS REPORTED:

As noted that, unless otherwise specified, the number of ents for each question below should equal the number of ents above.

(Required)

(c)nt each client only once)

- Male
- Female
- Transgender
- Unknown

(E)

- 13 Years or Under
- 13-19 Years
- 20-44 Years
- 45 Years or Older
- Unknown

(HILDREN)

Member of clients with dependent children (under the age 18 living with the client):

(V DIAGNOSIS)
(count each client only once)

- HIV negative
- HIV positive (not AIDS) Dg within past year
- HIV positive (not AIDS) Dg over 1 year
- AIDS
- Unknown

(ITAL/EThNIC HERITAGE)
(count each client only once)

- White (non-Hispanic)
- Black (non-Hispanic)
- Hispanic
- Asian/Pacific Islander (including Filipino/a)
- Native American/Aleutian/Native Alaskan/Eskimo
- Other
- Unknown

(LANGUAGE PREFERENCE)
(count each client only once)

- English
- Spanish
- Tagalog/Ilocano
- Mandarin
- Other (please specify)
ONTHLY INCOME FOR INDIVIDUAL CLIENTS
OF HOUSEHOLD)
(int each client only once)

- $350 or Below
- $350 - $660
- $661 - $1,200
- $1,201 - $2,630
- Above $2,630
- Unknown

SOURCE OF INCOME
(cify all that apply)

- GA
- TANF
- Food Stamps
- Salary
- Unemployment Benefits
- Veteran’s Benefits
- SSI
- SSDI
- State Disability Insur.
- SSA Retirement
- Long-term Disability
- Other

EMPLOYMENT STATUS
(int each client only once)

- Full Time (30 or more hours per week)
- Part Time (< 30 hours per week)
- Not Employed
- Unknown
- Disabled

PE OF HEALTH CARE COVERAGE
(int only primary coverage)

- Private Insurance (include HMO’s)
- Kaiser
- Medi-Cal/Medicaid
  Count clients who have applied and are awaiting administrative approval as well as clients who have Medi-Cal through a private insurance company.
- Medicare
- Other Public Insurance
  Includes CARE funded primary care clinics, Champus, VA, Wker’s Comp and IHS
- Uninsured
- Unknown

HEALTH INSURANCE FOR MENTAL HEALTH SERVICES

- No coverage
- Emergency or short-term only (24 or fewer sessions per year)
- Over 24 sessions per year
- Unknown

MEDI-CAL ELIGIBILITY
What is your current case load for this contract exhibit? ________
How many of these clients are enrolled in Medi-Cal ________
TYPES OF CLIENTS SERVED
AND SEVERITY OF NEED
(ALL CLIENTS)

Please provide information here on all clients seen as of January 1, 1998.

M-IV DIAGNOSES

Using the DSM-IV categories, please list the types of diagnoses served by this contract exhibit. (Please do not diagnostic numbering codes.) Show the number of clients with primary and secondary diagnosis for each diagnostic category listed.

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<thead>
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INTENSITY OF SERVICES REQUIRED

Specify the number of clients who:

1. Need day treatment, sub-acute, or residential mental health treatment to maintain stability and avoid acute care: ______
2. Have had one or more psychiatric hospitalizations within the last 12 months: ______
3. Have taken psychotropic medications since beginning treatment: ______
4. Are considered severely and persistently mentally ill: ______

GLOBAL ASSESSMENT OF FUNCTIONING (GAF)

Using the GAF Scale, please indicate the number of clients within each range.

1 - 10
11 - 20
21 - 30
31 - 40
41 - 50
51 - 60
61 - 70
71 - 80
81 - 90
91 - 100

MULTI-DIAGNOSED

Number of current clients who have an active substance abuse/dependency problem that warrants treatment or will affect client’s ability to access care along with an active psychiatric illness that warrants treatment or will affect client’s ability to access care. ______

AIDS DEMENTIA

Number of clients with diagnosis of: HIV-Related Cognitive Impairment ______

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TYPES OF CLIENTS SERVED AND SEVERITY OF NEED (LONG-TERM CLIENTS)

We provide information here only on clients who received over 24 sessions per year (Long-term clients).

DSM-IV DIAGNOSES

Please list the types of diagnoses served by this contract exhibit. (Please do not diagnostic numbering codes.) Show the number of its with primary and secondary diagnosis for each diagnostic category listed.

IMBER IMARY NUMBER SECONDARY DIAGNOSIS

GLOBAL ASSESSMENT OF FUNCTIONING (GAF)

Using the GAF Scale, please indicate the number of clients within each range.

INTENSITY OF SERVICES REQUIRED

Specify the number of clients who:

Need day treatment, sub-acute, or residential mental health treatment to maintain stability and avoid acute care:

Have had one or more psychiatric hospitalizations within the last 12 months:

Have taken psychotropic medications since beginning treatment:

Are considered severely and persistently mentally ill:

MULTI-DIAGNOSED

Number of current clients who have an active substance abuse/dependency problem that warrants treatment or will affect client’s ability to access care along with an active psychiatric illness that warrants treatment or will affect client’s ability to access care.

AIDS DEMENTIA

Number of clients with diagnosis of:

HIV-Related Cognitive Impairment

AIDS Dementia
Mental Health Prioritization Committee Recommendations

I. Flat Funding: No change in funding for mental health. Increased emphasis on mental health assessments funded through outpatient mental health services for those clients not necessarily ready for ongoing treatment.

II. Decreased Funding: Proportional reduction in each sub-category relative to the reduction in funding for the fiscal year. Increased emphasis on mental health assessments funded through outpatient mental health services for those clients not necessarily ready for ongoing treatment.

III. Increased Funding:

1. Funding for staff and operating costs related to a mental health program being a part of the staffing of a drop-in type service center.

2. Increase funding for mental health assessments, particularly for clients who are not in on-going treatment, but require assessments for completion of benefits paperwork. Leave hotline funding at current level.

IV. Unobligated Funds: Explore possibility of one time funded addition to an existing contract to clean up any backlog of mental health assessments needed for SSI, SSDI, MediCal, etc. for clients not involved in on-going mental health services.

V. Programmatic Recommendations

1. Direct the AIDS Office to work with contractors to assure that existing contractors provide mental health assessments to existing clients as required by SSI, SSDI, MediCal, etc.

2. Direct the AIDS Office to assure that each agency assess for client eligibility including insurance and income.

3. Direct the AIDS Office to explore the implications of prioritizing the funding of group therapy more than individual therapy. This is not a recommendation to change the existing balance, but rather a request that there be an exploration of the ramifications, positive and negative, if such a shift were made.

4. Direct the AIDS Office to explore the implications of requiring that 20% of the mental health money be included in collaborations with non-mental health agencies.

5. Direct the AIDS Office to explore the implications of requiring that 10% of the mental health money be included in collaborations with youth-focused (25 y/o or under) agencies.
PRIORITIZATION 2000-2001
MENTAL HEALTH WORKGROUP

Providers’ recommendations:
Hold harmless for funding cuts
Increase funding to do mental health exams for purposes of eligibility for benefits
Strengths of the system: use of 3rd party payors (esp. MediCal)
“leaner and meaner” system, integration
Weaknesses: SSI assessments, Psych assessments for clients who don’t want mental health services

Discussion
Balance between off-site and on-site mental health services
Mental health exams for purposes of eligibility for entitlements are scarce EMA-wide; we should look at linking these services to the SSI project
No quantifiable information re: integration (eg. What proportion of services are integrated or off-site?)
What type of services are in the Integrated contracts? Crisis vs. psych evaluation?
Collected feedback from Council members on May 21st meeting:

Priority setting presentations: content
Charts are good but only if the narrator knows how to use them. There was a lot of repetition and mostly they were reading off the charts. We can do that. They need to tell us the significance of the charts and numbers.

The complementary care and dental care presentations ended up being more of a plea to fund them than a presentation of information. The most useful information was the number of people served by this service. What would have been especially valuable (but is probably not available) would be the number of people who need the service but don't get it and how many of those people could have the services provided if finances were not limited (ie the number not limited by lack of trained staff).

- what other information you wanted to hear
  > Demographic info on clients, better info on waiting lists, We needed an intro to dental care that broke down what the hell was going on.
- what did you learn from the presentations
  > Percentages of subcategories within primary care

I really would like to see demographics of clients served included in all presentations - can we have them pulled from last year's AARs if we can't get good data from Reggie? Do the DPH programs even do AARs or is that just the outside contractors? - I don't even know. It seems like we should be able to get some information from some source for the next meeting.

In general, I thought that the comments (especially from the providers) were too general and not focused enough on the service category in question (especially from primary care). I thought that the home care presentation was the best in that the program manager provided definitions of the services that were very specific to educate the council members and the providers discussed issues unique to their service category. I think we need to discourage people from simply asking for more money.

Priority setting presentations: dental
The most interesting for me was the dental portion. Many of our patients had and continue to have the same complaints discussed during the meeting.

The dental presentation was not useful to me, and I do not know why Gene Gowdey was allowed to continue speaking when it became clear that his "presentation" was not a presentation on decentralized dental services.

The dental presentation was problematic from the beginning. I did not think there was a clear definition of what decentralized dental was, at least what was given did not directly coincide with what my understanding was from the time we created this category. I don't understand why Gene Gowdey was given the floor. I know that his agency has been the provider of decentralized dental, but it was a foregone conclusion that he would talk about the recent contracting process to which no one could respond. The other presentations were interesting, some more informative
than others. I do like the way they are set up this year, that is the AIDS Office presenting and a provider or two.

The definition and justification for the decentralized dental services was not correctly presented. The original prioritization issue surrounding the creation of the decentralized dental services was to create an alternative to dental schools. This was further noted by the public testimony, which reiterated the need and desires of the consumers to have community based, private practice models of care as alternatives to the problems that occur with the dental schools. This same consumer feedback was noted in 1997, which lead to the creation of the decentralized (non-dental school) model of care in the first place.

Discussions pertaining to the most recent course of events regarding the decentralized dental services were limited and suppressed. Council members deserve to know the full perspective on how these decisions were made and what is happening to the disenfranchised consumers. It was, in my opinion, completely appropriate, during the meeting of May 21, to have taken a few minutes to openly discuss the process of prioritization of dental services in order to more fully address the issues and concerns that the Council members may have regarding the defunding of the decentralized dental provider. The Council needs all of this information in advance of the upcoming prioritization meetings, in order to be more fully informed about the pertinent issues. Unless the Council is willing to face these issues head on, it too will join the AIDS Office in the credibility problem that is developing.

Priority setting presentations: timing and length

The service category presentations started late. Given that we ended up running 45 minutes late, and many people had already left (I counted 11-12 council members there at the end), it is questionable whether everyone that needed to hear the presentations was there to hear them.

Thanks for your (and the steering committee's and prioritization committee's) work on this challenging task.

I was feeling anxious throughout last night's meeting, as I watched the agenda (and its timing) collapse from almost the beginning.

It seems apparent that we are not being realistic in estimating the amount of time needed for the presentations and discourse, and that this is not only unfair to the invited speakers (especially those forced to speak up to an hour after the scheduled end of the meeting) and to the Council members, but also detrimental to the prioritization process.

Possible solutions:

Temporarily schedule more frequent (weekly?) (but shorter?) Council meetings, perhaps alternating "prioritization" meetings with "council business" meetings?
Request that presenters be concise. (I know that this is in the eye of the beholder. But... To cite one program manager's presentation — system overviews are useful, but 15 minutes and full-page bar graphs just to explain that a category has achieved 105% of contracted UOS? Seems a bit much.) (Please consider us poor members who really do want to stay awake and who leave each meeting with what seems like a ream of papers -- not to mention the dead trees).

I think it's extremely important to have time after the providers' and program managers' presentations to contextualize the information into the prioritization process.

It is good to have presentations but there were too many. I, for one, cannot concentrate that long. These things should have started sooner so we could discuss them. As we get more tired we try to hurry things along just to get through them. Some presenters are better than others due mostly to the fact that they don't know how to present. They made all the charts and graphs but spent no time in learning how to present material in an interesting way that will keep people interested and awake. That may be too much to expect but if they are trying to inform and influence us the organization should send their best presenter. Not just the boss. The concept for us is to learn. The situation was not good for learning. Our co-chairs could help by better scheduling.

There was too busy an agenda so even with going way overtime there wasn't enough time. Less time amount of provider presentation. Instead of 4 make it for example only two and give them more time to present instead of being RUSHED like last night.

I found the presentations quite informative, however, I believe if at all possible, I think it would be helpful if the agenda order could be adjusted to allow presentations to begin immediately following role call. When there are many presentations to be done, I think it is important to have the entire council present to listen. As it turned out by the time the last presentation was made, many members had left the meeting, myself included. I think discussion and public comments could be done following presentations especially during the prioritization process. I realize I do have a lot to learn but have learned quite a bit in the short time I've been on board. I'm really looking forward to hearing about how providers will meet "unmet needs" without receiving more money?

**Overall scheduling and facilitation**

I found the meeting very frustrating right from the very beginning. We don't start on time. The chairs are not there. The chair that is bringing a presentation is not there at the time scheduled, nor is the material there. The AIDS Office seemed to get blamed for not being there with the material when, I don't think, it had anything to do with the AIDS Office. Unless it was the fact that their presentations got moved up on the agenda, i.e. approval of the 2001-2002 budget.

Apparently the chairs knew in advance that the Council Support budget would be problematic (they had the amendment in advance). But, scheduling did not seem to take this into account. Perhaps it was too late, but it seemed like the chairs lost control of the meeting here.

Once again scheduling seemed to be a problem.
I feel that I am being "co-dependent" by continuing to stay to the end of meetings that are poorly scheduled. If I and others are willing to stay late, then that just encourages the meeting starting late and ending late. I am to the point of saying that I will leave at the scheduled time regardless of whether the meeting is over or not. This is particularly the case when the meeting does not start on time.

When those who are chairing a meeting treat council members, public guests, or speakers with arrogance and disrespect, then what is already a trying process turns into a dispiriting, disempowering, miserable experience for everyone. Not a great way to retain members or entice new ones.

I was very disappointed in the meeting. I think that the co-chairs completely lost control of the agenda.

As for the process, when did the Council begin allowing full participation (except for voting) in its deliberations for all present in the room? We have always had a period at the beginning of the meeting for public comment. Several years ago, we decided to allow further public comment prior to any votes taken. At Monday's Council meeting, all persons in attendance were allowed to discuss the issues on the floor whenever they wanted to do so. As the co-chairs made lists of those waiting to speak, audience members (including contractors as well as consumers) were put on the lists whenever they raised their hands. While I am supportive of the Council's desire to include as much public comment as possible (especially from consumers) in our deliberations, allowing everyone present to participate in the Council's discussions will be very time-consuming. If what occurred on Monday is to be allowed in future meetings, then I believe that the Council must schedule more frequent, or longer, meetings with shorter agendas.

I left the meeting at 7:30, so I missed several of the presentations. I've stayed after 7:30 on a number of occasions in the past, but I am no longer willing to do so when we've failed to follow the agenda, presenters are late, co-chairs arrive late or leave early, meetings start late, etc.
## Prioritization Council Meetings

### June 11th

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### June 25th

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<td><a href="mailto:Marsha_herring@dph.ucsf.edu">Marsha_herring@dph.ucsf.edu</a></td>
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<tr>
<td></td>
<td>554-9036</td>
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<tr>
<td>Client Advocacy</td>
<td>Hilda Jones &amp; Joseph Cecere</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:Hilda_jones@dph.ucsf.edu">Hilda_jones@dph.ucsf.edu</a></td>
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<tr>
<td></td>
<td><a href="mailto:Joseph_cecere@dph.ucsf.edu">Joseph_cecere@dph.ucsf.edu</a></td>
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<td>554-9027 (Joseph)</td>
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<tr>
<td>Transportation</td>
<td>Hilda Jones</td>
<td>n/a</td>
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<tr>
<td>Respite Child Care</td>
<td>Joseph Cecere</td>
<td>n/a</td>
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<td><a href="mailto:Joseph_cecere@dph.ucsf.edu">Joseph_cecere@dph.ucsf.edu</a></td>
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### July 9th

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<thead>
<tr>
<th>Service Area</th>
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<tr>
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### Prioritization Council Meetings

#### June 11th

<table>
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<tbody>
<tr>
<td>Substance Use</td>
<td>Celinda Cantu</td>
<td>Gary Harrel</td>
</tr>
<tr>
<td>5:40-6:20</td>
<td><a href="mailto:Celinda_cantu@dph.sf.ca.us">Celinda_cantu@dph.sf.ca.us</a></td>
<td><a href="mailto:Gary_h@tts-sf.com">Gary_h@tts-sf.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>922-2727 (h)</td>
</tr>
<tr>
<td></td>
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<td>788-8808 (w)</td>
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<tr>
<td>Mental Health</td>
<td>David Macias</td>
<td>M. Jay Sanders</td>
</tr>
<tr>
<td>6:30-7:10</td>
<td><a href="mailto:David_macias@dph.sf.ca.us">David_macias@dph.sf.ca.us</a></td>
<td><a href="mailto:Mjavsf@aol.com">Mjavsf@aol.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>252-8855</td>
</tr>
<tr>
<td>Food</td>
<td>David Macias</td>
<td>Brad Hume</td>
</tr>
<tr>
<td>7:10-7:20</td>
<td><a href="mailto:David_macias@dph.sf.ca.us">David_macias@dph.sf.ca.us</a></td>
<td><a href="mailto:Wynsok@worldnet.att.net">Wynsok@worldnet.att.net</a></td>
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<td></td>
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<td>Russ Zellars</td>
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<td></td>
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<td>554-9105</td>
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<td>Congressional Black</td>
<td>Marsha Herring</td>
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<td><a href="mailto:Marsha_herring@dph.ucsf.edu">Marsha_herring@dph.ucsf.edu</a></td>
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<td>Client Advocacy</td>
<td>Hilda Jones &amp; Joseph Cecere</td>
<td>n/a</td>
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<td>554-9027 (Joseph)</td>
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</tr>
<tr>
<td>Transportation</td>
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#### July 9th

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<tr>
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<tr>
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<td>Facility-based Home Care</td>
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<td>Residential Programs and Subsidies</td>
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<tr>
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|          |          |          | $3,319,561 | $300,000 | $34,407,588 | $1,217,434 | $39,244,583 |
## Breakdown of Integrated Services (API) - CARE FY99/00 Contracts

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<td>Integrated Services (combined w/ another collaborative as of 06/01/99)</td>
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<td>3/01/99-2/29/00</td>
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<td>3/01/99-2/29/00</td>
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<td>3/01/99-2/29/00</td>
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**5/19/99, 2:31 PM**
**Health Care:**
- Primary Care: 15 Exhibits/ 6 MOUs w/out Demo. Info. 1,064
  - Percent: 437, 26%, 15, 1%, 93, 5%, 249, 15%, 31, 2%, 825, 50%, 804, 48%, 35, 2%
- Dental Care: 2 Exhibits/ All Demo. Info. Present 1,642
  - Percent: 224, 16%, 9, 1%, 40, 3%, 243, 16%, 0, 0%, 516, 34%, 903, 60%, 95, 6%
- Pharmaceuticals: 1 Exhibit/ 1MOU w/out Demo. Info. n/a
  - Percent: n/a
- Complementary Therapies: 5 Exhibits/ 1 MOU w/out Demo. Info. 1,031
  - Percent: 76, 7%, 32, 3%, 60, 6%, 143, 14%, 20, 2%, 330, 32%, 670, 66%, 31, 3%
- Home-based Care: 4 Exhibits/ All Demo. Info. Present 732
  - Percent: 105, 14%, 0, 0%, 98, 13%, 132, 18%, 9, 1%, 344, 47%, 388, 53%, 0, 0%
- Facility-based Home Care: 2 Exhibits/ All Demo. Info. Present 466
  - Percent: 62, 13%, 0, 0%, 64, 14%, 84, 18%, 6, 1%, 216, 46%, 250, 54%, 0, 0%
- Integrated Srvc. Models: 11 Exhibits/ 3 MOU's w/out Demo. Info. 2,891
  - Percent: 743, 26%, 54, 2%, 192, 7%, 313, 11%, 73, 3%, 1,375, 48%, 1,216, 42%, 300, 10%
- **TOTALS:** 40 total exhibits 8,298
  - Percent: 1,646, 20%, 110, 1%, 547, 7%, 1,164, 14%, 139, 2%, 3,760, 43%, 4,233, 51%, 461, 6%

**Housing:**
- Emergency Housing: 1 Exhibit/ All Demo. Info. Present 189
  - Percent: 60, 32%, 5, 3%, 4, 2%, 22, 12%, 5, 3%, 96, 51%, 90, 48%, 3, 2%
- Perm. Hsng.(Rdsll Sites/Subs): 8 Exhibits/ All Demo. Info. Present 657
  - Percent: 141, 21%, 20, 3%, 24, 4%, 95, 14%, 28, 4%, 308, 47%, 342, 52%, 7, 1%
- Transitional Housing: 1 Exhibit/ All Demo. Info. Present 34
  - Percent: 34, 100%
- **TOTALS:** 10 total exhibits 887
  - Percent: 235, 27%, 25, 3%, 28, 3%, 117, 13%, 33, 4%, 438, 50%, 432, 49%, 10, 1%

**Food:**
- Food Bank/ Delivered Meals: 2 Exhibits/ All Demo. Info. Present 2,003
  - Percent: 692, 33%, 87, 4%, 53, 3%, 175, 8%, 15, 1%, 1,022, 49%, 1,068, 51%, 3, 0%
- Nutritional Counseling: 1 Exhibit/ All Demo. Info. Present 54
  - Percent: 20, 6%, 0, 0%, 14, 4%, 195, 57%, 10, 3%, 239, 70%, 102, 30%, 0, 0%
- Congregate Meals: 1 Exhibit/ All Demo. Info. Present 156
  - Percent: 51, 33%, 1, 1%, 2, 1%, 12, 8%, 3, 2%, 69, 44%, 67, 56%, 0, 0%
- **TOTALS:** 4 total exhibits 2,591
  - Percent: 763, 29%, 88, 3%, 69, 3%, 343, 15%, 25, 2%, 1,330, 51%, 1,297, 49%, 3, 0%

**Mental Health:**
- Outpatient Mental Health: 13 Exhibits/ All Demo. Info. Present 3,456
  - Percent: 602, 17%, 109, 3%, 103, 3%, 439, 13%, 99, 3%, 1,352, 39%, 1,949, 56%, 155, 4%
- Psychiatric Consultation: 3 Exhibits/ All Demo. Info. Present 783
  - Percent: 143, 18%, 18, 2%, 15, 2%, 146, 19%, 24, 3%, 345, 44%, 357, 46%, 79, 10%
- Crisis Mental Health: 2 Exhibits/ All Demo. Info. Present 3,063
  - Percent: 558, 18%, 24, 1%, 67, 2%, 234, 8%, 15, 0%, 898, 29%, 1,543, 60%, 621, 20%
- Residential Mental Health Srvcgs: 3 Exhibit/ All Demo. Info. Present 117
  - Percent: 60, 51%, 1, 1%, 3, 3%, 12, 10%, 3, 3%, 79, 68%, 67, 32%, 1, 1%
- **TOTALS:** 21 total exhibits 7,417
  - Percent: 1,363, 18%, 152, 2%, 188, 3%, 831, 11%, 141, 2%, 2,675, 36%, 3,886, 52%, 856, 12%

**Substance Abuse:**
- Residential Treatment: 11 Exhibits/ 1 MOU w/out Demo. Info. 2,421
  - Percent: 972, 40%, 68, 3%, 33, 1%, 169, 8%, 2, 0%, 1,274, 53%, 1,121, 46%, 26, 1%
- Methadone Maintenance: 2 Exhibits/ All Demo. Info. Present 322
  - Percent: 146, 45%, 12, 4%, 3, 1%, 100, 3%, 1,242, 12%, 1,119, 32%, 124, 39%, 0, 0%
- Outpatient Counseling: 4 Exhibits/ All Demo. Info. Present 1,480
  - Percent: 529, 36%, 26, 2%, 24, 2%, 126, 9%, 7, 0%, 712, 48%, 604, 41%, 164, 11%
- Detox: 1 Exhibit/ All Demo. Info. Present 687
  - Percent: 259, 38%, 20, 3%, 9, 1%, 60, 9%, 0, 0%, 348, 51%, 338, 49%, 1, 0%
- Assmnt. & Case Coordn.: 2 Exhibits/ All Demo. Info. Present 327
  - Percent: 76, 23%, 9, 3%, 3, 1%, 22, 7%, 12, 4%, 122, 37%, 180, 55%, 25, 8%
- **TOTALS:** 20 total exhibits 5,231
  - Percent: 1,982, 38%, 127, 2%, 76, 1%, 447, 9%, 23, 0%, 2,654, 51%, 2,367, 45%, 216, 4%
## HIV Health Services

**FY 98/99 CARE-funded Contracts**

Demographic Analysis by Service Sub-Categories

### Service Category and Sub-Categories

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<th>Notes on Contract Exhibits</th>
<th>Gender Demographic Information</th>
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2 of 4

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HIV Health Services
FY 98/99 CARE-funded Contracts
Demographic Analysis by Service Sub-Categories
## HIV Health Services
### FY 98/99 CARE-funded Contracts
#### Demographic Analysis by Service Sub-Categories

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<td>Percent</td>
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<td>Client Advocacy: Treatment Advocacy</td>
<td></td>
<td>No FY 98/99 CARE-funded contracts</td>
<td>671</td>
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<tr>
<td>Peer Advocacy</td>
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<td>1845</td>
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<td>Benefits Counseling</td>
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<td>831</td>
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<tr>
<td>Legal/Immigration Assistance</td>
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<td>543</td>
<td>85%</td>
</tr>
<tr>
<td>Money Management</td>
<td></td>
<td>7</td>
<td>39%</td>
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<tr>
<td>TOTALS</td>
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<td>576</td>
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<td>Adoption/ Foster Care:</td>
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<td>17</td>
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</tr>
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<td></td>
<td>1476</td>
<td>79%</td>
</tr>
<tr>
<td>Direct Financial Emergency Asst</td>
<td></td>
<td>1476</td>
<td>79%</td>
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<td>Counties:</td>
<td></td>
<td>Marin County: No Demo. Info. Available</td>
<td>n/a</td>
</tr>
<tr>
<td>Marin County: No Demo. Info. Available</td>
<td></td>
<td>San Mateo County: No Demo. Info. Available</td>
<td>n/a</td>
</tr>
</tbody>
</table>
Mental Health Work Group Meeting Minutes
Wednesday, January 10, 2001
9 – 10:30 a.m.

Present: Michael Lipp, David Macias, Russ Zellers, Jim Dilley, Nan O’Connor

Announcements
Castro-Mission Health Center has an opening for an 8-hour psychiatrist with HIV experience and Spanish language ability. Call Michael Lipp at (415) 487-7535.


Neuropsychiatric Testing at CMHC – After having previously announced a surplus of testing hours, Michael said they have since had an influx of clients and he doesn’t foresee any additional openings until February.

Standardizing Outcome Objectives/Contracting
Russ Zellers stated that the Planning Council is not sure exactly what the funding amounts will be and that contract completion will be delayed this year as reduction protocol, award letters, etc. take time. He anticipates that contracting will commence before the end of February and continue possibly into June. In the interim, funding will be provided via continuing resolutions. Four-month extensions will be requested rather than the usual 3. The prioritization process will begin in July 2001 for FY 2002-2003.

Grants
Jim Dilley reported that Nancy Pelosi was able to procure from Congress 1.2 million dollars for HIV Primary Care at Ward 86. Jim also said he heard that Marin County had 1 million dollars of HOPWA funds that may be unspent. He also said there was 1 million dollars for Treatment On Demand (Substance Abuse) – mostly GF money for the Proposition 36 treatment vs. jail State initiative that voters passed last November to provide substance abuse treatment to first time offenders.

HOPWA
California Endowment Grant - Jim has submitted an application for a grant ($90K) for a research position dedicated to planning for HIV services for the next 5 years. He foresees the MHWG participating, but more in depth than it currently does in terms of working with the Planning Council in defining and forecasting needs, locating funding sources, etc. The position would involve the collection, compilation and analysis of existing data from diverse sources, which has proved to be a daunting task due in part to the lack of standardization of coding systems among bureaucracies and providers. The grant application has survived the first round and is currently under review.
Planning Council Conflict of Interest

Continuum’s E.D. submitted a formal grievance regarding the issue of conflict of interest on the Council surrounding their decisions at the 12/4/00 Implementation & Evaluation Committee meeting to decide what should be designated as core services. At that meeting, a resolution was passed declaring only Primary Care Services as defined by HRSA would be designated as core services. Because Council members are routinely personally employed/involved in local health care agencies and issues, their ability to be objective is being questioned. Whether this means they should not participate in the dialogue at meetings, should recuse themselves, etc. may need to be explored. The implication for the future is that present and prospective council members will need training regarding issues of conflict of interest.

Client Satisfaction Surveys

In reference to Wayne’s memo of 9/11/00, the survey approach should be the same as it is for other types of services. Mental Health should be held to the same standards as other service modalities. While the GAF measures outcomes from the clinician’s point of view and the MHSIP is an assessment of the client’s opinions, which is “more valid” is a difficult call in that clinicians may (unintentionally) exhibit a bias and clients’ perceptive/interpretive abilities could be impacted by their condition. In addition, client satisfaction alone can be problematic. For ex: Nan said that approximately 30% of CSP’s longer - term therapy clients have complained that the 1700 Jackson location is inconvenient. Even though CSP outstations personnel at a number of sites, the complaint persists. She is concerned about the validity of the complaint and also how this outcome could impact on her agency’s funding. It was suggested that the members return to their agencies and poll their staffs on the GAF vs. MHSIP question.

Michael said that clients get annoyed at having to complete multiple surveys as each service has its own. What about combining the surveys? Jim responded that the current effort to develop standardized outcome objectives using information from the survey instruments already required from CMHS is an attempt to do just that.

Contracting

Russ said program managers are going to take last year’s contract narrative and make changes such as adding HRSA requirements, altering dates, reworking the contract into a 2-year agreement, and for contracts requiring changes to their objectives, boilerplates would have to be created and plug-ins identified, which would take longer. Jim was assured that contractors would be made aware of any changes being considered and be given an opportunity to contribute input before final approval. Russ reiterated that we need to try and nail down objectives before contracting gets underway. David asked if incorporating monitoring recommendations (changes) into new contracts will be subject to this same review process. Also, Reggie, HRSA, the DPH and the contractors all want changes. What about those?
Russ wants to set a goal of finalizing objectives by the first week in March. Some members requested that the minutes be sent to them well in advance of the next meeting. We will do our best to send meeting minutes out within two weeks. The next meeting was set for Wednesday, February 7, at 25 Van Ness in room 330B.
SURVEY OF MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICE PROVIDERS

What existing linkages (e.g., out-stationed staff, active referral relations, etc.) do you have with Integrated Service Providers and do these linkages work effectively?

ATSP has active referral relations with all; no current out-stationed staff, however. We believe our linkages work well.

What specific services could you offer to ISP clients? To which populations? How many hours could you potentially make available?

Psychotherapy, hemoglobin testing, psychiatric evaluation, and monitoring could be offered by ATSP at Lyon Martin and at the Community Clinic Consortium. Serve all populations.

If your program were to provide services at an ISP site, what would you need from the ISP (e.g., confidential space, access to client files, regular meetings or other methods for coordinating, reception, secretarial, telephone, etc.)?

Confidential space; access to client files; access to primary provider or means of communicating (case conference, etc.).

Based on the population you serve and other factors, do you have an initial preference for one or more ISP with whom you would like to collaborate?

Lyon Martin
Community Consortium
Would you be interested and willing to participate in this effort?

Yes.

What are your hopes and fears about this effort?

That staff will be underutilized at the ISP while clients requesting services are denied services at the offering agency.

Agency: ATP

Name of Individual Completing Survey: Jim Miller

Position of Individual Completing Survey: ED

Telephone Number: 476-644-2
From: Wayne
To: MHAIDS workgroup
Re: Client Satisfaction and Outcomes

1) All MHAIDS providers will survey their clients annually with the Mental Health Systems Improvement Project (MHSIP) client outcome and satisfaction questionnaire.

2) At least twenty percent of the client surveys per clinic will be returned.

3) Client outcomes and satisfaction will be measured in four domains (scales are 1 to 5, with five being the highest score):
   - Satisfaction: That a random group of clients surveyed will have an average score of no less than 3.1 on the client satisfaction (did the client like the services received) domain of the MHSIP.
   - Access: That a random group of clients surveyed will have an average score of no less than 3.1 on the access to services (how available and convenient are the services) domain of the MHSIP.
   - Appropriateness: That a random group of clients surveyed will have an average score of no less than 3.1 on the appropriateness of care (did the services meet their needs) domain of the MHSIP.
   - Outcomes: That a random group of clients surveyed will have an average score of no less than 3.1 on the client perceived level of functioning (do they think they are doing better) domain of the MHSIP.
Mental Health Workgroup Meeting Minutes
Wednesday, August 09, 2000
9:00 – 10:30 a.m.

Present: Wayne Clark, Jim Dilley, Laura Feren, Estela Garcia, Vicki McGuire, Nancy Mosher, Michael Lipp, Joe Neisen, Ellen Soto, Russ Zellers

Announcements
Wayne announced that a Board of Supervisors meeting is scheduled for later today and a press conference will be held tomorrow on the number of new HIV infections in San Francisco.

Russ said that San Francisco is currently at risk of a significant reduction in Ryan White CARE funding. San Francisco is perceived as receiving more than its fair share of funding.

Standardized Outcome Objectives / Cultural Competency

Jim asked Wayne to talk re: CMHS’s experience with the Basis 32 and the Lehman QOL. He reported that these scales are flawed as a pre and post assessment methodology because there seems to be very little change in the course of a year among mental health patients. (Possible exceptions to this finding are clients with PTSD or depression.) Another pblm with these is that for various reasons, it’s difficult to get both tests for many clients. Clients who are in the office for a 10-minute visit would probably be reluctant to spend an additional 2 hours being tested.

Another approach would be to use CMHS’s Clt Satisfaction Tool, the MHSIP; (Mental Health Satisfaction & Improvement Profile) and/or we could also use the GAF. Wayne suggested that an assessment be done one time per year over a two-week period using the MHSIP which would give us a cross-section of clients. The MHSIP asks their opinions about access, client satisfaction, and their perceptions about how they are doing.

Estela stated that most agencies have their own client satisfaction survey and a review process to analyze the outcomes and recommendations for improvement from clients. Instituto also provides a suggestion box for their clients. She feels that the nuance of culturally specific inquiry such as family-centered questions based on norms, traditions, and practices of the community will be lost if the process is standardized, but would be willing to try and work with a standardized survey and see what happens. She also has some concern that putting emphasis on administering, retrieving, analyzing and reviewing tests will divert resources from direct service delivery. Russ suggested that perhaps we should encourage additional client satisfaction efforts (beyond the standardized CMHS instrument). Agencies could still do suggestion boxes and their own culturally specific client satisfaction survey. Some mechanism to ensure that all clients have an opportunity to register their satisfaction or dissatisfaction must be in place if we decide to use a standard instrument that samples clients. Wayne reiterated his proposal to distribute surveys in a two-week period one time per year. No Basis 32 or QOL would be
administered on a regular basis. A subcmtee of Jim, Wayne, Laura and Russ agreed to meet next week to discuss this further and come up with a draft. They will meet at AHP’s offices, 1930 Market St.

Planning Council Priorities (See attached memo of 6/27/00)

#4 Group vs. Individual therapy
#8 Devise strategy for social support – drop-in centers
#10 Link psychiatric case management services to PES

#4 – Group vs. Individual Therapy

Perceived as a fiscally-driven cost cutting move. Groups are less expensive. What about client need? It was suggested that data be collected at the time of intake that indicates what type of therapy the clients prefer. Currently, it is known that most clients request individual therapy. Jim said that his agency has a waiting list of 50+ clients seeking individual therapy. Russ thought that perhaps a survey needs to be done that looks at client preferences and waitlists. The group agreed to ask providers to submit the numbers of clients requesting or determined to need group intervention, the types of groups offered, and wait list numbers for groups.

Discussion of objective #10 - Linking psychiatric case management services to PES

The Planning Council believes that additional mental health case management would help keep people out of PES/acute situations.

Jim reported that in AHP’s inpt Psychiatric Consult/Liaison service at SFGH, the number of clients is down while the UOS is up due to repeat business (the “revolving door syndrome”). One measurement indicated that out of 635 clients, only 46 were unknown. It’s clear that although these clients have case managers, it’s not working. Jim suggested targeting these high-use patients with intensive case management. The community treatment mode dictates a team approach, a small client-to-staff ratio, and “in-your-face” case management. Perhaps AB2034 funds could be used to intensely manage people on the street who are frequently using services. Jim further noted that in recent months, his agency’s crisis team has responded to more 5150’s than ever before. We need to track this State funding to determine if it will help HIV patients going to PES and in need of intensive case management.

The group set a goal of conducting a snapshot survey on groups and a list of social
support activities that are currently offered to clients. This data should be collected by 9/1/00.

Next Meeting: Wednesday, September 13, 2000, 25 Van Ness, Room 330B.
MEMORANDUM

TO: Mental Health Work Group Members
FROM: David Macias, M.P.A.
DATE: June 27, 2000
SUBJ: PLANNING COUNCIL PRIORITIES, FY 2001-2002

Attached are the priorities for Mental Health that were developed by the HIV Health Services Planning Council as part of their priority setting effort last summer. It would be helpful if you could please review the attached list prior to the next Mental Health Work Group meeting scheduled for Wednesday, August 9, 2000.

Several of the priorities have already been addressed or need further data collection and analysis by our office. In our opinion, there are several priorities that especially need provider input and we would like to spend some time discussing these, and others that you think are important, at our August 9th meeting.

Priority #4 is to direct the AO to explore the implications of prioritizing the funding of group therapy more than individual therapy in relationship to cost-effectiveness and client needs. The AIDS Office, in collaboration with the Mental Health Work Group, has been asked to develop an assessment tool and procedure. We wonder if attaching a question to each agency’s client satisfaction survey might be one way of collecting information about client preference?

Priority #8 is to develop strategies to address clients’ need for social support. While this priority needs to be referred to the PWA Caucus, we wondered if you know of ways to strengthen strategies within mental health programs to address clients’ need for social support?

Priority #10 is to link psychiatric case management services to Psychiatric Emergency Services (PES). Some existing psychiatric case management programs with links to PES are:

- City Wide Case Management
- Family Service Agency – Adult Care Management & Community Aftercare Program
- Center for Special Problems – Mental Health Case Management
- The Crisis Resolution Team – a short-term (90 days) case management program based at SFGH Psychiatric Emergency Services

Is there a need for additional psychiatric case management for people with HIV/AIDS and, if so, how can this need be met with future decreased CARE funding?

Thank you for taking the time to review this material ahead of our meeting in August. Your input is very valuable and will be appreciated.
<table>
<thead>
<tr>
<th>2001-02 OBJECTIVES</th>
<th>GOAL S OR L</th>
<th>PRIORITY 1</th>
<th>IMPLEMENTATION TASKS</th>
<th>HIV HEALTH SVRS Respnse: 2001-02</th>
<th>Contract Lang Chng or $ needed in 2001-02</th>
<th>WHO RESP FOR IMPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase the emphasis on mental health assessments funded through outpatient mental health services for those clients not necessarily ready for on-going treatment, but who require assessments for completion of benefits enrollment. Ask the AIDS Office (AO) to work with contractors to assure that existing contractors provide mental health assessments to existing clients as required by SSI, SSDI, etc.</td>
<td>S</td>
<td>1</td>
<td>ACHIEVED</td>
<td>Was evaluated and found that the back log of need had been taken care of but needs to be reviewed in 2001 to see if need is there.</td>
<td>May need one time funding will have to be eval in 2002-04 prioritization process.</td>
<td>HHS</td>
</tr>
<tr>
<td>3. Direct the AO to assure that each agency assess for client eligibility including insurance and income.</td>
<td>S</td>
<td>1</td>
<td>CONTRACT LANGUAGE AND MONITORING ISSUES. APPLIES TO ALL CATEGORIES NOT JUST MENTAL HEALTH. Training piece added to help contractor's implement</td>
<td>Likely to be achieved. We will develop contract language for all contracts/service categories to require financial eligibility screening. Agencies will vary as to income cut-off and co-pay policies. Monitoring procedures need to be developed. Training piece added to help contractor implement this. Will be evaluated in 2001-02 to see if effective.</td>
<td>Contract language done in 2000-01 contracts.</td>
<td>HHS</td>
</tr>
<tr>
<td>4. Direct the AO to explore the implications of prioritizing the funding of group therapy more than individual therapy, in relationship to cost-effectiveness and client needs. This is not a recommendation to change the existing balance, but rather a request that there be an exploration of the ramifications, positive and negative, if such a shift were made.</td>
<td>S/L</td>
<td>2</td>
<td>ASSESSMENT IN FIRST YEAR PERHAPS BY TASK FORCE OF AO/PLANNING COUNCIL AND PROVIDERS. POSSIBLE CONTRACT LANGUAGE MODIFICATION IN THE 2ND YEAR.</td>
<td>Short-term goal (assessment) is likely to be achieved. Suggest this be referred to Mental Health Work Group (MHWG)</td>
<td>No. BUT ASSESSMENT NEEDS TO BE CREATIVE AND TO TAP INTO OTHER POTENTIAL SOURCES OF INFORMATION REGARDING NEEDS. Refer BACK TO METAL HEALTH TASK FORCE FOR PLAN OF HOW TO CARRY THIS OUT.</td>
<td>HHS AND MHWG TO WORK OUT ASSESSMENT TOOL AND PROCEDURE</td>
</tr>
<tr>
<td>OBJECTIVES</td>
<td>GOAL S OR L</td>
<td>PRIORITY 1</td>
<td>IMPLEMENTATION TASKS</td>
<td>HIV HEALTH SVRS Rspns</td>
<td>Contract Lang Chng or $ needed in 2001-02</td>
<td>WHO RESP FOR IMPL</td>
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</tr>
<tr>
<td>5. Direct the AO to explore the implications of requiring that 20% of the mental health money be included in collaborations with non-mental health agencies.</td>
<td>S/L</td>
<td>1</td>
<td>HOW MUCH MENTAL HEALTH MONEY IS IN INTEGRATED SERVICES? ASSESSMENT OF IMPLICATIONS AND NEED. POSSIBLE FUNDING CHANGES, MOVING MH MONEY TO ISP OR CONTRACT LANGUAGE Modification.</td>
<td>Short-term goal (assessment) is likely to be achieved. Suggest this be referred to Mental Health Work Group. Need to see through monitoring process how much of this was achieved AO to report back.</td>
<td>No BUT ASSESS CURRENT STATUS- MAY be ALREADY Accomplished. BE CREATIVE IN ASSESSING NEED. REFER BACK TO MENTAL HEALTH TASK FORCE TO WORK WITH AO AND OTHERS ON ASSESSMENT AND RECOMMENDATIONS ABOUT HOW THIS MIGHT OCCUR.</td>
<td>HHS AND MHWG TO WORK OUT ASSESSMENT TOOL AND PROCEDURE</td>
</tr>
<tr>
<td>6. Direct the AO to explore the implications of requiring that 10% of the mental health money be included in collaborations with youth-focused (25 y/o or under) agencies.</td>
<td>S/L</td>
<td>1</td>
<td>SAME AS # 5</td>
<td>Short-term goal (assessment) is likely to be achieved. Suggest this be referred to Mental Health Work Group. Need to see through monitoring process how much of this was achieved AO to report back.</td>
<td>Need to evaluate what title 4 monies are currently available for this age group to be tapped into.</td>
<td>HHS AND MHWG TO WORK OUT ASSESSMENT TOOL AND PROCEDURE</td>
</tr>
<tr>
<td>7. Provide clear and easily-utilized procedures to non-mental health providers for referring clients who are in emotional crisis to timely and adequate mental health assessment and access to appropriate care.</td>
<td>S</td>
<td>2</td>
<td>EDUCATION OF NON MENTAL HEALTH PROVIDERS ABOUT MENTAL HEALTH SERVICES</td>
<td>Contractor's to provide in-services on current resources for clients in crisis. Also HIV resource manual will be available</td>
<td>Uncertain</td>
<td>REFER BACK TO MHWG FOR FURTHER WORK ON IMPLEMENTATION DETAILS</td>
</tr>
<tr>
<td>8. Develop strategies to address clients’ need for social support.</td>
<td>L</td>
<td>1</td>
<td>Collect Data about what social support is available now and what the needs for social support are for different ethnic, racial and cultural groups are.</td>
<td>Uncertain</td>
<td>Refer to PWA for input and plan.</td>
<td></td>
</tr>
<tr>
<td>2001-02 OBJECTIVES</td>
<td>GOAL S OR L</td>
<td>PRIORITY 1</td>
<td>IMPLEMENTATION TASKS</td>
<td>HIV HEALTH SVRS Respns: 2001-02</td>
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<tr>
<td>9. RESIDENTIAL CARE: To fund/create a residential facility for PWAs with moderate dementia/cognitive impairment</td>
<td>L</td>
<td>3</td>
<td>Need an assessment by the Mental Health Work Group to assess what the issues are currently for persons with cognitive impairment.</td>
<td>April 14th, 2000 trainings to help residential facilities with clients who are demented. Need to evaluate what current dementia unit's capacity and issues are before making further recommendations about this priority</td>
<td>Uncertain</td>
<td>REFER BACK TO MHWG and HHS FOR FURTHER WORK ON IMPLEMENTATION DETAILS</td>
</tr>
<tr>
<td>10. LONG/SHORT TERM M.H. SERVICES (OUTPATIENT): Link psychiatric case management services to Psychiatric Emergency Services (PES)</td>
<td>L</td>
<td>3</td>
<td>NOT DONE; The following assessment needs to occur prior: need to determine a model for linked service; determine the number of HIV+ clients utilizing PES services and, within psychiatric case management services, how many clients are HIV+?</td>
<td>Need to ask providers what current linkages are and how they can be better strengthened.</td>
<td>Uncertain</td>
<td>HHS and MHWG and I&amp;E on integration of mental health, substance use, and primary care services. (see Health care priorities # 9, 12)</td>
</tr>
</tbody>
</table>
8/21/00

SUMMARY OF SERVICE MODALITIES AND INTAKE PATTERNS

For the Period of January, 2000 – July, 2000

Total Number of New Intakes: 48

Number of Intakes for Individual Mental Health Services: 43 (90%)
Number of Intakes for Group Services: 5 (10%)

Program Closings:

No wait list was kept during this period. However, due to capacity, we closed for intakes for new clients requesting individual services beginning in March, 2000, and reopened in late June, 2000. Intake remained open for group services.

Groups Offered: General HIV+ Process Group
                   HIV+ Art Therapy Group

Number of CARE clients using Group Services: 8

Units of Service: Individual: 996.5 Group: 68

Currently we are over-producing on our individual UOS, and having difficulty meeting our group UOS. Because a number of our clients utilizing group services have MediCal and are no longer CARE clients, we sometimes do not have enough clients in a group in order to count it on the CARE contract.

Client Feedback:

54 Client satisfaction surveys were returned during this period; the survey asks client for their input on any additional services that they would like to see New Leaf offer. Of all the feedback, one client (2%) asked for additional group services.
September 14, 2000

Dear Russ:

I am faxing you a list of all of the groups we have offered since January 2000. We are currently exceeding our group goal. We contracted for 149 from 3/1/00 - 2/28/01 and as of 8/31 we have delivered 109.75 group units of service or 73.7% of our goal. As we are only 1/2 way through our contract we are 23.7% above our goal. We do not have a waitlist for group services. Currently we have 4 people on waitlist for individual treatment. We asked on our client survey what clients experience of loss in group was. Those results are being
# HIV Mental Health Case Management Program

## 2000 Group Schedule

<table>
<thead>
<tr>
<th>Beginning Date</th>
<th>Time</th>
<th>Topic</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 13</td>
<td>5:00-7:00 pm</td>
<td>Mothers Living with HIV. Group therapy offered for infected and affected children held concurrently.</td>
<td>10-week groups on Thursday evenings. Dinner, Transportation and Childcare provided.</td>
</tr>
<tr>
<td>Jan 18</td>
<td>5:00-7:30 pm</td>
<td>Gay Men’s Spirituality.</td>
<td>8-week group held on Thursday evenings.</td>
</tr>
<tr>
<td>Mar 02</td>
<td>10:00-11:30 am</td>
<td>Gay Men’s Mid-Life. Must be between the ages of 40-65.</td>
<td>10-week group held on Thursday mornings.</td>
</tr>
<tr>
<td>Mar 02</td>
<td>5:30-7:30 pm</td>
<td>Gay Men’s Spirituality.</td>
<td>16-week group held on Thursday evenings.</td>
</tr>
<tr>
<td>Mar 07</td>
<td>1:30-3:00 pm</td>
<td>Living skills group for HIV+ Men and Women. Facilitated by Peer Support Staff.</td>
<td>8-week group held every Tuesday. Weekly topics, discussion and presentations.</td>
</tr>
<tr>
<td>Mar 08</td>
<td>2:00-3:30 pm</td>
<td>Therapy for Heterosexual Men with HIV.</td>
<td>10-week group held on Wednesday afternoons.</td>
</tr>
<tr>
<td>Apr 13</td>
<td>5:00-7:00 pm</td>
<td>Mothers Living with HIV. Group therapy offered for infected and affected children held concurrently.</td>
<td>10-week groups on Thursday evenings. Dinner, Transportation and Childcare provided.</td>
</tr>
<tr>
<td>July 17</td>
<td>10:00-11:30 am</td>
<td>Psychotherapy for HIV+ Gay Men.</td>
<td>12-week group held on Monday mornings.</td>
</tr>
<tr>
<td>Sept 07</td>
<td>5:00-7:00 pm</td>
<td>Mothers Living with HIV. Group therapy offered for infected and affected children held concurrently.</td>
<td>10-week group on Thursday evenings. Dinner, Transportation and Childcare provided.</td>
</tr>
<tr>
<td>Sept 27</td>
<td>2:00-3:30 pm</td>
<td>Gay Men’s Mid-Life. Must be between the ages of 40-65.</td>
<td>10-week group held on Wednesday afternoons.</td>
</tr>
<tr>
<td>Sept 28</td>
<td>5:00-7:30 pm</td>
<td>Gay Men’s Spirituality.</td>
<td>8-week group held on Thursday evenings.</td>
</tr>
<tr>
<td>Sept 28</td>
<td>3:00-4:30 pm</td>
<td>Therapy for Heterosexual Men with HIV.</td>
<td>10-week group held on Thursday mornings.</td>
</tr>
<tr>
<td>Oct 11</td>
<td>2:00-3:30 pm</td>
<td>Gay Men’s Mid-Life. Must be between the ages of 40-65.</td>
<td>10-week group held on Wednesday afternoons.</td>
</tr>
<tr>
<td>Nov 01</td>
<td>4:40-6:00 pm</td>
<td>HIV+ Expressive Art.</td>
<td>8-week group held on Wednesday evenings.</td>
</tr>
</tbody>
</table>
MEMORANDUM

TO: Russ Zellers
FROM: Nan O'Connor, LCSW and Eleanor Soto, LCSW
RE: Ryan White clients request for group therapy
DATE: 8/17/00

Eleanor and I have reviewed all intake assessments completed by staff at the Center for Special Problems from May 17th through August 17th of this year. Upon completion of this task, we determined that of the 32 clients opened during this period, only three requested group therapy services. The breakdown is as follows: twenty-nine clients requested individual psychotherapy only, while two clients requested group psychotherapy therapy only. One client requested both group and individual psychotherapy.

We offer group therapy throughout the year. All of our groups are well advertised as we send out mass mailings before each group to other HIV agencies in the city. In addition, we contact by phone colleagues who have provided group referrals to us in the past. Because we offer groups all year long and advertise them extensively, we believe this three month period represents an accurate snapshot of our clients’ demand for group services.

Moreover, it should be noted, that many of the clients who participate in our groups do not initially request this modality but rather become involved in group treatment as a result of their work in individual therapy where they frequently determine, with the help of their therapist, that group work could further enhance their progress. If you have questions regarding this information, please feel to call Eleanor or me at (415)292-1500.
AIDS Health Project

1. Groups by Facilitator and Type (at any given moment in time):

Time-Limited Peer Facilitated Support Group - 2
Ongoing Peer Facilitated Support Group - 20
Time-Limited Staff Facilitated Support Groups - 1
Ongoing Staff Facilitated Support Groups - 4
Staff Facilitated Drop-In Groups - 3

Topic/Status Specific Groups @ AHP:
KS Group (peer facilitated)
Women's Support Group (staff facilitated)
Hep C/HIV Co-infection group (peer facilitated)
Bay+ Group (collab w/Bay+, young people living w/HIV)(peer facilitated)
Early Recovery Groups (staff facilitated)
(at least 6 months clean time)

Considering Work Group (staff facilitated)
Coping at Work Group (staff facilitated)
Return to Work Workshop (staff facilitated)
(drop in group to begin exploring work issues)

Rhythm & Blues Discussion/Social Group (staff facilitated)
(targets Af-American G/Bi men: collab w/ BCA)

Total at any given time of approx. 30 groups - 8-10 clients/grp

2. RE: Waitlists for groups. Varies depending on the request. For time-limited groups, both staff and peer facilitated, it depends on the timing of the referral. A staff facilitated time-limited groups starts about every 3 months and a peer facilitated group starts about every two months. For ongoing peer facilitated groups, we are usually able to place clients within about 4 weeks. This is based primarily on scheduling needs of clients. For staff facilitated ongoing groups, since we have only one, which is currently full, the waitlist will depend on turnover. There are currently a
University of California-San Francisco
Center on Deafness
3333 California Street, Suite 10
San Francisco, CA 94143-1208
415-476-4980 (Voice)
415-476-7600 (TTY)
415-476-7113 (FAX)
UCCD@itsa.ucsf.edu

FAX COVER SHEET

TO: Russell Zellers
DEPT: AIDS Office

FAX #: 431-7547
PHONE #: 554-9105

FROM: Dan Langhoff
DATE: 9/6/00

Number of pages (including this sheet): __________

COMMENTS: This is to inform you that all of our clients receive individual therapy—one in crop or group.

Dan
Draft

MINUTES

Mental Health Workgroup Meeting
Wednesday, September 13, 2000

Present: Estela Garcia, Nan O’Connor, Jim Dilley, Wayne Clark, Michael Lipp, David Macias, Russ Zellers

Minimizing the Impact of Potential Reductions in CARE Funding

Nan suggested that the group take a proactive stance and begin planning and developing strategies to minimize the impact of any future cuts. Since the Planning Council will be making the decisions about cuts, Estela thinks it would be a good idea for the group to track the activities of the Planning Council and its subcommittees and make direct contact with council and committee members in order to raise their awareness about mental health needs in the community and the challenges providers are facing in meeting those needs. Gaining their support is essential so that mental health services do not have to absorb yet another disproportionate share of funding cuts. The MHW membership roster will be given to the Planning Council office to ensure that MHW members receive agendas and minutes. Russ will invite Laura Thomas to our next meeting to provide an update on Planning Council activities, reauthorization of the CARE Act, and other policy updates.

Russ invited those present to attend the Planning Council I & E meeting on 9/19 to weigh in on the mental health priorities that are on the agenda.

It was also suggested that PHP management be kept informed about the MHW activities. Maximizing Medi-Cal is one area where the Department can play an active role.

Strategies for Maximizing Revenue Streams

Estela noted that Instituto is experiencing a higher-than-expected uninsured population. Many clients who qualify for Medi-Cal are eligible for only emergency care.

Estela suggested that having someone at the AIDS Office to work on maximizing Medi-Cal reimbursement. Wayne offered to bring in a spreadsheet showing how well HIV contracts are doing vis-à-vis Medi-Cal and non-Medi-Cal reimbursements.

Planning Council Priorities

MH Priority #9 – Residential Care

Possibly has become less urgent. Currently, there is an RFP out for a 34-bed facility for a long-term permanent residence for people with multiple medical problems. This would be strictly residential care, not a SNF.
St. Mary’s has no residential program available to transition patients to, so clients end up staying in the medical facility longer.

Recommendation: Interdepartmental review, Bridge Committee (for transitioning of hard-to-place clients)

**MH Priority #5**

David is presently doing some research by polling contractors about how much of their integrated services funding is dedicated to mental health. Wayne thinks that maybe we need to reexamine our priorities. Jim said we can provide information about what currently exists, but there is a clinical component to this issue as well as a fiscal one.

Estela feels that we have to maintain flexibility and be responsive without, for instance, locking ourselves into a mandated number of group therapy sessions. For the Council to mandate a specified type of therapy without regard to client need/preference goes beyond their purview and enters the realm of micromanagement.

**Existing Cooperative Arrangements**

Estela: Instituto has a person working 6 hrs. per week at MNHC assisting in crisis intervention. They are considering placing someone off-site an additional 2 hrs.

Nan: 30 hrs. of group at Rita de Cascia for HIV+ mothers, collaborations with UCSF, FSSBA, Mano a Mano and St. Mary’s.

Jim: Lyon-Martin, SFGH Ward 86. Also, there is a heavy demand for his crisis team. They sometimes go beyond the scope of their duties by providing referrals. (See Priority #10- Linkage of psych case management to PES)

**Linkages**

Estela noted the need to better inform the Psychiatric Crisis Unit about HIV service providers and ask them to notify HIV providers when a client is hospitalized. There is a need for training; we need to educate the Council about what is already being provided with regard to Mental Health Case Management.

The standard case management programs don’t seem to be adequate for severe-need clients because they do not provide intensive case management.

Next Meeting: Wednesday, October 11, 9-10:30 AIDS Office, Room 330A
### CURRENT MENTAL HEALTH CONTRACTS – OCTOBER, 2000

<table>
<thead>
<tr>
<th>Fiscal Agent / Service Providers</th>
<th>Exhibit / Service</th>
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<tr>
<td>API Wellness Center</td>
<td>Mental Health Case Management</td>
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<td>Mental Health Services</td>
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<td>Psychotherapeutic Support</td>
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<td>Iris Center</td>
<td>Mental Health Counseling for HIV+ Women</td>
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<td>New Leaf</td>
<td>Outpatient Mental Health Services</td>
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<td>San Francisco General Hospital</td>
<td>AHP Ward 86 / Mental Health Services</td>
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<td>Psychotherapy Services</td>
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<td>Mental Health &amp; Support Services</td>
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<td>Mental Health Crisis Services</td>
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<td>Therapy Psych Assessment &amp; Crisis Intervention / A Woman’s Place</td>
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<tr>
<td>Saint Mary’s Medical Center</td>
<td>AIDS Dementia Unit</td>
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DSM IV Diagnosis - Axes I, II (must be within past 12 months)
Indicate qualified source and date if other than writer.

| GOALS: Specific, Observable or Quantifiable. Include target symptom/behavior as relates to area of impairment: Living Arrangement/Daily Activities/Social Relationships/Health |
| INTERVENTIONS: Include Modality |
| TIME FRAME: Will be 12 months unless specified |

Individual's diagnosis, symptoms, and/or psychiatric history supports medical service necessity. Yes ☐ No ☐

Clinician/Staff Signature Date

Client/Parent/Guardian/Conservator Signature(s) Date

Signifies that s/he understands &/or has participated in the development of the plan of care and has been informed of freedom of choice and grievance procedure. If no signature, document items in progress note dated ________.
Goals Continuation:

Name: _______________________

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### BIS Service Slip for Recording and Entering Unit of Service Data with Corresponding CIS Service Categories

**Client Name**

**Client BIS ID#**

**Client CIS ID#**

**Reporting Unit**: 38A33

**Service Date**: mm/dd/yy

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| CM Brokerage (391) | Referral Cnslt-cmhs00 |        |      |     |        |            |      |     |        |

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### STAFF NUMBERS:

- 1769...M. Wallis
- 2412...J. Dilley
- 2413...E. Leavitt
- 2414...D. Ali
- 2415...E. Bulger
- 2416...J. Daly
- 2417...D. Karasic
- 2418...L. Hewitt
- 2420...R. Harris
- 2502...S. Grossi
- 2808...S. Laird
- 2566...S. Ouellette
- 2599...P. Parmar
- 6072...J. Baker
- 10497...L. Thoemmes
- 10569...G. Harrison
- 10571...M. Pacheco
- 10780...M. Salmon
- 2725...J. Barker
- 1042...S. Lynch

### FOR PA USE ONLY:

- BIS to CIS Time Conversion: In CIS, enter minutes as if they were decimals. (e.g., enter 1 hr, 37 min. as 1.37)

### Location of Services (check one):
- 1-Office
- 2-Field
- 3-Phone
- 4-Home
- 5-Satellite School
- 6-Satellite Clinic

- Entered in BIS______ (data entry staff initials)
- Entered in CIS______ (data entry staff initials)
- Entered in Tracking Record (data entry staff initials)
### Comparison of Outcome Objectives and Evaluations

<table>
<thead>
<tr>
<th>Agency/ Program</th>
<th>Unit of Service Description</th>
<th>Impact/ Outcome Objective</th>
<th>Impact/ Outcome Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>To reduce client symptoms of mental disorder by ten points on the Global Assessment of Functioning Scale (primary relationships, jobs/school performance, friendships/peer relationships, financial situation, hobbies/interests/play activities, physical health and activities of daily living.)</td>
<td>Assessment of client's baseline categories of life functioning (e.g. primary relationships, activities of daily living, leisure activities, etc.) will be obtained at initial intake using the Global Assessment of Functioning Scale (DSM-IV) (100 to 0). Following twelve months of outpatient treatment, a determination will be made reflecting progress in treatment as evidenced by improvement on the GAF by at least 10 points. The rating would be determined through staff clinical observation as well as client self-report. Progress in treatment will be reviewed and documented in the chart annually.</td>
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<td>#2</td>
<td>By February 29, 2000, 70% of clients presenting with psychiatric concerns will achieve an improved outcome, such as a stabilization or decrease in psychiatric symptoms. This improvement will be measured by a random sample chart review of a least 30 charts conducted by the Deputy Director. Comparison will be made between symptom identification and diagnosis and subsequent follow-up visit notes.</td>
<td>A random sample of at least 30 patient charts will be conducted. Of the charts reviewed, 70% will indicate an improved outcome by achievement of treatment goals such as stabilization or decrease in psychiatric symptoms. The results will be documented at the end of the contract term or as requested. Documentation recording the review will be in Services Center office.</td>
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<td>#3</td>
<td>By February 29, 2000, 80% of referring providers will rate their ability to make appropriate referrals of their HIV infected substance abusing clients as satisfactory or better (greater than or equal to three on a five point scale) measured by a provider satisfaction survey. A minimum of 12 provider satisfaction surveys will be analyzed by the Deputy Director.</td>
<td>The Deputy Director (DD), in consultation with the Team and the Manager of Research and Evaluation, has developed a Provider Satisfaction Survey. The Program Assst., as tracked by the DD, will mail Provider Satisfaction Surveys to Providers. By February, 29, 2000, the responses to the survey will be collected and summarized. This information will be reviewed and analyzed by the Medical Director and the DD. A report summarizing the results will be prepared by the DD and submitted to the AIDS Office. Services will be modified, as appropriate, subsequent to this analysis. Startegies for quality improvement will be developed by the DD and submitted for review to the Quality Improvement Office. Any necessary changes will be implemented by the DD. Surveys will be kept on file in Services Center office.</td>
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<td>#4</td>
<td>By February 29, 2000, 80% of contact agencies or providers will rate their ability to manage their clients as a result of the efforts of the PCS as satisfactory or better (greater than or equal to 3 on a 5-point scale) measured by a provider satisfaction survey.</td>
<td>The Medical Director, in consultation with the PCS Team, and the AHP Manager of Research and Evaluation, has developed a Provider Satisfaction Survey. The Program Assistant, as tracked by the Medical Director, will mail Provider Satisfaction Surveys to providers. By February 29, 2000, the responses to the Survey will be collected and summarized. This information will be reviewed and analyzed by the Director of Care Services and the Deputy Director. A report summarizing the results will be prepared by the Program Coordinator and submitted to the AIDS Office.</td>
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<td>#5</td>
<td>By the end of the contract period, no more than 20% of clients receiving psychiatric client consultation services will require psychiatric hospitalization during the contract period.</td>
<td>The Medical Director, in consultation with the Medical Director of PES, will compare a representative number of clients served to determine the percentage of PCS clients with previous psychiatric hospitalizations who required subsequent psychiatric hospitalization. A report summarizing the results will be prepared by the Program Coordinator and submitted to the AIDS Office.</td>
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<tr>
<td>#6</td>
<td>Clients receiving psychiatric consultation services will be asked to complete the Client Satisfaction Survey. Of the clients responding, 75% will rate services satisfactory as measured by response of 3 or better on a 4-point scale in the Client Satisfaction Survey.</td>
<td>The Medical Director, in consultation with the PCS Team, has developed a Client Satisfaction Survey. Client Satisfaction Surveys will be given to clients who have received psychiatric medication evaluation services. By February 29, 2000, the responses to the Survey will be collected and summarized. This information will be reviewed and analyzed by the Director of Care Services and the Deputy Director. A report summarizing the results will be prepared by the Program Coordinator and submitted to the AIDS Office.</td>
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<tr>
<td>#7</td>
<td>All clients receiving therapy services will be asked to complete the Client Satisfaction Survey. It is anticipated that a total of 25% of therapy clients will respond to the survey. Of the clients responding, 75% will report an improved sense of emotional function as measured by responses of 3 or better on a 4 point scale in the Client Satisfaction Survey.</td>
<td>The Medical Director will work with the Program Assistant to compare a random sample of 100 clients and note the date and time of the request for services from the service request log. These times will be compared to the data and times of the completed consultation.</td>
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<td>#8</td>
<td>Upon initiation by the San Francisco Department of Public Health HIV Health Services Section, contractor agrees to participate in a workshop to develop standardized objectives and evaluation measures.</td>
<td>By the end of the second quarter, August 31, 1999, all Volunteer Therapist Program clients will be sent the Client's Self Report of Satisfaction to be completed and returned. The internship clients will complete this self-report at the end of their course of therapy. This information will be tallied by the Program Assistant on an annual basis and will be reviewed and analyzed by the Director of Psychosocial Services. Every effort will be made to encourage the maximum return of this questionnaire by the respondents. An initial report summarizing the results will be prepared by the Clinical Coordinator of Psychosocial Services and submitted to the AIDS Office with the annual monitoring protocol response and the annual program report.</td>
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<tr>
<td>#9</td>
<td>All clients receiving therapy services will be asked to complete the Client Satisfaction Survey. Of the clients responding, 75% will report an improved ability to deal more effectively with problems as measured by response of 3 on a 4-point scale in the Client Satisfaction Survey.</td>
<td>By February 29, 2000, the data from the Clinician's Rating Scale of Global Improvement for clients receiving therapy services, will be summarized. This Information will be reviewed and analyzed by the Clinical Coordinator of Psychosocial Services. A report summarizing the results will be prepared by the program coordinator and the Deputy Director.</td>
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</table>

*Page 1 of 6*
## Comparison of Outcome Objectives and Evaluations

<table>
<thead>
<tr>
<th>Agency/ Program</th>
<th>Unit of Service Description</th>
<th>Impact/ Outcome Objective</th>
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<tbody>
<tr>
<td>1-Ind/Family/Couples Therapy or Consultation Hour. 2-Mental Health Therapy Group Hour. 3-Hour of Psych. Consult, Evaluation and Med. Montrg.</td>
<td>By February 29, 2000, all clients receiving therapy services will be asked to complete the Beck Depression Inventory (BDI). Of the clients responding, 85% will report an improved ability to deal more effectively with problems.</td>
<td>By February 29, 2000, the data from the Beck Depression Inventory (BDI), for clients receiving individual psychotherapy services, will be summarized. This information will be reviewed and analyzed by the Clinical Coordinator of Psychosocial Services and the Deputy Director. A report, summarizing the results, will be prepared by the program coordinator and submitted to the AIDS Office.</td>
</tr>
<tr>
<td>1-Ind/Family/Couples Therapy or Consultation Hour. 2-Mental Health Therapy Group Hour. 3-Hour of Psych. Consult, Evaluation and Med. Montrg.</td>
<td>By February 29, 2000, 60% of the group members enrolled in closed groups, who have attended 10 sessions or more, will be asked to complete a Client Satisfaction Survey. Of those responding, 75% will report an improved ability to deal more effectively with psychosocial issues in their lives as measured by responses of 3 or better on a 4 point Likert scale in the Client Satisfaction Survey.</td>
<td>By February 29, 2000, the responses to the Client Satisfaction Survey, for clients receiving closed group services, will be collected and summarized. This information will be reviewed and analyzed by the Clinical Coordinator of Psychosocial Services and the Deputy Director. A report, summarizing the results, will be prepared by the program coordinator and submitted to the AIDS Office.</td>
</tr>
<tr>
<td>1-Ind/Family/Couples Therapy or Consultation Hour. 2-Mental Health Therapy Group Hour. 3-Hour of Psych. Consult, Evaluation and Med. Montrg.</td>
<td>By February 29, 2000, all providers who have referred a client for neuropsychological testing will be asked to complete a Provider Satisfaction Survey. Of those responding, 75% will report an improved understanding of the client's functioning and their ability to provide care for the client as measured by responses of 3 or better on a 5 point Likert scale in the Provider Satisfaction Survey.</td>
<td>By February 29, 2000, the responses to the Providers Satisfaction Survey, for providers referring clients to neuropsychological testing services, will be collected and summarized. This information will be reviewed and analyzed by the Clinical Coordinator of Psychosocial Services and the Deputy Director. A report, summarizing the results, will be prepared by the program coordinator and submitted to the AIDS Office.</td>
</tr>
<tr>
<td>One Hour of F-I/F (or Non-F-I-F) Psychologist intervention. (intake, assessment, client, consultation, treatment planning, indiv (no therapy), adminstr and scoring of psych tests.</td>
<td>At least 75% of clients who have completed a client satisfaction survey will report a score of 4 or higher on a 5-point scale by the end of the contract period.</td>
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</tr>
<tr>
<td>One Hour of F-I/F (or Non-F-I-F) Psychologist intervention. (intake, assessment, client, consultation, treatment planning, indiv (no therapy), adminstr and scoring of psych tests.</td>
<td>At least 70% of the clients who receive a mental health reassessment will self-report an improvement in mental health status by the end of the contract period.</td>
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<tr>
<td>One Hour F-I/F (or Non-F-I-F) with Psychiatrist b/w client, medical provider or nursing care team.</td>
<td>By February 29, 2000, 75% of clients presenting with psychiatric concerns will report an improved outcome by client self report.</td>
<td>By February 29, 2000, 75% of clients presenting with psychiatric concerns will report an improved outcome by client self report.</td>
</tr>
<tr>
<td>One Hour F-I/F (or Non-F-I-F) with Psychiatrist b/w client, medical provider or nursing care team.</td>
<td>By February 29, 2000, 75% of providers responding to an annual Provider Satisfaction Survey will report an overall satisfaction rating of &quot;Satisfactory&quot; or better.</td>
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</tr>
<tr>
<td>One Hour F-I/F (or Non-F-I-F) with Psychiatrist b/w client, medical provider or nursing care team.</td>
<td>By February 29, 2000, 100% of a random sample chart review will contain a complete psychiatric assessment, including a mental status exam and a treatment plan.</td>
<td>By February 29, 2000, 100% of a random sample chart review will contain a complete psychiatric assessment, including a mental status exam and a treatment plan. This improvement will be measured by a random sample chart review of at least 30 charts utilizing guidelines developed by the Department of Psychiatry. These will be submitted for review to the Quality Improvement Office. Any necessary changes will be implemented by the Deputy Director.</td>
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<tr>
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<tr>
<td>#5</td>
<td>1-One Hour of NeuroPsych testing 2-One Hour Psych Encounter (evalin, med monitng, consnltn).</td>
<td>At least 70% of HIV patients will demonstrate improved psychological and social functioning at discharge, as measured by an increase of at least 10 points on the GAF (Global Assessment of Functioning) Scale.</td>
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<td>#8</td>
<td>1-One Hour of NeuroPsych testing 2-One Hour Psych Encounter (evalin, med monitng, consnltn).</td>
<td>At least 70% of clients referred out for specialized mental health, substance abuse services, and social services based on clinical evaluations, will follow through with referrals received by the end of the MOU period.</td>
</tr>
<tr>
<td>#8</td>
<td>1-One Hour of NeuroPsych testing 2-One Hour Psych Encounter (evalin, med monitng, consnltn).</td>
<td>At least 75% of clients that have been seen for at least 3 months, and have completed the Client Satisfaction Survey will rate services provided by the MDP staff as &quot;Always&quot; or &quot;Often&quot; satisfactory.</td>
</tr>
<tr>
<td>#8</td>
<td>1-Physician/Psychiatrist Hour (consult, psych med evalin, tfmmt, mtrng) 2-Non-Physician Hour (psych asmnt, plan devlpnmt, indiv/family/couple therapy, crss intvntn, consnltn) 3-Mental Health Group Psychotherapy Hour.</td>
<td>To reduce clients' level of difficulty .20 average score concerning depression/anxiety including depressed and/or anxious mood, suicidality and coping with stressful life events.</td>
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<td>#8</td>
<td>1-Physician/Psychiatrist Hour (consult, psych med evalin, tfmmt, mtrng) 2-Non-Physician Hour (psych asmnt, plan devlpnmt, indiv/family/couple therapy, crss intvntn, consnltn) 3-Mental Health Group Psychotherapy Hour.</td>
<td>This is assessed initially through the BASIS 32 and biannually thereafter. Treatment objectives are monitored regularly through clinical supervision, and biannually and at discharge, when possible, through the Annual Plan of Care.</td>
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<td>#8</td>
<td>1-Physician/Psychiatrist Hour (consult, psych med evalin, tfmmt, mtrng) 2-Non-Physician Hour (psych asmnt, plan devlpnmt, indiv/family/couple therapy, crss intvntn, consnltn) 3-Mental Health Group Psychotherapy Hour.</td>
<td>To reduce clients' level of difficulty .10 average score concerning overall BASIS-32 average which includes relation to selfothers, daily living skills, impulsive/ additive, and psychosis. This is assessed initially through the BASIS-32 and biannually thereafter. Treatment objectives are monitored regularly through clinical supervision, and biannually and at discharge, when possible, through the Annual Plan of Care.</td>
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<td>To achieve an average score of 4.0 (on a 5 point likert scale) by enrolled clients responding to a locally developed client satisfaction questionnaire that is administered in August.</td>
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<td>One Hour of Psych. Consult. To clients</td>
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<td>One Hour of Individual, Couple or Family Therapy</td>
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<tr>
<td>#12 1-Non-Physician Mental Health F-4</td>
<td>Hour. 2-Mental Health Group Hour. 3- Psych. Consult Hour</td>
<td>By the end of the contract period, 70% of clients who receive at least three months of treatment will indicate a decrease in psychiatric symptoms as measured by the agency four point symptom scale, to be administered pre- and post-treatment by the client's intake worker and the primary therapist. A decrease in symptoms will be defined as an average of one point decline in the severity of symptoms.</td>
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<tr>
<td>#12 1-Non-Physician Mental Health F-4</td>
<td>Hour. 2-Mental Health Group Hour. 3- Psych. Consult Hour</td>
<td>By the end of the contract period, 70% of clients who receive at least three months of treatment will indicate an improvement in coping with the impact of HIV as measured by the agency four point symptom scale to be administered pre- and post-treatment by the client's intake worker and the primary therapist. An improvement in coping will be defined as an average of one point increase on the scale.</td>
</tr>
<tr>
<td>#12 1-Non-Physician Mental Health F-4</td>
<td>Hour. 2-Mental Health Group Hour. 3- Psych. Consult Hour</td>
<td>By the end of the contract period, 50% of those clients for whom treatment goals have been established around chemical dependency will indicate a decrease in their substance use as measured by the agency four point symptom scale to be administered pre- and post- treatment by the client's intake worker and the primary therapist. A decrease in substance use will be defined as an average of one point decline in the severity of the problem.</td>
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<tr>
<td>#13 One Hour of Individual Group Counseling</td>
<td>At the end of the contract period, 45% of those clients who completed therapy will experience improved mental health as demonstrated by improved functioning in one of the life domain areas addressed in treatment.</td>
<td>The number of clients completing therapy is tracked throughout the contract year. For these clients, a comparison will be made between their level of functioning at intake and their level of functioning at discharge. It is expected that an improvement will be found in at least 45% of cases. This comparison is possible because of documentation on intake and discharge summaries. Staff records on these forms the functioning in life domain areas (These domains are: Friends, Parenting Skills, Employment, Finances, Housing, Community Participation, Health Care, and Health Habits) An improvement in one or more of these domains is taken as evidence of improved mental health. This information is collected in order to determine the efficacy of short-term and long-term therapy in improving the mental health of women with HIV.</td>
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<tr>
<td>#14 1-Psych. Consult. (MD) Hour. 2- Mental Health Service (non MD)</td>
<td>To prevent the psychiatric hospitalization of 90% of clients measured by comparing Clinical Review Form data to the Intake Referral Form. Outcomes after 16 weeks in treatment with clinical information on the Intake Referral Form. Page 5 of 6</td>
<td>The Clinical Review Form will be completed by the Provider and submitted to the MCRC after clients have been in treatment for sixteen weeks and for clients in ongoing treatment every six months thereafter. The information from the Clinical Review Form will provide treatment outcome data when it is compared with baseline clinical information from the Intake Referral Form. The comparison will provide data to measure:</td>
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<tr>
<td>#14</td>
<td>1-Psych. Consult. (MD) Hour. 2-Mental Health Service (non MD) Hour. 3-Heuropsych. Asmnt. Hour</td>
<td>To insure medication compliance in 90% of clients receiving psychotropic medication measured by comparing Clinical Review Form data submitted after 16 weeks in treatment with clinical information on the Intake Referral Form.</td>
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<tr>
<td>#14</td>
<td>1-Psych. Consult. (MD) Hour. 2-Mental Health Service (non MD) Hour. 3-Heuropsych. Asmnt. Hour</td>
<td>To reflect a reduction in psychiatric symptoms in 90% of patients measured by comparing Clinical Review Form data submitted after 16 weeks in treatment with clinical information on the Intake Referral Form.</td>
</tr>
<tr>
<td>#14</td>
<td>1-Psych. Consult. (MD) Hour. 2-Mental Health Service (non MD) Hour. 3-Heuropsych. Asmnt. Hour</td>
<td>To obtain an overall 85% or higher client satisfaction rating measured by 15 or better positive responses to 19 questions on the returned Client Satisfaction Surveys.</td>
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<tr>
<td>#14</td>
<td>1-Psych. Consult. (MD) Hour. 2-Mental Health Service (non MD) Hour. 3-Heuropsych. Asmnt. Hour</td>
<td>One hour of individual or group mental health therapy</td>
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<td>#15</td>
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<td>#15</td>
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5/10/00 8:54 AM
COMMUNITY MENTAL HEALTH WORKGROUP
MINUTES
Wednesday, 8/11/99, 9:00-10:30AM

Legend: ☑- Present ☐ - Absent

Agenda:

I. Announcements:

A. SAMHSA Grant: Congrats to Wayne for getting this in—-we should hear about this in the next several months.

II. CARE Prioritization: Follow-up

Russ announced that the council may take out their insistence on integration of all services at a single site. We discussed briefly our relationship to the council.

We also discussed the specific percentages of money being allocated to “non-mental health primary” sites, and “youth-serving agencies”. Agreed that as the recommendation is to study these proposals, we could live with them at present. Future of this meeting—-tabled for discussion next month.

III. Presentation: Barbara Garcia, SFDPH Director, Population Health and Prevention

Barbara gave a brief overview of her work history and how she came to her current position. Of note was that she was an ED of a nonprofit organization for many years prior to going to work for the Feds (at HRSA) and eventually for the city. She has “seen it all”—-and has had to manage from both sides of the public-private continuum. She described some of the plans currently in the works to reduce the amount of duplication in the contracting processes of the Health Dept. She is creating a “Joint Council”—a council made up of members from various councils (Ryan White, Prevention, Treatment on Demand and perhaps others) to begin to provide better coordinated planning. (A member of the CMHS Workgroup should be invited to participate). Eventually, she is hoping to develop a system wherein individual contractors with multiple contracts from various parts of DPH will not have to answer to “multiple masters”, but rather the contract managers from DPH will work together to manage the contractor. The goal is to reduce duplicate paperwork: so the contractor would have one set of grievance procedures, one annual report, etc.

In consideration of future anticipated cuts in RW funding, a recommendation was to write up for the Joint Council a summary of the Workgroup’s experience/process of maximizing Medical billing.

Future Discussion: Future of the workgroup

Next meeting scheduled for Sept. 8, 1999 at 9:00AM at AO in the training room.

Minutes taken by Jim Dilley.
COMMUNITY MENTAL HEALTH WORKGROUP MINUTES
Wednesday, 8/11/99, 9:00-10:30AM

Legend: ☑- Present ☒- Absent

| ☑ Mike L. | ☐ Estella G. | ☐ Russ Z. | ☐ Wayne C. | ☐ Vickie M. |
| HC #1     | I.F.D.R.     | AO        | DPH        | IRIS       |
| ☒ Joe N.  | ☑ Jim D.     | ☐ Melissa B. |           |            |
| NL        | AHP          | CSP       |            | FSA        |

Agenda:
I. Announcements
II. CARE Prioritization: Follow-up
III. Barbara Garcia, SAMHSA Coordinator

I. Announcements:
1. Implementation of next year - CMHS Workgroup.

II. CARE Prioritization: Follow-up
1. Took out: funding streams.
2. Took out: integration at a single site.
3. SAMHSA grant
4. Future of this meeting.

Recommendations:
1. Write a summary of our experience of developing Medi-Cal.

III. Barbara Garcia, SAMHSA Coordinator, Director of Health, Prevention for 11 years, was a Community Health Care Worker.

1. Manage an organization vs. program management.
2. Quality assurance.
   - want to develop out. Aby's for the Dept.
3. Continuity.

Fiscal Strategies for Future:
1. How do we manage organizations with language problems?
2. Health Dept. is to develop a Strategies Planning Process - where we're going as a Dept. No reorganization in the near future; but c? re: how to ask for money from city.
3. Dept. Heads and CHN will be meeting to develop.
4. Council Joint Committee - has been meeting: Change to develop a unified approval to planning for potential cuts - in 2 years. Treatment on Demand.
5. Shall attempt to do the following: (1) SAS Residential Programs - do they know re: HIV; how to manage methadone and meds, etc. CMHS programs - need.

Future Discussion: Future of the workgroup

Next meeting scheduled for Sept. 8, 1999 at 9:00AM at AO in the training room.

Minutes taken by Jim Dilley.
COMMUNITY MENTAL HEALTH WORKGROUP
MINUTES
July 7, 1999

Present: Jim Dilley, AHP; Melissa Bloom, Cr for Special Problems; Mike Lipp; HC #1; MH Center; Russ Zellers, AO; “stand-in” for Marianne O’Connor, Iris Center.

Absent: Laura Feren, Family Svcs Agency; Joe Neissen, New Leaf; Wayne Clark, DPH
Estella Garcia, Instituto Familiar de la Raza,

Announcements:
1. CARE Prioritization meeting for mental health has been moved to July 12, from 3 to 5 PM.

I. CARE Prioritazation Data
   1. Mental Health Services Utilization - Outpatient services - 100% of funding was spent in 98-99. UOS = 104%, UDC = 129%. Psych Consult was at 196% of UDC; Crisis was at 113% UOS, 110% UDC, Residential 91% UDC. These numbers are not complete: see Russ if you want the full text.
   2. CARE Needs Assessment - initial presentation will be given later today, full presentation is scheduled for 7/12. Mental health was discussed briefly as part of the qualitative analysis - focus groups stated that MH services are an essential element of CARE services and that depression is the most common complaint. Russ noted that the integration of MH and SA services within ISPs has been coming up in other prioritazation meetings and expressed concern that existing mental health providers were not voluntarily working to achieve the goal of integration. Jim D noted that AHP is about to begin providing services at Lyon-Martin Clinic and Community Consortium. Russ suggested that in the long view that ISPs are going to stay on CARE funding, while other free standing services will likely be the first to be phased out under any mandated budget cut.
   3. Baseline Budget. Russ distributed a baseline budget for MH services: Outpatient Services: $1,865,747 (includes $156,000 of General Fund); Psych Consult: $351,887; Crisis: $436,404; and Residential $847,782.

II. Medi-Cal Update
   Contractors have moved ahead with securing CMHS Medi-Cal contracts for the FY99-00. One problem is the duplication of different, but similiar administrative requirements between the AIDS Office and CMHS (e.g. consent forms, grievance procedures, posting of same, etc.) Jim will invite Barbara Garcia to attend the next meeting to discuss this issue.

III. AIDS “Disinformation” Issue
   Mike L. noted that several patients have presented at HC#1 wishing to discontinue their antiretroviral meds, because of the community discussion, promoted by Act Up SF, that “HIV does not cause AIDS”. Discussion ensued re: the need for providers and Health Department to respond.

IV. Next Meeting
   Scheduled for Aug. 11 @ 9:00AM at AO in the Training Room.

Minutes taken by Jim Dilley.
Implementation? next yr - CMHS Wkgrp / ADD AS Present

- Vicki McGuire, HIV Coordinator@ IDP's

- Care Prioritisation -
  - took out: funding stream
  - ? integration at a single site
  - SAnSA grant

- Future of this ref?

* iii

Director of Health Prevention for 11yrs was a Community Health Ch.

- Message an organization - vs. program mgmt.
  - Quality Ass x
  - Continuity

Fiscal Strategic for Future -

- How do we manage org's & clinical objecns?
- Health Dept is to develop a Strategic Planning Process when are going as a Dept. No recognition in
  The new fact, but challenge is: how to ask for $ from city.

- Dept Hts & CHN will be rely to develop
- Council HT Centre - has been outg: charge is to develop a
  unified approach to planning for potential cuts - n 2 yrs.

Tx on Demond

- Shall attempt to do the following:
  1) Prenatal papers - do they help w/ HIV
  2) How to use methadone / meth, etc.
  3) CMHS papers - need
April 18, 2000

Dear Colleague:

We have been asked by the AIDS Office to send a letter to Ryan White AIDS Service Providers to ensure that providers are aware of how to access the HIV Mental Health Crisis Team here at the UCSF AIDS Health Project (AHP). AHP has been the HIV crisis service provider since December 1995.

The Crisis Team provides on-site and mobile services to HIV infected clients in need of mental health crisis intervention. Services are available in Spanish and English and include: (1) assessment, psychiatric evaluation, care, and referral; and (2) short-term crisis management, brief psychotherapy, and medication evaluation and monitoring. In the execution of these services, the Crisis Team also facilitates the transfer of acute crisis clients requiring involuntary hospitalization to the hospital.

We welcome referrals and questions from providers, clients, and clients’ friends and family. We can be contacted Monday through Friday between 8:30 a.m. and 6:00 p.m. by calling 476-3902 and asking for the Crisis Team. A voice mail message gives alternative crisis numbers after hours.

Please feel free to call Mary Pacheco, PhD, at 476-6181, or Emily Leavitt, LCSW, Clinical Coordinator of the Crisis Team, directly at 476-5499 with any questions or concerns about the HIV Mental Health Crisis Team or any of AHP’s other mental health services.

Sincerely,

James W. Dilley, MD
Executive Director
HIV HEALTH SERVICES PLANNING COUNCIL

IMPLEMENTATION AND EVALUATION COMMITTEE

PRIORITIZATION AND SPRING UNFUNDS (ROLLOVER REQUEST) SCHEDULE

February - June, 2000

February 21
Prioritization¹ and Unfunds Working Group² Schedule
Minority AIDS Initiative Prioritization

March 06
Housing Prioritization

March 20
Mental Health Prioritization

April 03
Health Care Prioritization
Establish Cost Caps Working Group

April 17
Substance Abuse Prioritization

May 01
Other Support Services Prioritization

May 15
I & E Committee vote on 2001/2002 Prioritization
Unfunds Task Force Update

May 22
Council Vote on Prioritization 2000/2002

June 05
Unfunds Working Group Recommendations
Preliminary Discussion of Six Month Plan

June 19
Match Unfunds Recommendations with final dollar amounts
Committee Vote on Spring Unfunds (Rollover Request)
Finalize I and E Six Month Plan for July-December, 2000
Establish Working Groups for July-December, 2000

June 26
Council votes on Spring Unfunds (Rollover Request)
Promulgate the I & E Six-Month (July-December) Plan to Council

¹This process is to prioritize the remaining items left from the 2000/2001
prioritization for the 2001/2002 contract year less the 30 items prioritized in the
fall of 1999.

²The Unfunds Working Group will concentrate on developing recommendations
for the HRSA rollover request. The final dollar amount will less the amount(s)
pulled forward and approved by the Council on 2/7/00 to offset the reduction in
the 2000/2001 award.
<table>
<thead>
<tr>
<th>Month</th>
<th>Senate Activity</th>
<th>House Activity</th>
<th>Important Related Activity</th>
<th>Grassroots Advocacy</th>
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</thead>
<tbody>
<tr>
<td>February</td>
<td>Senate Recess February 11-21, 2000</td>
<td></td>
<td>Presidential Primaries Begin Release of Administration's FY 2001 Budget, February 7, 2000</td>
<td>Mobilize and Educate Title I Planning Councils about CARE Act Reauthorization</td>
</tr>
<tr>
<td></td>
<td>Draft of Senate Reauthorizing Bill Released</td>
<td></td>
<td></td>
<td>Cities Advocating Emergency AIDS Relief (CAEAR) Coalition Meeting and Advocacy Days, Washington, DC February 27-March 1, 2000</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Senate Co-Sponsor Drive Continues</td>
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<tr>
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<td></td>
<td>AIDSWatch Lobby Days, Washington, DC March 25-29, 2000</td>
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<tr>
<td>April</td>
<td>Floor Statements and Morning Business Speeches on CARE Act Floor Vote on Bill</td>
<td>Floor Statements/One Minute Speeches on CARE Act</td>
<td>On-Site Congressional Visits to Local AIDS Service Organizations</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>House Bill Introduced</td>
<td></td>
<td>House Co-Sponsor Drive</td>
</tr>
<tr>
<td>May</td>
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<tr>
<td>June</td>
<td>House Commerce Committee Hearing and Mark-Up of CARE Act Reauthorization Bill</td>
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<tr>
<td>July</td>
<td></td>
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<tr>
<td>August</td>
<td></td>
<td></td>
<td>Republican Convention July 31-August 3, 2000</td>
<td>Push for House-Senate Conference on Reauthorized CARE Act and Vote for Final Passage</td>
</tr>
<tr>
<td></td>
<td>Stories from clients =&gt; SFAF Cards + Calls to fence sitters</td>
<td></td>
<td>Democratic Convention August 14-17, 2000</td>
<td></td>
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<tr>
<td>September</td>
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### 2000-01

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<td></td>
</tr>
<tr>
<td>Vol 50 Sats</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>T.Sugs 15</td>
<td>98</td>
<td>F/Sats</td>
</tr>
<tr>
<td>Silo 30</td>
<td>15</td>
<td>Trees</td>
</tr>
<tr>
<td>Private 60</td>
<td>20</td>
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<tr>
<td>FATS</td>
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### 2000-02

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<tr>
<td>A4A 25</td>
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<tr>
<td>Cost (other) 20K</td>
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<td></td>
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<tr>
<td>Grps 32K</td>
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</tbody>
</table>

To Regale:

- 30 Pans
- 150K Prais
- 9K 1930
- 25K wid.
- 566 CFATS

---

224
Date: March 9, 2000

To: Wayne Clark, Ph.D.
CMHS

From: Joanna Rinaldi
AIDS Health Project

Subject: Modification of AHP Contract for Mental Health Services

As I believe you are aware, Jim Dilley sent a letter to Jo Ruffin describing a public/private partnership to increase services available to clients with HIV who present with mental health concerns. The purpose of this memo is to detail this proposal as well as to identify concerns and to suggest next steps. I would like to propose the following for your consideration.

Background

AHP began contracting with CMHS in the spring of 1999. Our first contract was for four months. AHP spent those four months sorting out systems issues, obtaining MediCal certification and learning CMHS standards and practices.

AHP productivity for each month of the contract year has steadily increased. AHP is contracted to provide 1150 hours of services for 110 clients. In the first half of the year we are currently over producing by 200%, 207%, and 174% in contracted categories. (Please see attached variance report generated by Michele Ruggels dated February 17, 2000.)

Current Situation

AHP received $50,000 in grants from The Gap and Wells Fargo Foundation for FY 1999/2000 to permit AHP to offer additional MediCal specific psychiatric and mental health services utilizing a MediCal match formula (see attached). AHP proposes modifying the current contract exhibit in the following manner to permit utilization of these grants:

<table>
<thead>
<tr>
<th>Current Contract Exhibit</th>
<th>Proposed Contract Deliverables</th>
</tr>
</thead>
<tbody>
<tr>
<td>General funds</td>
<td>General funds</td>
</tr>
<tr>
<td>MediCal portion</td>
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</tr>
<tr>
<td>CMHS Total</td>
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</tr>
<tr>
<td>$164,520</td>
<td>214,520</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UOS</th>
<th>UDC</th>
<th>110</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,150</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Program Budget</th>
<th>$264,520</th>
</tr>
</thead>
<tbody>
<tr>
<td>UOS</td>
<td>1,849</td>
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</table>

<table>
<thead>
<tr>
<th>UDC</th>
<th>175</th>
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</thead>
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In addition, AHP was approached by Norm Nickens to assist in implementing Mayor Brown's HIV Return to Work Initiative. The request was to provide mental health services for people who have mental health needs as a result of their Return to Work concerns. This project has an allocation of $35,000 in GF monies with oversight from the AIDS Office. AHP has engaged in extensive discussions with Return to Work Coordinator, Eric Ciasullo. Per Eric's direction AHP has developed a workplan that meets AIDS Office and DPH MOU standards. We have done a client analysis to determine the percentage of clients in this sub-group with MediCal. It is our best judgement that over 65% of the clients presenting for this service will have MediCal and thus are appropriate for a MediCal match thereby maximizing the number of clients seen by the Mayor's Return to Work Initiative. There is also an element of program development, which is not MediCal, reimbursable. This contract is for a six month term: 1/1/2000 to 6/30/2000. It is anticipated that there will be more funding available for FY 2000/2001, but the details have yet to be confirmed. The proposed MOU is attached for your review.

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<tr>
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<th></th>
</tr>
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<tbody>
<tr>
<td>General funds</td>
<td>35,000</td>
</tr>
<tr>
<td>MediCal portion</td>
<td>20,000</td>
</tr>
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UOS 560 UDC 80

The above UOS includes start up and program development, which are not billable to MediCal thus we are not asking for a “full” match in this FY.

**FY 2000/2001 Program Planning**

AHP anticipates the referrals for MediCal services to remain steady which will require additional staffing and funding. As you know Ryan White funding is the funding of last resort therefore clients with MediCal cannot be billed to Ryan White funded contracts. AHP has been aggressive in seeking additional monies to provide the projected demand in FY 2000/2001 for MediCal services. We have committed $125,000 in private $125,000 in private monies for the upcoming FY which represents an additional $75,000 above our FY 99/2000 matching request. We hope CMHS will again match these private monies with MediCal funding. Regarding the Return to Work Project, we do not yet know the award amount for next F/Y, we anticipate a modest funding increase, we are projecting an additional $20,000 in matching for a total of $40,000 in matching MediCal funds for this project.

**Conclusion**

We would like to modify our contract and request your review of our request. Jim Dilley, Executive Director of AHP, is available if you have any questions, or you can reach me at 476-3951. Jim can be reached at 476-6442. Lastly, we are very grateful to you and your colleagues for their efforts

cc: Ellen Busteed, SFGH Dept of Psychiatry
    Eric Ciasullo, AIDS Office
    James W. Dilley, MD
    Nick Nickens, DPH
    Michele Ruggels, CMHS, DPH
    Helen Prince, AHP Operations
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<table>
<thead>
<tr>
<th>UOS</th>
<th>560</th>
</tr>
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<tbody>
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<td>UDC</td>
<td>80</td>
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Eric Ciasullo, AIDS Office
James W. Dilley, MD
Nick Nickens, DPH
Michele Ruggels, CMHS, DPH
Helen Prince, AHP Operations
Mental Health Workgroup Meeting Minutes
Wednesday, January 5, 2000
9:00 – 10:30 a.m.

Present: Melissa Bloom, Celinda Cantu, Wayne Clark, Jim Dilley, Laura Feren, Estela Garcia, Michael Lipp, Joe Neisen, Mitzi Rossi

Contract Analysis Variance Report
Wayne distributed copies of a “Contract Analysis Variance Report” to the members of the group. He requested that everyone review the statistical data that includes projections for program service units and revenues for MediCal vs. what was budgeted. The next report will be issued during the first week in February.

Proposed Standardized Contract Language
Celinda presented the proposed standardized contract language that addresses the HIV Health Services Planning Council’s priorities for the upcoming contract period within this service category. Issues such as the intake process (SSI/MediCal screening, eligibility assessments), concerns about doing evaluations in lieu of treatment, and having enough qualified staff on hand to provide these services are currently being examined in terms of merging Planning Council expectations with the realities of delivering service. Celinda invited those present to provide feedback on the proposed language. Jim will be the contact person with the AIDS Office on this matter.

Neuropsychology Testing Available
Michael Lipp announced that he has a neuropsychologist on staff who has hours available for testing that need to be used before the end of February. Referrals were encouraged.

Contract Language for SSI Applications - Proposed Modifications
Draft language relating to the process objective for contracts that provide psych evaluations had already been modified by Russ. The group proposed further modifications (in Italics):

95% of requests for initial SSI evaluations of existing clients will be scheduled within two weeks of the request (for re-evaluations within one month of the request). Of those clients who schedule appointments, 70% will be conducted (percentage is due to “no show” rates). 95% of initial SSI evaluations that are conducted will be written up within two weeks of the evaluation meeting (for re-evaluations, within one month of the evaluation meeting). All new clients referred for SSI evaluation that meet CMHS/MediCal medical necessity criteria will be scheduled within two weeks of the request.

Next Meeting
Rescheduled to February 2nd. A representative from the Positive Resource Center will be asked to attend.
Mental Health Workgroup Meeting Minutes
Wednesday, 2/2/00
9:00 – 10:30 a.m.

Present: Wayne Clark, Jim Dilley, Laura Feren, Estela Garcia, Hilda Jones, Michael Lipp, Joe Neisen, Nan O’Connor, Russ Zellers

Guests: Laura Carcagno-Guzman & Maari McKeever (ABC Positive Resource Center)
        Andrew DeMott & David Franks (San Francisco AIDS Foundation)

Evaluations for SSI and other benefits

Maari McKeever from ABC Positive Resources distributed a sample of a “Report of Psychological Assessment,” David Franks from SFAF and Maari walked the group through the evaluation process. The following are some of the key points made during their presentation:

- **Comprehensive assessments are needed.**
  - Any review should be comprehensive. 10 hours – initial or follow-up. 8 hrs. exam, 2 hrs. write-up.

- **Minimum Tests Administered for Initial Assessment**
  - Wechsler Adult Intelligence Scale, Wechsler Memory Scale, Bender Visual Motor Gestalt, Trail Making Test, Parts A & B

- **Points Related to Psychological Evaluations**
  - A Social Security-paid psychologist evaluation is done by 1 hr. visit.
  - A good evaluation assists the primary care provider with treatment (e.g., prescribing psychotropic meds.)
  - Nearly 100% of SSI referrals are homeless, most with substance use, but not all-primary substance use diagnosis.
  - Social Security – likes *objective measured* findings.

- **Number of Projected Referrals**
  - Positive Resource – 8 patients per month not in mental health treatment at time of referral
  - SFAF – 4 patients per month not in mental health treatment at time of referral
  - 12 patients total

Mental Health Providers Current Capacity

IFR and New Leaf – no psychologist; cannot do Social Security comprehensive evaluations
CSP – same as above
Health Center #1 (through FSA) – 1 or 2 currently. Spanish-speaking unless no sub-contract. If contract $ continue, 2 next year.
AHP – 2 current + 2 additional = 4 Spanish-speaking is available
FSA – 4 current + 2 additional = 6

During PRC and SFAF presentation the group agreed that FSA, AHP & Castro/Mission should specify number of slots that will be made available per month in their respective contracts.
Questions for HIV Health Services

- Can CARE $ match $95/exam (paid to the Social Security)?
- SSI Project – (City program for non-HIV patients) does evaluations, but treatment under-funded.
- Russ will speak with Barbara Garcia.

- Future Planning

To continue the dialogue, it was suggested that Benefits Counseling programs return to meet with this group 2 months from now.

Benefits Counseling staff requested that a written protocol be developed that specifies the number of evaluations slots available per agency, how to refer, who determines if psychological or neuropsychological evaluations, and other matters.

Next Meeting – Wednesday, 3/1/00, 9 – 10:30 a.m., 25 Van Ness, Seventh Floor, Room 710
Mental Health Group Meeting Minutes
Wednesday, December 8, 1999
9:00 – 10:30 am

Present: Melissa Bloom, Wayne Clark, Jim Dilley, Laura Feren, Estela Garcia, Hilda Jones, Joe Neisen, Marianne O’Connor, Russ Zellers

Corrections to previous minutes
Let the record reflect that Laura Feren was in fact present at the 11/15/99 meeting. Estela will submit updated stats for Joe’s SSI Discussion chart at a later date.

Care/General Fund Dollar Allocation
Some agencies are not on target vis-à-vis CARE and Medi-Cal Units of Service. Contractors asked if CARE dollars could be moved between agencies. Russ said that this is possible. Wayne and Russ will work with CSP and New Leaf to determine the amount that needs to change for next year.

Potential CARE Reductions
The Reductions Protocol for FY 00-01 CARE dollars that has been approved by the Planning Council was distributed by Russ. This assumes a 2% reduction although the actual reduction, if any, will not be known until mid-January.

Medi-Cal Referrals
Insisting on preauthorization causes some patients to drop out of seeking treatment. Wayne will work with Medi-Cal providers to make it easier to obtain authorization for HIV clients for Medi-Cal.

Evaluations for SSI Applications
The work group discussed the Planning Council priority to increase the number of psychological evaluations conducted for SSI and other benefits. Russ later modified the draft language (process objective for contracts that provide psych evaluations) as follows:

- 95% of requests for initial SSI evaluations will be scheduled within two weeks of the request (for re-evaluations, within one month of the request). Of those clients who schedule appointments, 70% will be conducted (percentage is due to “no show” rates). 95% of initial SSI evaluations that are conducted will be written up within two weeks of the evaluation meeting (for re-evaluations, within one month of the evaluation meeting).

It was noted that a representative from Positive Resources Center was scheduled to be at today’s meeting but did not show. It is important to discuss the need for these evaluations with PRC.

January Meeting/Agenda
The next meeting is scheduled for January 5, 2000 9-10:30 am. (Members will receive a reminder call). Agenda items include CMHS Medi-Cal arrangements and contract language in regards to objectives (psychiatric evaluations).
CARE REDUCTIONS PROTOCOL
TO BE APPLIED TO COVER REDUCTION IN
FY 00-01 AWARD AMOUNT

Scenario: Planning for a potential reduction in CARE Title I funds of 2% as well as augmentation of Congressional Black Caucus Initiative of $67,788 to expand the target population.

Goal: to make reductions while minimizing the impact on service provision and clients.

To be assessed by HIV Health Services:

First Level of Reduction:

$88,853 Harm Reduction at an ISP (dollars will not be awarded)

Second Level of Reduction:

Under-utilization of funds (> $10,000) in FY 98-99
[Exclude discontinued programs such as REGGIE. Hold harmless programs new in 1998-99 and 1999-00, programs transitioning between providers, and Marin & San Mateo Counties. Housing and Planning Council Support will be held harmless.]

Generate savings until $67,788 (CBC Initiative Augmentation) + 2% of grant contractual dollars is reached. (Two percent is estimate of maximum reduction in award amount and will change when grant award amount is known.) If not reached, proceed to 3rd level of reduction.

Third Level of Reduction: Contractual Performance
Defund entirely any program that meets both (a) and (b) below except for hold harmless conditions.

Spread the balance of the reduction proportionately among programs where one or more of the following conditions is met:

a) "Needs Improvement" or "Unacceptable" monitoring in FY 98-99; or
b) "Needs Improvement" or "Unacceptable" monitoring in FY 99-00; or

At discretion of HIV Health Services, the total exhibit amount for programs that received a "Needs Improvement" or "Unacceptable" monitoring report in either year may be redirected. The redirection of dollars must be within the respective sub-category and
must be used to expand services within Integrated Service Programs or to otherwise expand services provided in the sub-category. This redirection is above and beyond the reduction in contracts required to compensate for the decrease in the grant award amount. This redirection is to be applied after the reduction in contracts required to compensate for the decrease in the grant award amount.
## Quarterly Individual Variance Report

**Program:** Center for Special Problems  
**Revenue:**

<table>
<thead>
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<th>RU</th>
<th>Name</th>
<th>Service</th>
<th>1999-00</th>
<th>1999-00</th>
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<th>1999-00</th>
<th>1999-00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Budget</td>
<td>Actual</td>
<td>Projected</td>
<td>Jul-Sep</td>
<td>Fiscal Year</td>
<td>Variance</td>
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<td></td>
<td>n/a</td>
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</tbody>
</table>

**Federal Medi-Cal TOTALS:**  
- Budget: $319,616  
- Actual Jul-Sep: $85,794  
- Projected Fiscal Year: $343,176  
- Variance: $23,560

Data from 10/99 KFR run  
CMHS: DB, 12/9/99
## Quarterly Individual Variance Report

**CSP**

**Units of Service**

<table>
<thead>
<tr>
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<tr>
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Data from the 10/99 KFR run
CMHS: DB, 12/9/99
## Contract Performance Analysis
### UC Center for Deafness
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*Federal Medi-Cal includes FFP portion of EPSDT Medi-Cal, where applicable*

Data from 10/99 KFR run
CMHS: DB, 12/9/99
## Contract Performance Analysis
### UC Center for Deafness
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Data from the 10/99 KFR run
CMHS: DB, 12/9/99
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Data from 10/99 KFR run
CMHS: DB, 12/9/99
## Contract Performance Analysis

### UC Citywide

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### Contract Performance Analysis

#### Federal Medi-Cal Performance Analysis

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**Federal Medi-Cal Sub-total**

- $116,164
- $113,390
- ($2,774)

**Mosaic Medi-Cal Sub-total**

- $16,450
- $3,746
- ($12,704)

**Medicare Sub-total**

- $0
- $0
- $0

**ALL TOTALS**

- $132,614
- $117,136
- ($15,478)

- $157,085
- $25,883
- $103,532
- ($53,553)

* Federal Medi-Cal includes FFP portion of EPSDT Medi-Cal, where applicable

---

Data from 10/99 KFR run
CMHS: DB, 12/9/99
# Contract Performance Analysis

**IFR**  
**Units of Service**

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<th>RU</th>
<th>Name</th>
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<th>1998-99 Actual</th>
<th>Variance</th>
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<td>533</td>
<td>148</td>
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<td>1,714</td>
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<tr>
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<td>526</td>
<td>45</td>
<td>180</td>
<td>(346)</td>
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<td>588</td>
<td>47</td>
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<td>(400)</td>
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<td>1</td>
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<td>50</td>
<td>6</td>
<td>24</td>
<td>(26)</td>
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<td>3</td>
<td>(2)</td>
<td>20</td>
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<td>Medication Support</td>
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<td>4</td>
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<td>109</td>
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<td>352</td>
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<td>487</td>
<td>119</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>ALL TOTALS</strong></td>
<td></td>
<td>3,513</td>
<td>3,209</td>
<td>(304)</td>
<td>4,035</td>
<td>842</td>
<td>3,368</td>
<td>(272)</td>
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Data from the 10/99 KFR run  
CMHS: DB, 12/9/99
## Contract Performance Analysis
### New Leaf
#### Revenue

<table>
<thead>
<tr>
<th>RU</th>
<th>Name</th>
<th>Service</th>
<th>1998-99 Actual Service</th>
<th>1999-00 Projected Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Budget</td>
<td>Fiscal Year</td>
<td>Variance</td>
</tr>
<tr>
<td>89933</td>
<td>New Leaf...Srvcs for our Comm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>76,760</td>
<td>79,092</td>
<td>2,332</td>
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<td>NEW LEAF EPSDT</td>
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<tr>
<td></td>
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<td>24,320</td>
<td>10,340</td>
<td>(13,980)</td>
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<td>New Leaf-AIDS Mental Health</td>
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<tr>
<td></td>
<td></td>
<td>49,070</td>
<td>13,465</td>
<td>53,860</td>
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**Sub-total**

| Federal Medi-Cal Sub-total | 101,080 | 89,432 | (11,648) |
| Mosaic Medi-Cal Sub-total  |         |       |          |
| Medicare Sub-total         |         |       |          |
| **TOTALS**                 | 151,340 | 36,876 | 147,504  |

*Federal Medi-Cal includes FFP portion of EPSDT Medi-Cal, where applicable*

---

Data from 10/99 KFR run
CMHS: DB, 12/9/99

---

DRAFT
### Contract Performance Analysis

**New Leaf**  
**Units of Service**

<table>
<thead>
<tr>
<th>RU</th>
<th>Name</th>
<th>Service</th>
<th>1998-99 Actual</th>
<th>Variance</th>
<th>1999-00 Projected</th>
<th>Variance</th>
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<td></td>
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<td>Contract Jul-Sep Fiscal Year Variance</td>
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<td>8</td>
<td></td>
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<td>Crisis Intervention</td>
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<td>6</td>
<td>6</td>
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<td></td>
</tr>
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<td></td>
<td></td>
<td>Mental Health Services</td>
<td>512</td>
<td>232</td>
<td>(280)</td>
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<td><strong>Sub-Total</strong></td>
<td>512</td>
<td>238</td>
<td>(274)</td>
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<td>89934*</td>
<td>New Leaf-AIDS Mental Health</td>
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<td>TBD</td>
<td>(264)</td>
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<td>(264)</td>
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<td><strong>Sub-Total</strong></td>
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<td>TBD</td>
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<td>2,712</td>
<td>933</td>
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Data from the 10/99 KFR run  
CMHS: DB, 12/9/99
### Quarterly Individual Variance Report

**Program:** OMI  
**Revenue**

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<tr>
<th>RU</th>
<th>Name</th>
<th>Service</th>
<th>Budget</th>
<th>Actual Jul-Sep</th>
<th>Projected Fiscal Year</th>
<th>Variance</th>
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<tbody>
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<td>38803</td>
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<td>Federal Medi-Cal</td>
<td>$444,319</td>
<td>$51,587</td>
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<td>($237,971)</td>
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<td></td>
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<td></td>
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<tr>
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<td></td>
<td>Medicare</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3880M1</td>
<td>OMI Partners</td>
<td>Federal Medi-Cal</td>
<td>$12,500</td>
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<td></td>
<td>Medicare</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTALS**  
- Budget: $456,819
- Actual Jul-Sep: $54,183
- Projected Fiscal Year: $216,732
- Variance: ($243,135)

Data from 10/99 KFR run  
CMHS: DB, 12/9/99
## Quarterly Individual Variance Report

### OMI

#### Units of Service

<table>
<thead>
<tr>
<th>RU</th>
<th>Name</th>
<th>Service</th>
<th>Budget</th>
<th>Actual 1999-00</th>
<th>Projected Fiscal Year</th>
<th>Variance</th>
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<td>TBD</td>
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<td><strong>TOTALS</strong></td>
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<td><strong>2,234</strong></td>
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</tbody>
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Data from the 10/99 KFR run
CMHS: DB, 12/9/99
CARE REDUCTIONS PROTOCOL
TO BE APPLIED TO COVER REDUCTION IN
FY 00-01 AWARD AMOUNT

Scenario: Planning for a potential reduction in CARE Title I funds of 2% as well as augmentation of Congressional Black Caucus Initiative of $67,788 to expand the target population.

Goal: to make reductions while minimizing the impact on service provision and clients.

To be assessed by HIV Health Services:

First Level of Reduction:
$88,853 Harm Reduction at an ISP (dollars will not be awarded)

Second Level of Reduction:
Under-utilization of funds (> $10,000) in FY 98-99
[Exclude discontinued programs such as REGGIE. Hold harmless programs new in 1998-99 and 1999-00, programs transitioning between providers, and Marin & San Mateo Counties. Housing and Planning Council Support will be held harmless.]

Generate savings until $67,788 (CBC Initiative Augmentation) + 2% of grant contractual dollars is reached. (Two percent is estimate of maximum reduction in award amount and will change when grant award amount is known.) If not reached, proceed to 3rd level of reduction.

Third Level of Reduction: Contractual Performance
Defund entirely any program that meets both (a) and (b) below except for hold harmless conditions.

Spread the balance of the reduction proportionately among programs where one or more of the following conditions is met:

a) "Needs Improvement" or "Unacceptable" monitoring in FY 98-99; or
b) "Needs Improvement" or "Unacceptable" monitoring in FY 99-00; or

c) Achievement of < 75% of contracted UOS in FY 98-99

At discretion of HIV Health Services, the total exhibit amount for programs that received a "Needs Improvement" or "Unacceptable" monitoring report in either year may be redirected. The redirection of dollars must be within the respective sub-category and
must be used to expand services within Integrated Service Programs or to otherwise expand services provided in the sub-category. This redirection is above and beyond the reduction in contracts required to compensate for the decrease in the grant award amount. This redirection is to be applied after the reduction in contracts required to compensate for the decrease in the grant award amount.
5. Schedule, Plan to Stagger Cycles, and Extensions

DRAFT CONTRACT PREPARATION TIMELINE FOR FY 2000-01

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 1 – Dec 31</td>
<td>Contracting Work Group Planning</td>
</tr>
<tr>
<td>Jan 7th</td>
<td>Award Letters &amp; Program Letters sent out (excluding reduced &amp; terminated contracts)</td>
</tr>
<tr>
<td>Febr 1st</td>
<td>Award Letters &amp; Program Letters for reduced and terminated contracts sent out</td>
</tr>
<tr>
<td>Febr 15th</td>
<td>1st draft of Cycle #1 contracts due</td>
</tr>
<tr>
<td>March 13th</td>
<td>1st draft of Cycle #2 contracts due</td>
</tr>
</tbody>
</table>

Cycle #1 (3 Month Extensions)
Contracts with little chance of reduction in funding.
Contracts needing significant changes based on Planning Council priorities.
Contracts with history of longer negotiations, late materials & problems.

To the extent possible, first drafts submitted as complete and quality documents before the due day will be processed in the order received.

Cycle #2 (3 Month Extensions)
Contracts with a significant chance of reduction in funding.
Contracts needing few changes based on Planning Council priorities.
Contracts with history of short negotiations, on-time materials & few problems.

To the extent possible, the first draft of contracts that are submitted as a complete and quality document by February 15th will be processed as part of the Cycle #1.
Date: 10/22/99
From: James W. Dilley, MD
To: Laura Guzman
Phone: 476-6442

Agency: Positive Resource
Fax #: 777-1770
Phone#: 777-0333

Notes:

Laura —

Please give me a call if you want to talk about these #s (overall, we thought they looked pretty good vis-a-vis the expected need).

Also, would you be available to attend the next meeting Wed, 12/9/99 @ 9 AM in Training Room A of the AIDS OC? I think the group would appreciate hearing your perspective. Please let me know.

Transmitted By: G.V. For: JD

Box 0884
San Francisco, CA
94143-0884
(415) 476-6430
(415) 502-7271 (FAX)
1. SSI Discussion

<table>
<thead>
<tr>
<th>AGENCY</th>
<th># New Clients</th>
<th># Referred for SSI Eval.</th>
<th># SSI Evals. completed</th>
<th>Neuro-psychological Assessment</th>
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</thead>
<tbody>
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<td>10</td>
<td>10</td>
<td></td>
</tr>
<tr>
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<td>?</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CSP Center for Special Problems</td>
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<td>17</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>*FSA Family Service Agency</td>
<td>117</td>
<td>32</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>AHP AIDS Health Project</td>
<td>426</td>
<td>6</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>UCCD UC Center for Deafness</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Iris</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*FSA All are 8 hr NP assessments

Is SSI currently paying for psychiatric evaluations by CARE funded providers? No.

2. Care Council Update

A. Evaluation/implementation subcommittee recommendations: The subcommittee has been trying to flush out the Care Council’s Prioritization Recs with a goal of further prioritizing for year 1 or year 2. Some may involve moving funds from one category to another, e.g., there’s a plan to take residential SA money and put it into housing. LF will contact MJ Wood re: our attending these meetings and the schedule. LF will also contact workgroup members by phone with this info.

B. Expecting a 1-3 percent initial. Should know by early January 2000. Also a health department committee is being created to look at future funding in light of expected cuts.
3. ISP's Meeting: Russ provided data on a meeting with ISP providers and their requests for mental health and Substance Abuse services onsite. Important to note that while a considerable request was made by most of the sites, space availability was also an identified problem and there is no clear understanding of the method used to support the request.

4. Program Changes at HIV/Nightline
   A. Nightline has gone to a national program for English Language Services
   B. Spanish Language Suicide program is now state-wide
   C. Hep C Nightline to be started in early January (Billy Pick in AIDS office is the local Hep C expert)

5. Future Issues

Next Meeting is scheduled for December 8, 1999, at 9 a.m.
CMHS INTEGRATION WORKGROUP
AGENDA
5/2/99

1. Update on CMHS census

2. BIS Victory


4. Memo from CMHS regarding transfer of clients receiving services prior to 3/1/99
   A. Access must be contacted for clts receiving services after 3/1/99; unclear if clt must place the call; AHP's position is to advocate for clt-centered system which minimizes confusion and barriers to service.
   B. Memo directed to all HIV mental health providers; discussions with CSP
   C. Presentation to Access staff scheduled, but clarification still needed (e.g. low-acuity clients—Medi-Medi, and MediCal only; parolees and veterans).
   D. Verbal agreement with Wayne Clark had been that if above presentation did not resolve problems, we would go to CSP's procedure of not contacting Access. Memo does not reflect this.
   E. AHP's response strategy?

5. Need to establish system for triaging referrals from Access.
   A. What was meaning of Access contract which was cancelled?
   B. What is agency's position regarding referrals of uninsured clients? Are they to be seen via CMHS or via Ryan White? If the latter, how is this to be communicated to CMHS? If the former, can our PURQC reauthorize CMHS services for these clients, with billing via BIS as usual?
   C. Ideas for triaging these calls: Ed, Will, BoD. Interim plan is that these calls are being directed to Ed.

6. Waitlist issues—2+ month wait for clients referred to nac waitlist. Need to balance need to be fair to all with need to meet CMHS contract. Should CMHS status be a factor in waitlist position? Should we open up more CMHS "slots" and start filling them now?

7. Consider phasing in some crisis clients now; clarification on multi-staff billing.

8. Phase-in of additional staff for assessments and treatment
   A. Who?
   B. Staff training 5/6

9. PURQC changes

10. MediCare training

11. Odds and Ends—tracking form, med consent followup/policy, site visit, letter from Michele Friedman on documentation, Acronyms list, defining "contract for safety".
CMHS INTEGRATION WORK GROUP
MINUTES
3/22/99

In Attendance: Joanna Rinaldi, Dymond Austin, Emily Leavitt, Ed Schultz, Helen Prince

1. Scheduling update—MediCal clients are now being scheduled and 2 have been evaluated. The first also had private insurance and was deemed ineligible for CMHS services. The second was seen today and service request will be sent to our PURQC. A third client is scheduled for later this week.

2. Access response—When Access staff are called for assessment authorization, they ask very detailed questions about the mental health history in the process of determining whether an initial assessment should be authorized. Staff also were not aware that UCSF AIDS Health Project is now a CMHS contract agency. In addition, staff at first said that MediCare-MediCal clients should be referred to a private practitioner or that MediCare should be billed, but did authorize the assessment after writer relayed information we were given by Maria Poulo, billing manager, on 2/7/99—that is, that such clients can be seen by us, and MediCal billed, because we are not MediCare certified. Authorization letters are to be faxed to us, but this cannot occur until the agency is entered into the Access database.

3. Phasing in existing clients—Michael McGrenra called Steve Seidman, the director of Access. The call was intercepted by Mr. Seidman's assistant, who indicated that Mr. Seidman and Wayne Clark would need to meet to discuss protocol for determining medical necessity of existing clients. It was left that Michael would call to follow-up on this next week.

4. BIS update—The terminal has been installed, but now is not working (it worked at first, but now does not allow anyone to log in). Reflection software installation will need to wait until the dummy terminal is operational, as will assignment of the print queue to an AHP printer. Dymond is following up on all of this, although it has been difficult to get a response from BIS staff.

5. The PURQC proposal has been completed and has been forwarded to Jim Dilley for signature. There is a question as to whether the method by which a 10% sample of cases will be annually reviewed was adequately delineated (e.g. that it was explicitly stated that a chart review would occur). Ed will follow up with Jim's assistant and Michael McGrenra regarding this.

6. Charting issues—Ed and Michael McGrenra met with Jim Dilley and George Harrison on 3/19, and the following was decided: We will not implement a separate Physicians Orders sheet in the chart, as all orders are currently listed in the "Plan" section of each note and there is no clinical advantage to "double-listing" these. However, the "Medication Sheet" will be implemented. The SFGH Dept of Psychiatry Medication Sheet will also be used, as we are part of this dept and it would be preferable to use the same form for all clients. It was decided that the CMHS forms would be used until the SFGH form (under revision) was obtained. The revised form is expected to be available in approximately 2 weeks. The Ryan White-CMHS chart structure (using a chart with a divider) was also reviewed. When a new CMHS client is being seen by psychiatry, all existing lab reports will be transferred to the CMHS section of the chart and placed in the appropriate subdivider. Ed has obtained all of the necessary CMHS forms.
7. UOS database issues—the Service Type issue identified at last week’s meeting has been resolved. The various service types identified on the billing slip are combined into larger categories, and it is these larger categories that are written into the contract language. The only service type not included is Case Management/Brokerage. There are no plans to include this service type during the current contract period. Referrals made in the context of therapy or assessment can be “billed” to those respective service types. The database into which units of service will be entered is being designed. Dymond distributed an initial draft of a guide which relates CMHS service types to CARE service types. Discussion regarding the database design and the guide was deferred until next week’s meeting.

8. Site visit—The CMHS site visit has not yet been scheduled by CMHS staff. Dymond has spoken to Michele Friedman, who indicated she could do a preliminary informal visit, and that she would likely be participating in the formal site visit. Dymond also spoke with Michele about using more “Exit” signs with arrows, rather than posting more evacuation maps, and Michele agreed to this.

9. Tracking form—Dymond has consulted with Ed about this, and is making final revisions.

10. Nac Coordinator position—A decision has been made to establish one permanent FTE position for the purpose of overseeing the CMHS program along with other Nac services.

11. Private insurance issues—There has been some activity regarding this, but discussion was deferred until next week.

Edward M. Schultz, LCSW
MEMO

October 9, 1998

To: Program Directors

From: PURQC Monitoring Committees

Re: Notice of Action (NOA) and System Of Care Authorization and Reauthorization

The following points are intended to clarify the Notice of Action policy which you have already received. Most questions should be answered by the policy. You are strongly encouraged to read the policy. If you need a copy of the policy, please call Susan Sturtevant at 255-3484.

When are system of care programs required to issue a NOA B?

Issuance of a NOA (B) is required when the PURQC has eliminated a provider requested service modality that the client had been receiving, e.g., day treatment is being discontinued and the client is only reauthorized for outpatient services.

It is not necessary to issue a NOA-B when the client's standard outpatient bundle is modified or reduced in number as long as there is an option for the care manager or other providers to request a further modification during the usual one year reauthorization period. If the PURQC denies a provider requested extension or modification during the usual reauthorization period, a NOA-B will need to be issued.

Who and How are the NOA A & B issued?

In the event that a system of care clinic intends to deny service to a client for lack of medical necessity (NOA-A) after completing an assessment, the care manager, clinician or program director should complete the NOA-A form**. The care manager, clinician or program director should also complete a separate brief memo substantiating the reason for the denial of service and send both documents to Steve Seidman, the Director for Access at 1380 Howard Street. He will then issue the NOA.

In the event that a PURQC intends to deny an extension or permanently reduce service, the PURQC should complete the NOA - B form**. The PURQC should also complete a separate brief memo substantiating the reason for the denial of service and send both documents to the age sector director. The age director, or designee, will then issue the NOA.

**Note that these forms are contained in the NOA policy.
Notice of Action Flow Chart

Client seeks services

Info & Referral
No NOA Needed

Client obtains Assessment

Client does not meet Medical Necessity

NOA - A within 3 days

Provider requests services

Services approved

Services modified or denied re: Age Director or designee

Provider requests reauthorized services

Services approved
No NOA Needed

Services modified or denied

Defer > 30 days

NOA - B within 3 days

NOA - B
10 days prior to effective date; issued within 3 days of decision
## POLICY/PROCEDURE REGARDING:

<table>
<thead>
<tr>
<th>Denial of MediCal Funding for Specialized Mental Health Services, Notice of Action</th>
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**Issued By:** Jo Ruffin, LCSW
Director of Community Mental Health Services

**Date:** June 30, 1998

**Manual Number:** 3.11-04

**Reference:** Title 9, CCR, Section 1820.205

**Substantive revision.** Replaces Policy 3.11-04 of 1/20/95.

### NOTICE OF ACTION AND FAIR HEARING PROCESS DESCRIBED

According to the San Francisco Mental Health Plan (SFMHP), consumers (beneficiaries) must be prior authorized for services, and consumers (beneficiaries) must be informed when funding for Specialty Mental Health Services has been 1) denied or 2) modified by the County Mental Health Plan. In either case, this notification is called a Notice of Action. (NOA)

A beneficiary who receives a notice of action has a right to appeal the MHP's decision to the State within 90 days of the date on the Notice of Action. (A member of the clinical staff may not appeal on their behalf.) The Administrative Adjudication's Division of the State Department of Social Services will then hold a Fair Hearing and may uphold or overturn the county's decision.

Beneficiaries are notified of their right to a Fair Hearing at the time of application to Medi-Cal, on a quarterly basis by California Department of Health Services, in beneficiary brochures and through NOA's. Beneficiaries can exercise their rights to file a complaint or grievance in lieu of or in addition to filing for a fair hearing.

### DEFINITION OF TERMS

**Aid Paid Pending** - A beneficiary or his/her authorized representative may request aid paid pending when the MHP sends a NOA-B indicating it intends to discontinue or reduce services that had been previously approved by the MHP. When the Notice of Action is issued to discontinue or reduce services that had been previously approved by the MHP, it must be issued at least 10 days prior to the effective date, so that Aid Paid Pending status can be requested to permit a beneficiary to continue receiving services from the MHP pending the disposition of a fair hearing.

**Applicant** - an individual seeking services from a SFMHP service provider.

**Assessment** - means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or
behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures. (§1810.204)

Authorization - Authorization is a clinical decision based on an assessment that services are medically necessary, and the payment is approved for services those services are thereby authorized.

Beneficiary - means any person certified as eligible under the Medi-Cal program according to Title 22, Section 51001. (see members, applicants)

Complaint - it is the practice of SFMHP to resolve consumer/parent concerns, issues and complaints on an informal basis as part of the regular delivery of service. Informal complaints are to be handled promptly by the consumer’s service provider or by the program director.

Denial - when the MHP or a provider assesses a beneficiary and decides that the beneficiary does not meet medical necessity and thereby determines that services are not authorized as a result of an assessment. This requires a Notice of Action.

Eligibility - the process of determining whether an individual qualifies for services offered by a Mental Health Plan, by verifying certain information about the individual including but not limited to items such as medical necessity, financial status, and residency.

Grievance - The grievance procedure provides a formal avenue for the resolution of consumer concerns when the informal process is not sufficient to resolve the problem. A complaint becomes a grievance when it is put in written form and submitted to the Quality Improvement Office at 1380 Howard Street, 2nd floor. The person filing a grievance may obtain assistance from the Office of Consumer Relations, Patient’s Rights Advocate Services (PRAS), or any one else at the client’s request. While the use of the complaint process to resolve issues promptly and informally is to be encouraged, a grievance may be filed without a complaint and without reprisal at any stage of the process. This is to be made clear to all clients. Grievance forms and self-addressed envelopes shall be available for beneficiaries to pick up at all SFMHP sites.

State Fair Hearing - A fair hearing is a State hearing provided to beneficiaries pursuant to Title 22, Section 50951 and 50953 of the California Code of Regulations. It is part of the problem resolution processes available to beneficiaries who have concerns about Medi-Cal specialty mental health services. (Fair hearings are also used for many other State programs.) In addition to the fair hearing, the MHP must have complaint and grievance processes. The complaint and grievance processes are independent from the state fair hearing process. a beneficiary does not have to access these problem resolution processes sequentially.
Members - consumers who are eligible due to residency and medical necessity to receive services provided by the San Francisco Mental Health Plan. The only members who may receive a Notice of Action or request a fair hearing are Medi-Cal beneficiaries. (see beneficiaries, applicants)

Medical Necessity - Medically Necessary services are those specialty mental health services which are provided to an individual with the expectation that s/he will benefit because the service will diminish an impairment that is the result of an included DSM IV diagnosis. State guidelines list the included diagnoses, define impairment and intervention related criteria by which Medical Necessity is determined. (§1830.205)

Mental Health Plan (MHP) - In the City and County of San Francisco, the MHP is called the San Francisco Mental Health Plan (SFMHP), and serves residents of San Francisco who qualify for Specialized Mental Health Services paid by Medi-Cal and by other county funds.

Notice of Action (NOA) informs Medi-Cal beneficiaries of denial of eligibility based on medical necessity criteria (NOA-A), or changes in provider-requested mental health services from the SFMHP (NOA-B), and the beneficiary’s rights for appeal if they don’t agree with the MHP decision. Note: NOA-A and NOA-B are interim forms, to be finalized in the next few months, and will be translated into other languages at that point.

Provider - Certified site where the provision of Specialized Mental Health Services takes place, identifiable by a provider number (38xx) and certified to meet standards under those established by the SD/MC Manual, and other criteria determined by the MHP.

Reauthorization - the process of reviewing the client’s care and determining if extended care is warranted, and thus authorizing care at previous or more appropriate levels based on clinical considerations. If services are reduced or terminated then the action requires a Notice of Action. (NOA-B)

Reduction - means approval by the MHP for non-acute continuing services at less than the amount or frequency requested by the provider and less than the amount or frequency approved on the immediately preceding authorization. This requires a Notice of Action. (NOA-B)

Screening - a brief evaluation for the purposes of information and referral, usually done by telephone, or brief person to person contact to determine eligibility and determine whether a full assessment is warranted. The results of a screening do not require a NOA.

Termination - means denial by the MHP of a request from a provider for non-acute continuing services. This requires a Notice of Action. (NOA-B)
General Information Regarding Notices Of Action:

1. A Notice of Action (NOA) informs beneficiaries of some changes in requested mental health services from the SFMHP and their rights of appeal if they don't agree with the SFMHP decision.

2. The NOA requirements apply only to Medi-Cal Specialty Mental Health Services and are provided to eligible beneficiaries.

3. The State forms, Interim NOA-A and Interim NOA-B, must each be used with the Interim NOA-BACK. These forms are being piloted. The State DMH will provide translated copies of the final NOA-A, NOA-B, and NOA-BACK to the MHP's. (see Attached)

4. The San Francisco Mental Health Plan will want three copies of each Notice. One is given/sent to the beneficiary, one to the provider, and one must be kept in a central file. These Notices (NOA's) should not be placed in the client's chart.

5. While the issuing of an Interim NOA-A or Interim NOA-B begins the 90 day period that a beneficiary has to file for a state fair hearing, beneficiaries may request fair hearings in circumstances when no notices of action are generated.

6. Beneficiaries who are in on-going services must file a request for a Fair Hearing within ten (10) days of the date of issue to be eligible for Aid Paid Pending.

ISSUING NOTICES OF ACTION IN SAN FRANCISCO COUNTY

Notice of Action (Assessment) - Form "Interim NOA-A"

1. When the SFMHP Access team determines that, on an individual case-by case basis, there is no medical necessity for Specialized Mental Health Services, the Access team will issue a Notice of Action. (NOA-A)

2. When any of the SFMHP Bed Committees (Child, Adult, or Geriatric) determines that, on an individual case-by case basis, that there is no medical necessity for Specialized Mental Health Services, the SFMHP Bed Committees will issue a Notice of Action. (NOA-A)

Notice of Action - Form "Interim NOA-B"

A. A NOA-B must be issued when any action, other than approval, is taken by the SFMHP on a request by a provider for any Medi-Cal Specialty...
Mental Health Services which have not already been provided.

A NOA-B must be issued in the following circumstances:

Provider request Denial - The SFMHP does not approve requested services.

Provider Request Modification - SFMHP approves a different type of service or lower frequency than requested by the provider. This applies to both new service requests, as well as reauthorization (continuation) requests.

Provider Authorization Modification - Provider authorization for services is in effect and the SFMHP changes that authorization to a different type of service or a lower frequency, or

Provider Authorization Termination - The SFMHP changes current authorization to disapprove services.

B. Deferral of More than 30 days - When the SFMHP has insufficient information to make the authorization decision within 30 days of receipt of the provider request for specialty mental health services which require prior authorization by the SFMHP. At the end of this period the SFMHP may choose to deny the request or to defer their decision pending submission of further information. In either case, an interim NOA-B would be sent/given to the beneficiary.

When Notices Of Action (NOA's) Are NOT REQUIRED

Notice of Action (Assessment) - Form "Interim NOA-A"

1. The SFMHP or its providers assess a beneficiary and determine that SFMHP specialty mental health services are needed. (see NOA-B)

2. The SFMHP provides general information on covered services and/or referral sources to beneficiaries who do not request specialty mental health services.

3. This form is never required for inpatient hospital services since inpatient services are authorized retrospectively.

Notice of Action - Form "Interim NOA-B"

1. When services requested by the provider are authorized by the SFMHP at the requested level and frequency.
2. For services that may be provided without prior authorization of the SFMHP, such as emergency services, acupuncture, etc.

3. When the SFMHP approves a shorter time period than requested, a NOA-B is not required. (because a provider can submit another request at that time.)

4. The SFMHP denies payment to a provider for services already delivered without having secured prior authorization.

5. The SFMHP's non-approval is a non-binding verbal description to a provider of the specialty mental health services which may be approved by the SFMHP.

6. Expiration of services does not require a NOA-B.

7. When a provider does not request continued services, no NOA is required. The grievance process continues to be available to the client.

Distribution of Notices of Action

In the event a beneficiary does not meet medical necessity, a NOA-A will be generated by Central Access and the respective Bed Committees (Child, Adult, or Geriatric) when informed by the authorizer that services have been denied according to this policy. For situations requiring NOA-B notification, the NOA-B will be generated by Central Access when informed by the provider that services have been modified or terminated according to this policy.

Authorizers must document the background and criteria of the decisions resulting in NOA's, and the documentation should be attached to the NOA copy sent to the Central file. In the event of a State fair hearing, this documentation is critical to defending the SFMHP's decision to deny or reduce services.

Notice of Action (Assessment) - Form "Interim NOA-A"

May be hand-delivered on the date of the action or mailed to the beneficiary or authorized representative within 3 working days of the decision by the SFMHP. This will be done by the SFMHP Central Access Team within 3 working days of the decision.

Notice of Action - Form "Interim NOA-B"

For situations described in Form "Interim NOA-B" (page 4), the NOA-B may be hand-delivered on the date of the action or mailed to the
beneficiary or authorized representative within 3 working days of the decision by the SFMHP. In situations where Provider authorization for services is in effect and the SFMHP changes that authorization to a different type of service or a lower frequency, the NOA-B must be issued at least 10 days prior to the action being implemented. This will be done by the SFMHP Central Access Team within 3 working days of the decision.

When either a NOA-A or a NOA-B is issued, the person distributing the NOA should attach the "Dear Applicant" letter describing alternatives which the consumer may explore.
ORDERING NOTICE OF ACTION FORMS

Copies of these forms can be obtained from Forms Control Clerk, 380 Howard Street, 5th Floor, 255-3913 (FAX 255-3567).

Contact Person: Rinna Flohr, LCSW or Jim Gilday, M.S.W.
(415) 255-3443 (415) 255-3661
(415) 252-3001 fax (415) 252-3001 fax

Distribution:

Direct Treatment Programs
Administrative Manual Holders
RAS
Forms Control

MS policies and procedures are distributed by the Quality Management Section, 255-3484.

Attachments (3)
The mental health plan for San Francisco County has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services through the plan.

Your mental health condition did not meet the medical necessity criteria, which are covered in the state rule at Title 9, California Administrative Code, Section 1830.205, for the reason checked below:

- [ ] Your mental health diagnosis as identified by the assessment is not covered by the mental health plan.
- [ ] Your mental health condition does not impair your functioning in a significant way that would make you eligible for specialty mental health services from the mental health plan.
- [ ] Your mental health condition is not likely to improve with the specialty mental health services available from the plan.
- [ ] Your mental health condition would be responsive to treatment by a physical health care provider.

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of your mental health plan at the place where you were assessed, or call or write to the Access Helpline. ((415) 255-3737, toll free 1-888-246-3333, TDD 1-888-484-7200), or write to Access Authorization Program, 1380 Howard, 2nd Floor, SF, CA 94103.
If you don't agree with the plan's decision, you may do one or more of the following:

- You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at the Access Helpline. ((415) 255-3737, toll free 1-888-246-3333, TDD 1-888-484-7200), or write to Access Authorization Program. 1380 Howard, 2nd Floor. SF, CA 94103.

- You may file a complaint or grievance with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at Consumer Relations. (415) 255-3433, or write to Quality Management, 1380 Howard St., 5th Fl. SF, CA 94103, or follow the directions the mental health plan has given you.

- You may request a state hearing. The last page of this form will explain how you may do that. In some cases, if you are receiving ongoing specialty mental health services, your services may continue while you wait for a hearing if you request a hearing within ten days of the date of this notice.

If you have questions about this notice, you may call and talk to a representative of your mental health plan at Consumer Relations. (415) 255-3433, or write to Quality Management. 1380 Howard St., 5th Fl. SF, CA 94103.
YOUR HEARING RIGHTS
To ask for a State Hearing
The right side of this sheet tells how.
• You only have 90 days to ask for a hearing. The 90
days started the day after we gave or mailed you this
notice.
• You have a much shorter time to ask for a hearing if
you want to keep your same Medi-Cal mental health
services.
To Keep Your Same Services While You Wait for A
Hearing
• You must ask for a hearing before the action takes
place.
• Your Medi-Cal mental health services will stay the
same until your hearing or until your provider says
you no longer need the services, whichever happens
first.
To Get Help
You can ask about your hearing rights or free legal aid at
the state information number.
Call toll free: 1-800-952-5253
TDD: 1-800-952-8349
• If you don't want to come to the hearing alone, you
can bring a friend, an attorney, or anyone else. You
must get the other person yourself.
• You may get free legal help at your local legal aid
office or welfare rights group.
• Hearing File: If you ask for a hearing, the State
Hearing Office will set up a file. You have the right
to see this file. The State may give your file to the
Welfare Department or the U.S. Department of Health
and Human Services (W&I Code Section 10950)
HOW TO ASK FOR A STATE HEARING
The best way to ask for a hearing is to fill out this page.
Make a copy of the front and back for your records. Then,
end or take this page to:
Administrative Adjudications Division
State Department of Social Services
744 P Street, Mail Station 19-37
Sacramento, CA 95814
Another way to ask for a hearing is to call
1-800-952-5253, TDD: 1-800-952-8349.

I want a hearing because of a Medi-Cal related
action by the Mental Health Plan of San
Francisco County.
Here's why:

I want the person named below to represent me
at this hearing. I give my permission for this
person to see my records or come to the hearing
for me.

Name _______________________________
Address _______________________________________

I need an interpreter at no cost to me. My
language or dialect is: _______________________

My name _______________________________
Address _______________________________________
Phone: _______________________________________
My signature: _____________________________
Date: _____________________________
Medi-Cal Specialty Mental Health Program
NOTICE OF ACTION B

Date: ________________

To: __________________
   (Name)
   __________________
   (Street)
   __________________
   City State Zip

The mental health plan for San Francisco County has □ denied □ changed or □ returned your provider's request for payment of the following service(s):

The mental health plan took this action for the reason checked below:

□ Your mental health condition as described by your provider does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (see the state rule at Title 9, California Code of Regulations (CCR), Section 1820.205).

□ Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services (see the state rule at Title 9, CCR. Section 1830.205).

□ Your mental health condition is not likely to be improved by the requested service (see the state rule at Title 9, CCR. Section 1830.205(b)(3)(A) and (B)).

□ The service requested is not covered by the mental health plan (see the state rule at Title 9, CCR. Section 1810.345).

□ The mental health plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.

□ Instead of the service requested by your provider, based on the available information on your mental health condition and service needs, the following services are approved:

□ Other: __________________

Top Copy - Consumer
2nd Copy - Assessor/Authorizer
3rd Copy - HCA Office, 1880 Howard St., SF, CA 94109
The request was made by:

[Signature]

If you don't agree with the plan's decision, you may do one or both of the items checked below:

☐ You may file a complaint or grievance with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at Consumer Relations. (415) 255-3433, or write to Quality Management, Community Mental Health Services, 1380 Howard, 5th Floor, San Francisco, CA 94103, or follow the directions the mental health plan has given you.

☐ You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at the Access Helpline. ((415) 255-3737, toll free 1-888-246-3333. TDD 1-888-484-7200), or write to Access Authorization Program, 1380 Howard, 2nd Floor, SF, CA 94103.

☐ You may request a state hearing. The last page of this notice explains how you may do that.

☐ You may request a state hearing. Because the services requested were previously approved by the plan for the period, your services may continue while you wait for a hearing if you request a hearing within ten days of this notice. The last page of this notice explains how to request a hearing.
HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of San Francisco County.

Here's why:

[Blank lines]

☐ Check here and add a page if you need more space.

I want the person named below to represent me at this hearing. I give my permission for this person to see my records or come to the hearing for me.

Name _____________________________
Address ___________________________

I need an interpreter at no cost to me. My language or dialect is: _______________________

My name __________________________
Address ___________________________
Phone: _____________________________
My signature: _______________________
Date: _____________________________
October 26, 1998

James W. Dilley, M.D.
Executive Director,
UCSF AIDS Health Project
1855 Folsom Street, Suite 670
San Francisco, CA 94103

Dear Jim:

Thank you for your letter on behalf of the Ryan White Mental Health Provider Workgroup regarding the issue of maximizing MediCal matching funds for HIV/AIDS clients receiving CARE funded mental health services. As you know, we have set up a meeting to discuss the issue for November 2, 1998, 1:00 p.m. 1380 Howard Street, Fiscal Conference Room, 4th floor. I look forward to seeing you then.

Before the meeting I wanted to respond to the questions posed in your letter and present a draft plan for addressing the problems. Wayne Clark from CMHS has been working on this plan and we hope that it is responsive to some of your issues and creates an efficient and effective method of serving the mental health needs of persons with AIDS.

The following is our response to the questions raised in your October 9, 1998 letter.

1. **What is the best structural relationship for the nature of the contractual arrangement?**

   CMHS would recommend that the AIDS Office General Funds and the Ryan White funds be transferred to the Mental Health contractors with existing CMHS contracts (see the Plan). The program would then become another component in the providers contract with CMHS, reporting of Ryan White service units through Reggie would continue, all other services would be accounted for and billed through CMHS BIS.

   **Is it possible that for CMHS to function as a fiscal agent, not as a “funder”?**

   We are not sure of the difference you are making here, in general we do not consider ourselves as a fiscal agent, but as a funder of mental health services.

2. **Would the CARE mental health providers be seen as System of Care providers?**

   Yes, for those contractors that will be MediCal certified by March 1999.

   **Would the CARE mental health providers be reimbursed for services at System of Care rates?**
We would first analyze and review the current rates paid by the AIDS Office and negotiate a comparable rate structure.

3. Do System of Care clients have a different standard for authorization for service and benefit package than Provider Network clients?

No, clients are authorized for mental health services in the San Francisco Mental Health Plan based on state of California medical necessity criteria.

4. In your view, would the proposed system work like this; if a client is HIV positive, meets medical necessity criteria and has Medi-Cal then they will be billed to CMHS Medi-Cal; if the client is HIV positive, and does not have Medi-Cal then they will be billed to Ryan White, regardless of medical necessity?

Yes, the goal is to provide mental health services for all HIV positive clients.

5. How will CMHS/AIDS Office contractors be assured that they will continue to provide services on the basis of their best clinical judgment?

The San Francisco Mental Health System is a clinically driven system with the clients and the providers best interest taken into account. Best clinical judgment relies on clinical need that is based on medical necessity criteria. We have had a surprisingly low rate of provider versus Access Team disagreement on level of service needed.

6. Is it possible to consider the Workgroup providers as "walk-in sites"?

Yes, a client seeking an assessment at any clinic can call the Access Team from the clinic, have a brief interview and be authorized for services.

Can the workgroup perform the initial assessments and authorize care in collaboration with the Access Team, much like some System of Care clinics currently do?

Yes as described above, a new client can be at a clinic, call the Access line, be authorized and get services at that clinic.

I hope the above and the attached plan gets us on the way to resolving the issue of funding for mental health services and allows us to concentrate efforts on the best quality services for our clients. We look forward to seeing you at the November 2nd meeting.

Sincerely,

Jo Ruffin, LCSW
Director

Attach.

cc: Wayne Clark, Ph.D.
FIRST DRAFT

A PLAN FOR MAXIMIZING REVENUES FOR
AIDS MENTAL HEALTH SERVICE SYSTEM

I. Background
   A. During the 98-99 planning process, the AIDS planning council significantly reduced the funding for outpatient mental health services for people with AIDS. The council anticipated that in some way the city would have financial resources to pick up these services and that Medi-Cal funding could be applied to a number of the clients being served. The simplicity of this idea belied the complexity of the Medicaid funding system and led to the reinstatement of the funds for the remaining portion of the 98-99 Ryan White fiscal year.
   
   An AIDS and Mental Health work group was formed to better analyze the data on who was being served and to get a report to the planning council. The report was presented in the spring of 1998. The AIDS mental health work group has continued to meet to develop a comprehensive and coherent plan for the maximizing of Medicaid funds for PWA in need of mental health services.
   
   This plan for maximizing mental health Medi-Cal funds identifies the key issues needed to be addressed and presents the most productive alternatives.

II. The plan
   A. Implementation timetable
      
      The group recommends a two-phase implementation timeline. The first phase will demonstrate through one existing provider the best contractual and financial mechanisms for serving people with AIDS with mental health problems. The provider will be set up in the Mental Health system as a certified Medi-Cal provider, and the billing for clients will occur through the CMHS billing information system. We will modify the contractual relationship to reflect an additional revenue source, in this case Medi-Cal and reduce the Ryan White obligation accordingly. There are many technical details involved in this dual contractual and billing procedure and therefore the demonstration through one provider will provide a blueprint for the second phase of the plan. The billing is scheduled to start on December 1, 1998. The goal is to have the technical billing aspects of the reporting relationship be invisible to the clinics, minimize paperwork, and assure quality care to the clients.
      
      The second phase will begin operations on March 1, 1999 and bring online current providers that have both a mental health and an AIDS Office contract to begin billing Medi-Cal. These providers include: FSA, Instituto, UCSF Deaf program, New Leaf, and the AIDS Health Project. These programs are already Medi-Cal certified and the contractual relationship will mirror the set up established in the phase one demonstration. Providers that do not have a current contract with CMHS (Native American Health Services, GAPA, Iris) or are FQHC Health Centers (Health Ctr. 1) will not be included until the next fiscal year if at all. The majority of clients seen 80-90% are seen in the
overlap clinics and therefore the Medi-Cal maximization will substantially be accomplished through the existing contractors.

While the phase one program demonstrates appropriate mechanisms, DPH staff will work with the phase two programs to get them ready for a March 1, 1999 implementation.

III. The details

A. Rates for service are currently being analyzed to bring the CMHS Medi-Cal rates and the Ryan White rates in line. This should standardize the rate structure for similar mental health services across revenue sources.

B. Billing in the first phase with only one provider (CSP) will enable CMHS and the AIDS Office to fully test mechanism that assure non-duplication of bills. In addition to assuring that each program is Medi-Cal certified, we will also be defining the protocols for service entry into CMHS billing system and HIV billing systems. Due to the complexity of FQHC Medi-Cal billing we will concurrently be investigating the best practice for setting up Health Center 1 to maximize Medi-Cal billing. Also we will work with any of the other providers that are not Medi-Cal certified (as of March 1999) to get them certified.

C. Contracting for services will either be performed by the AIDS Office or CMHS depending on the simplest and most accountable method for reimbursing the clinics. One approach is to place the AIDS mental health service in current CMHS contract as an additional component. A full budget and narrative will be presented and the contractor will only see that there are different revenue streams (e.g. General Fund, Medi-Cal, Ryan White). The contractor will submit all Medi-Cal billings to CMHS through the BIS and Reggie billings through CMHS to the AIDS Office.

D. General funds needed: The data provided to date on the clinics in phase one and two indicate that approximately 35% of the clients are Medi-Cal enrolled and meet Mental Health medical necessity criteria. It is then possible to estimate the annual general fund match that will need to be applied to make the programs whole. The analysis shows that $2,681,000 is spent annually on outpatient mental health services through Ryan White. The phase one and two programs account for 81% or $2,159,828. If we estimate that 30% of the $2,159 mil. ($647,948) are potentially billable to Medi-Cal that means that $323,975 of federal Medi-Cal funds could be allocated to those outpatient programs. The General fund obligation would then need to be $526,025 ($850,000 less $323,975). We would recommend that the AIDS Office, CMHS and the Health Department ask for $526,025 of general funds for the next Federal Ryan White fiscal year. Budget planning needs to take into account that the Federal fiscal year begins before the end of the current City fiscal year and Medi-Cal and general funds will need to be allocated this fiscal year beginning in March 1999.
October 9, 1998

Jo Ruffin
Director
Community Mental Health Services
1380 Howard Street
San Francisco, CA 94103

Dear Jo:

As you know, for some months now the Ryan White Mental Health Provider Workgroup has been discussing the issue of maximizing MediCal matching funds for HIV/AIDS clients receiving CARE funded mental health services. To achieve this goal, we have been discussing a new contract configuration for providers that would involve a mix of CARE dollars, General Fund dollars and federal Medi-Cal matching dollars obtained through billing CMHS for eligible services.

It appears that a plan is being proposed that would have CMHS receiving AIDS general funds that CMHS would, in turn, contract out to the existing Mental Health Providers.

This suggestion was met with interest. However, before proceeding further in our planning process, we would like to discuss several issues about how this plan might influence service delivery. As such, I am writing on behalf of the Workgroup to pose several questions about the implications of such a plan.

Questions

1. What is the best structural relationship for the nature of the contractual arrangement? For example, since the funds from the AIDS office are “special population” funds is it possible that for CMHS to function as a fiscal agent, not as a “funder”?

2. Would the CARE mental health providers be seen as System of Care providers and reimbursed for services at those rates?

3. Do System of Care clients have a different standard for authorization for service and benefit package than Provider Network clients?

4. In your view, would the proposed system work like this; if a client is HIV positive, meets medical necessity criteria and has Medi-Cal then they will be billed to CMHS Medi-Cal; if the client is HIV positive, and does not have Medi-Cal then they will be billed to Ryan White, regardless of medical necessity?
5. How will CMHS/AIDS Office contractors be assured that they will continue to provide services on the basis of their best clinical judgment?

6. Is it possible to consider the Workgroup providers as "walk-in sites" where we would perform the initial assessments and authorize care in collaboration with the Access Team, much like some System of Care clinics currently do?

Discussion of these questions will be helpful in our deliberations and will be essential in our quest to finalize a report to the Ryan White Planning Council on our recommendations for future funding for mental health services for people with HIV in San Francisco.

We look forward to talking with you, and would ask that your office suggest some times for a meeting to discuss these issues. Thank you in advance.

On behalf of the Working Group,

James W. Dilley, MD
Executive Director
UCSF AIDS Health Project

cc: Michelle Dixon, Director, AIDS Office
Russ Zellers, Associate Director, AIDS Office
Wayne Clark, SFDPH Community Mental Health Services
Laura Feren, Family Service Agency of San Francisco
Estella Garcia, Instituto Familiar de la Raza
Charlotte Moore, Iris Center
Joe Neisen, New Leaf
Melissa Bloom, SFDPH HIV Mental Health Case Management Program
Michael Lipp, SFDPH Community Public Health Services
Mental Health Workgroup Meeting  
March 17, 1999  
Wednesday, 9:00 a.m. – 10:30 a.m.

Community Members: Jim Dilley, Laura Feren, Marianne O'Connor

DPH Staff Present: Melissa Bloom, Wayne Clark, Michael Lipp, Russ Zellers and Aida Corpuz

I. Letter to the Mayor

Laura suggested that the group should send a letter to the Mayor or Bill Barnes and/or Mitch Katz to remind them of their commitment last year. Laura asked the group what exactly they would like to say in the letter. The letter will remind the Mayor and Mitch that $500,000 is needed in city General Fund dollars as a match for Medi-Cal.

II. Update on Funding

Jim Dilley asked if the Department of Public Health's General Fund problem has been resolved. Michael Lipp mentioned that they received an e-mail from Jan Murphy who is the head of the Primary Care for CHN. There will be no lay-offs, no closing of any programs but there will be a hiring freeze. The newspaper reports that the Mayor is taking $26,000,000 from the $145,000,000 General Fund surplus and transferring it to the Department of Public Health.

III. Report to the Planning Council

Russ said that the Planning Council just started their prioritization process for year 2000-2001 and he suggested that the workgroup postpone making a report to the Planning Council rather information can be presented during prioritization.

IV. Integrated Service Program Meeting on March 25

Russ announced that there will be a meeting scheduled on March 25 from 11:30 – 3:00 p.m. to discuss the further collaboration of Outpatient Mental Health, Outpatient Substance Abuse, and Residential Substance Abuse with the integrated service sites. The three co-chairs of the Planning Councils are scheduled to be present for the meeting. The idea of the meeting is to extend mental health and substance abuse services to the most severe need populations through integrated service delivery systems.

V. Federal Grant

Wayne mentioned that a grant application process has been announced for HIV and mental health $1.7 million a year will be made available for the next 5 years to fund 3 to 5 projects on mental health and HIV issues. One of the issue that they are looking is the impact of managed care on HIV clients.

The next meeting is scheduled for Wednesday, April 14, 1999 from 9:00 a.m. to 10:30 a.m. in the AIDS Office Training Room A.
Memo

To: Wayne Clark, PhD
From: Christopher Hall (415) 476-6440
Date: March 23, 1999
RE: Transmittal of PURQC proposal and agreement

Enclosed, please find a copy of the PURQC proposal, signed by Jim Dilley. Presuming that the document meets with your approval, I would ask that you sign the document, retain a copy for your records, and forward a copy to:

Michael McGrenra, LCSW
UCSF/AHP
Box 1312
San Francisco, CA 94143-1312

Michael McGrenra is the AHP contact for this action. Please direct any needs for revision, or questions to him at 476-3598.

cc: Michael McGrenra
    Joanna Rinaldi
    James Dilley, MD
A. **PURQC Membership**

The PURQC shall be comprised of three members

- George Harrison, MD
- Michael McGrenra, LCSW
- Lorraine Thoemmes, MFCC

B. **Record of PURQC Meetings**

The committee will meet every Thursday at 11:00 AM, at the AIDS Health Project Services Center. A confidential record of actions will be maintained in a binder in a secure location. A form has been developed for this purpose. This documentation will include the date of the meeting, names of those in attendance, a list of approved reauthorization requests, disapproved reauthorization request, requests which have been returned to the clinician for further clarification, and a summary of intensive reviews.

C. **Approval of Routine CM Requests**

All service intensity assignments and reauthorization requests will be reviewed and approved if appropriate. A licensed member of the committee will sign all requests. No member may approve his/her own request.

D. **Intensive Utilization and Quality of Care Review**

A 10% sample of cases will be intensively reviewed on a quarterly basis. The sample will include clients who require intensive services. The committee proposes to complete the intensive review in the following way:

A list of all clients seen within the last quarter will be reviewed. One client will be selected from the caseload of each clinician, repeating until a 10% sample is reached. Cases might be selected for their clinical or cultural complexity, high service use, acute service use, or non-adherence. The review process will address the following issue:

- Documentation
- Adherence to policy
- Safety
- Appropriateness of treatment
- Development of care plan with attention to diagnosis and cultural components
- Treatment outcomes
- Additional treatment needs

Those cases found to have problems will be referred to an AHP case conference for problem solving. If problems persist, the case may be referred to CMHS high
A record of intensive review findings will be maintained.

E. PURQC Monitoring and Oversight

A committee of Quality Management and SOC monitors will serve to review the functioning of the individual PURQC.

Program Director Signature: [Signature]

Date: 3/22/89

Approval Signature: 

Date: 

## FY 99-00 OUTPATIENT MENTAL HEALTH BUDGET

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Summary Request

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The Medi-Cal plan for the AIDS Ryan White cuts is getting concrete.

The pilot period for FY 98-99 Ryan White only used $30,000 in General Fund and $30,000 in Medi-Cal.

Beginning March 1 through June 30 there will need to be an additional $180,000 of general fund dollars, $120,000 available for Medi-Cal match and $60,000 available for the other programs.

The AIDS Office will only use $43,333 of that $60,000 and there will be $16,667 of General Funds still available.

For City FY 99-00 the AIDS Office will only use $150,000 of the $150,000, so there will be $20,000 general funds still available.

For City FY 99-00, using the same percentages of Medi-Cal there will be a $360,000 medi-cal match to general fund and $10,000 of the AIDS Office general fund unallocated.

There is approximately $16,667 GF left in FY98-99 and $10,000 GF left in FY 99-00.
**COMMUNITY MENTAL HEALTH SERVICES**
**CLIENT SERVICE AUTHORIZATION**

Client Care Manager: ____________________________ Staff # ____________ □ Care Mgr Clinic: ____________________________ RU#: ____________________________

Client Name: ____________________________ BIS#: ____________________________ Date Form Completed: __/__/____

DSM IV Diagnosis as of ____/____/______ Diagnosing clinician’s name: __________________________________________

Include secondary Substance Abuse diagnosis if applicable. Check box next to Primary diagnosis.

Axis 1: ☐ ☐ ☐ ☐ ☐ Axis 2: ☐ ☐ ☐ ☐ ☐ Axis 3/Medical Condition: __________________________________________________________________________

Primary Care MD: ____________________________ Phone: ____________________________

Axis 4: ____________________________ Axis 5 (GAF): ____________________________

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Totals:

Justification

__________________________________________________________________________________

Signatures:

__________________________________  _________________________  ____________________
Care Manager                      Date                           PURQC Approval

CMHS form
UR 04 (rev 1/22/99)

*****CONFIDENTIAL INFORMATION*****
Instructions
Client Service Authorization (CSA)

♦ Check only one Service Type per row. Use additional sheets if necessary.

♦ Incomplete CSAs will delay processing – be sure to include program name, RU, quantity and date range of services being authorized.

♦ The following services do not need authorization, but should be included in the client’s Plan of Care: Socialization, Vocational Rehab, Acupuncture.

♦ Do not use this form for Residential Treatment or Inpatient services, they are authorized by other means.

♦ When authorizing Adult Day Treatment, be sure to include authorization for Mental Health Services to cover the Initial Assessment, Medication Services, etc. This should be listed on a separate line.

♦ This is an authorization form, not a referral document.
Mental Health Workgroup Meeting  
Sept. 16, 1998  

Present: Melissa Bloom, Wayne Clark, Jim Dilley, Estella Garcia, Mike Lipp, Daniel Langholtz, Joe Neissen, Russ Zellers  

Absent: Laura Feren, Charlotte Moore  

Announcements:  

1. Dick Pabich, AIDS Policy Advisor to the Mayor has resigned due to health considerations. Bill Barnes will stand in for him until a new person is found.  

2. Daniel Langholtz announced that Peggy Kennedy (?) will be joining the group from UCSF Center on Deafness.  

3. Russ announced that Maria Martinez would no longer be attending our meetings.  

I. OLD BUSINESS  

A. Future meetings: The group decided to meet every other week, at 9:00 AM, at least until November 1st.  

B. RW Planning Council suggestion: analyze and negotiate down the caps for long and short term mental health services. This “recommendation” is thought to be in the event of reduced CARE funds, though the trend appears to be in this direction. Wayne discussed two sets of rates: System of care (chronically, seriously mentally ill—the “old” cluster clients and managed care (everyone else under the new guidelines). We also discussed the comparability of rates for contractors that have both CMHS and CARE contracts. Contrary to common belief the rates are in fact, very similar. (Note: previously Jo Ruffin agreed that HIV/AIDS clients were “medically complex” and thus eligible for higher reimbursement).  

C. Discussion of our report to the Planning Council (See handout from Wayne Clark)  

Action steps in preparing the report:  

1. Summarize background/findings  
   Melissa, Jim, Estella will meet Monday, 9/21 at 1PM at AHP to review the existing report and work on a summary.  

2. Estella will write a paragraph on maintaining AIDS MH system for the intro; highlighting the importance of the expertise of existing service providers.  

3. Phase I agencies (those with existing CMHS contracts) will report back to Wayne by 9/23 in an attempt to identify the largest possible numbers of clients who could be billed to Medi-Cal (those who both have Medi-Cal and meet medical necessity).
4. Russ will explore contracting and billing issues. Russ' view is that Medi-cal billing needs to be up and running by March 1st.

5. Wayne will look into billing requirements & data system in an attempt to establish an implementation plan for bringing on those CARE providers who do not have CMHS contracts.

D. Strategy Discussion

Agreed that Mitch Katz and Mayor's AIDS Policy Advisor were important people to promote our plan to maximize funding. Agreed that CMHS and AIDS Office are already on board; yet the lynchpin of the project will be to ensure that General Fund dollars are shifted over to allow for Medi-cal matching—something that will require support from Mitch and possibly the Mayor.

E. Coordination with Planning Council

Melissa reported speaking to Lisa ____ who is very supportive and wishes to receive our meeting minutes. Estella to Jorge----

Jim and Joe Neissen will meet with Bill Barnes next week to update him on our work and the need for general fund dollars to allow for Medi-cal matching.

Jim will also meet with Bart Casimir.

Next meeting Sep 30, 1998 -- 9:00 to 10:30 AM at AIDS Office
Date: August 12, 1998

To: AIDS Mental Health Work Group

From: Wayne Clark PhD

Subject: 99-00 AIDS Mental Health Priorities

The AIDS Planning Council Steering Committee met on August 10, 1998. I attended this very long meeting and was somewhat disappointed about the eventual results and translation of last Wednesday's meeting. I have attached the translation below (entitled 1999-2000 Prioritization Plan). The co-chairs stated that they thought there were at least four consensus items that the group agreed to:

- Support additional integrated services,
- provide psychiatric assessments in a variety of places,
- connect psychiatric case management to emergency rooms, and
- increase services to racial ethnic minority populations.

I had to object to the above list since it did not include the work groups' recommendations (see below) and completely ignored the data from the work group such as the fact that 40% of current clients are racial ethnic minorities. The implication that we were not doing enough was wrong. Instead we should be commended for doing so much and encouraged to do more. I also stated that the implication that more integration was needed belied the testimony from the providers about the MOU's and extensive networking that was developed during the past year. Further stating that the troika has been saying throughout the last month that year two could not move in even more radical directions since we did not have the results from year one. Suffice to say we did not complete the recommendations for the full council meeting next Monday (the 17th).

Two other points that I made were the recommendation regarding psych case management linked to PES was based on one clinician's perception from PES. Moreover, if the Council was informed they would know that there are at least two existing resources for that linkage, such as CRT and AHP. I finally went off on the SFGH psych bed item, saying that it was one person's opinion, the impact on SFGH was not explored, and it was at best reckless and at worse irresponsible.

Another thing is the troika is unwilling to place reinstatement of the $850,000 as one of the strategies or as one of the things to do with extra money.

The next three meetings of the planning council will be on Mondays from 4:30PM-7:30 PM. The meeting dates are August 17, 24, and 31. The full council prioritization process starts this next meeting at about 6:30PM and then becomes the primary agenda item the 24th and 31st.

Here are the work groups recommendations:
After some discussion of what the priority for mental health services should be, the group
### Mental Health Medi-cal eligible clients estimate, based on two clinics

<table>
<thead>
<tr>
<th>Multi-CMHS/CSP</th>
<th>CMHS/CSP</th>
<th>Long and Short</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Project-CHN</td>
<td>total</td>
<td>Medi-Cal Health Case M</td>
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</table>

<table>
<thead>
<tr>
<th>Caseload or unduplicated clients</th>
<th>Number</th>
<th>Caseload</th>
<th>Case</th>
<th>Number</th>
<th>Caseload</th>
<th>Caseload</th>
<th>Case</th>
<th>Number</th>
<th>Caseload</th>
<th>Caseload</th>
<th>Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current total medi-cal enrolled</td>
<td>42</td>
<td>100%</td>
<td>142</td>
<td>100%</td>
<td>107</td>
<td>75%</td>
<td>100%</td>
<td>149</td>
<td>56%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Current non-Medi-cal</td>
<td>84</td>
<td>67%</td>
<td>35</td>
<td>25%</td>
<td>119</td>
<td>44%</td>
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</tr>
<tr>
<td>Current total diagnosis included</td>
<td>33</td>
<td>26%</td>
<td>79%</td>
<td>83</td>
<td>58%</td>
<td>78%</td>
<td>116</td>
<td>43%</td>
<td>78%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current total diagnosis excluded</td>
<td>9</td>
<td>7%</td>
<td>21%</td>
<td>24</td>
<td>17%</td>
<td>22%</td>
<td>33</td>
<td>12%</td>
<td>22%</td>
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</tr>
</tbody>
</table>

Page 1
### Mental Health

<table>
<thead>
<tr>
<th>Sub-category</th>
<th>ProjAllo</th>
<th>Change</th>
<th>Rationale for Change</th>
<th>PropAllo</th>
<th>Rationale</th>
<th>Severe Need (Priority Population)</th>
<th>Target Services</th>
<th>If more $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long/short term psycho-therapy</td>
<td>$2,681,139</td>
<td>($850,000)</td>
<td>Doesn’t focus on populations of severe need. Re-direct to crisis, triage and short term services focused to Multiply dx, youth, women, people of color, homeless, children and AIDS dementia</td>
<td>$1,831,139</td>
<td>Multiply dx, youth, women, people of color, children, homeless, severely mentally ill, AIDS dementia assistance</td>
<td></td>
<td>Cut long-term, but do more analysis regarding who is using long term services. Re-direct to crisis, triage, and short-term</td>
<td>Expand youth and pre-crisis services, develop prevention and early intervention for HIV Dementia</td>
</tr>
<tr>
<td>Psych consult</td>
<td>$445,613</td>
<td>$0</td>
<td>Triage linked to Prim Care and Sub Abuse Tx</td>
<td>$445,613</td>
<td></td>
<td></td>
<td>Triage linked to Prim Care and Sub Abuse Tx</td>
<td></td>
</tr>
<tr>
<td>Crisis</td>
<td>$436,404</td>
<td>$0</td>
<td></td>
<td>$436,404</td>
<td></td>
<td></td>
<td>Develop harm reduction models for triply diagnosed. More in-home, “one stop” models</td>
<td></td>
</tr>
<tr>
<td>Residential Care</td>
<td>$977,412</td>
<td>($350,000)</td>
<td>Underutilization</td>
<td>$627,412</td>
<td>Cut Chateau Agape</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>$4,540,568</td>
<td>($1,200,000)</td>
<td></td>
<td>$3,340,568</td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Goals and Outcomes:**

- Triage to link primary care, substance abuse, case management.
- Develop Harm Reduction models for triply-diagnosed.
- Allow use of psych meds in Substance Abuse Treatment programs.
- Develop more in-home and "one-stop" models.
- Create a Mental Health drop-in center for PLWHIV with mental problems including depression (Staff includes Case Managers and Peer Advocates)
- Develop early intervention programs for HIV Dementia.

**Linkages to Other Available Resources**

CMHS for ongoing and long term psychiatric treatment.

**Linkages to other CARE Programs**

- Primary Care, Substance Abuse, Rehabilitation: Dementia Care, Hospice and Home Health.
DATE: Friday, August 14, 1998

TO: James Dilley MD, UCSF, AHP

FAX: 502 7271

FROM: Wayne Clark S.F.D.P.H.

PAGES: 2

MEMO

Jim: Back of this page is coming next.
wayne
MENTAL HEALTH QUESTIONNAIRE
SERVICES PROVIDED

TYPES OF SERVICE PROVIDED
Number of Clients Who Received:

___ Crisis
___ Assessment and Triage
___ Short term individual counseling/psychotherapy (< 24 hours per year for a single client)
___ Long-term individual counseling/psychotherapy (> 24 hours per year for a single client)
___ Short term group (< 24 hours per year for a single client)
___ Long-term group (> 24 hours per year for a single client)
___ Neuropsych Evaluations
___ Psychiatric services (evaluations, medication monitoring, etc.)
___ Case Management
___ Other (please specify: ______________________)

Percentage of Total Hours During FY 97-98:

3%___ Crisis (non-M.D.)
11%___ Assessment and Triage (non-M.D.)
24%___ Short term individual counseling/psychotherapy (< 24 hours per year for a single client) (non-M.D.)
32%___ Long-term individual counseling/psychotherapy (> 24 hours per year for a single client) (non-M.D.)
2%___ Short term group (< 24 hours per year for a single client) (non-M.D.)
5%___ Long-term group (> 24 hours per year for a single client) (non-M.D.)
3%___ Neuropsych Evaluations (non-M.D.)
9%___ Psychiatric services (evaluations, medication monitoring, etc.)
12%___ Case Management

WAIT LIST
As of today, does your program have a wait list for non-Psychiatric services? 4 programs Yes 5 programs No 3 programs Unknown
If yes, how many people are on the wait list? 63____

As of today, does your program have a wait list for Psychiatric services? 0____ Yes 8____ No 1 Non-Applicable 3 Unknown
If yes, how many people are on the wait list? 0____
DEMOGRAPHICS

TOTAL NUMBER OF CURRENT CLIENTS (SEEN SINCE JANUARY 1, 1998) 
REPORTED: 1429

GENDER
(count each client only once)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count (as a percentage of the total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>85.02%</td>
</tr>
<tr>
<td>Female</td>
<td>12.95%</td>
</tr>
<tr>
<td>Transgender</td>
<td>1.75%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0.28%</td>
</tr>
</tbody>
</table>

AGE

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Count (as a percentage of the total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 Years or Under</td>
<td>0.00%</td>
</tr>
<tr>
<td>13-19 Years</td>
<td>0.77%</td>
</tr>
<tr>
<td>20-44 Years</td>
<td>76.07%</td>
</tr>
<tr>
<td>45 Years or Older</td>
<td>22.88%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0.35%</td>
</tr>
</tbody>
</table>

CHILDREN

Number of clients with dependent children (under the age of 18 living with the client): _______

HIV DIAGNOSIS
(count each client only once)

<table>
<thead>
<tr>
<th>HIV Status</th>
<th>Count (as a percentage of the total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV negative</td>
<td>0.35%</td>
</tr>
<tr>
<td>HIV positive (not AIDS) Dg within</td>
<td>2.38%</td>
</tr>
<tr>
<td>HIV positive (not AIDS) Dg over 1 year</td>
<td>51.61%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIV Status</th>
<th>Count (as a percentage of the total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>40.76%</td>
</tr>
<tr>
<td>Unknown</td>
<td>4.90%</td>
</tr>
</tbody>
</table>

RACIAL/ETHNIC HERITAGE
(count each client only once)

<table>
<thead>
<tr>
<th>Heritage</th>
<th>Count (as a percentage of the total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White (non-Hispanic)</td>
<td>61.20%</td>
</tr>
<tr>
<td>Black (non-Hispanic)</td>
<td>15.30%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>15.08%</td>
</tr>
<tr>
<td>Asian/Pacific Islander (including Filipino/a)</td>
<td>2.18%</td>
</tr>
<tr>
<td>Native American/Aleutian/Na Alaskan/Eskimo</td>
<td>1.96%</td>
</tr>
<tr>
<td>Other</td>
<td>2.54%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1.74%</td>
</tr>
</tbody>
</table>

LANGUAGE PREFERENCE
(count each client only once)

<table>
<thead>
<tr>
<th>Language</th>
<th>Count (as a percentage of the total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>90.81%</td>
</tr>
<tr>
<td>Spanish</td>
<td>6.95%</td>
</tr>
<tr>
<td>Tagalog/Ilocano</td>
<td>0.08%</td>
</tr>
<tr>
<td>Mandarin</td>
<td>0.08%</td>
</tr>
<tr>
<td>Other (please specify: Includes .52% American Sign Language)</td>
<td>1.04%</td>
</tr>
</tbody>
</table>

CURRENT LIVING SITUATION

<table>
<thead>
<tr>
<th>Living Situation</th>
<th>Count (as a percentage of the total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>street, park, car or abandoned building</td>
<td>9.88%</td>
</tr>
<tr>
<td>shelter</td>
<td>0.38%</td>
</tr>
<tr>
<td>emergency housing, not shelter</td>
<td>0.49%</td>
</tr>
<tr>
<td>living with friend or family and not paying rent</td>
<td>36.97%</td>
</tr>
<tr>
<td>halfway house or drug/alcohol program</td>
<td>3.37%</td>
</tr>
<tr>
<td>single room occupancy hotel room</td>
<td>13.36%</td>
</tr>
<tr>
<td>hospital/institution</td>
<td>5.92%</td>
</tr>
<tr>
<td>jail/incarcerated</td>
<td>3.37%</td>
</tr>
<tr>
<td>renting or own house, apartment or flat</td>
<td>19.82%</td>
</tr>
<tr>
<td>other</td>
<td>1.52%</td>
</tr>
<tr>
<td>unknown</td>
<td>4.94%</td>
</tr>
</tbody>
</table>
MONTHLY INCOME FOR INDIVIDUAL CLIENTS (NOT HOUSEHOLD)

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>$350 or Below</td>
<td>29.49%</td>
</tr>
<tr>
<td>$350 - $660</td>
<td>28.44%</td>
</tr>
<tr>
<td>$661 - $1,200</td>
<td>30.89%</td>
</tr>
<tr>
<td>$1,201 - $2,630</td>
<td>7.41%</td>
</tr>
<tr>
<td>Above $2,630</td>
<td>2.52%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1.26%</td>
</tr>
</tbody>
</table>

SOURCE OF INCOME (specify all that apply)

- 16.72% GA
- 0.14% TANF
- 4.27% Food Stamps
- 9.66% Salary
- 0.70% Unemployment Benefits
- 0.56% Veteran’s Benefits
- 34.85% SSI
- 18.12% SSDI
- 2.94% State Disability Insur.
- 3.92% SSA Retirement
- 3.36% Long-term Disability
- 16.86% Other

EMPL-OYMENT STATUS (count each client only once)

- 3.78% Full Time (30 or more hours per week)
- 6.14% Part Time (< 30 hours per week)
- 19.09% Not Employed
- 48.49% Unknown
- 22.50% Disabled

TYPE OF HEALTH CARE COVERAGE (count only primary coverage)

- 2.57% Private Insurance (include HMO’s)
- 1.64% Kaiser
- 33.54% Medi-Cal/Medicaid
  - Count clients who have applied and are awaiting administrative approval as well as clients who have Medi-Cal through a private insurance company.
- 25.27% Medicare
- 6.11% Other Public Insurance
  - Includes CARE funded primary care clinics, Champus, VA, Wker’s Comp and IHS
- 25.17% Uninsured
- 5.70% Unknown

HEALTH INSURANCE FOR MENTAL HEALTH SERVICES

- 30.67% No coverage
- 6.19% Emergency or short-term only (24 or fewer sessions per year)
- 0.76% Over 24 sessions per year
- 62.38% Unknown
TYPES OF CLIENTS SERVED
AND SEVERITY OF NEED
(ALL CLIENTS)

Please provide information here on all clients seen since January 1, 1998.

DSM-IV DIAGNOSES
Using the DSM-IV categories, please list the types of diagnoses served by this contract exhibit. (Please do not use diagnostic numbering codes.) Show the number of clients with primary and secondary diagnosis for each diagnostic category listed.

<table>
<thead>
<tr>
<th>NUMBER PRIMARY</th>
<th>NUMBER SECONDARY</th>
<th>DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

SEVERITY INDICATORS
Specify the number of clients with:

A mental health impairment so severe as to affect ability to access Primary Care services or adhere to medical treatment for HIV: 28.20%_____

History of suicide: 30.44%_____

Violent behavior within the last year: 16.38%_____

History of violent behavior prior to the preceding year: 17.49%_____

Homicidal ideation within the last year: 8.40%_____ 

History of physical or sexual abuse: 41.08%_____

INTENSITY OF SERVICES REQUIRED
Specify the number of clients who:

Need day treatment, sub-acute, or residential mental health treatment to maintain stability and avoid acute care: _ 15.89%_____

Have had one or more psychiatric hospitalizations within the last 12 months: 14.07%_____

Have taken psychotropic medications since beginning treatment: 52.48%_____

Are considered severely and persistently mentally ill: 30.72%_____

GLOBAL ASSESSMENT OF FUNCTIONING (GAF)
Using the GAF Scale, please indicate the number of clients within each range.

- 0.33%_____ 1 - 10
- 2.77%_____ 11 - 20
- 5.46%_____ 21 - 30
- 9.93%_____ 31 - 40
- 23.86%_____ 41 - 50
- 34.61%_____ 51 - 60
- 14.74%_____ 61 - 70
- 8.14%_____ 71 - 80
- 0.16%_____ 81 - 90
- 0.00%_____ 91 - 100

MULTI-DIAGNOSED
Number of current clients who have an active substance abuse/dependency problem that warrants treatment or will affect client’s ability to access care along with an active psychiatric illness that warrants treatment or will affect client’s ability to access care: 37.30%_____

AIDS DEMENTIA
Number of clients with diagnosis of:
HIV-Related Cognitive Impairment 7.63%_____
AIDS Dementia 3.71%_____

4
TYPES OF CLIENTS SERVED AND SEVERITY OF NEED (LONG-TERM CLIENTS)

Please provide information here only on clients who have received over 24 sessions per year (Long-term clients).

DSM-IV DIAGNOSES
Using the DSM-IV categories, please list the types of diagnoses served by this contract exhibit. (Please do not use diagnostic numbering codes.) Show the number of clients with primary and secondary diagnosis for each diagnostic category listed.

<table>
<thead>
<tr>
<th>NUMBER PRIMARY</th>
<th>NUMBER SECONDARY</th>
<th>DIAGNOSIS</th>
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</tbody>
</table>

SEVERITY INDICATORS
Specify the number of clients with:

A mental health impairment so severe as to affect ability to access Primary Care services or adhere to medical treatment for HIV: 34.95%_____

History of suicide attempts: 28.23%_____

Violent behavior within the last year: 18.82%_____

History of violent behavior prior to the preceding year: 25.00%_____

Homicidal ideation within the last year: 10.22%_____

History of physical or sexual abuse: 52.69%_____

INTENSITY OF SERVICES REQUIRED
Specify the number of clients who:

Need day treatment, sub-acute, or residential mental health treatment to maintain stability and avoid acute care: 25.27%_____

Have had one or more psychiatric hospitalizations within the last 12 months: 13.44%_____

Have taken psychotropic medications since beginning treatment: 57.26%_____

Are considered severely and persistently mentally ill: 46.51%_____

GLOBAL ASSESSMENT OF FUNCTIONING (GAF)
Using the GAF Scale, please indicate the number of clients within each range.

1.34%____ 1 - 10
5.65%____ 11 - 20
9.68%____ 21 - 30
18.28%____ 31 - 40
22.85%____ 41 - 50
29.57%____ 51 - 60
10.75%____ 61 - 70
0.00%____ 71 - 80
0.00%____ 81 - 90
0.00%____ 91 - 100

MULTI-DIAINED
Number of current clients who have an active substance abuse/dependency problem that warrants treatment or will affect client’s ability to access care along with an active psychiatric illness that warrants treatment or will affect client’s ability to access care: 45.16%_____

AIDS DEMENTIA
Number of clients with diagnosis of:

HIV-Related Cognitive Impairment _ 5.65%_____
AIDS Dementia 3.23%_____

5
MENTAL HEALTH QUESTIONNAIRE
SERVICES PROVIDED

PROVIDER: __________________________

EXHIBIT: ____________________________

INDIVIDUAL COMPLETING THIS QUESTIONNAIRE:

PHONE: ____________________________

TYPES OF SERVICE PROVIDED
Number of Clients Who Received:

A1 Crisis
A2 Assessment and Triage
A3 Short term individual counseling/psychotherapy (<24 hours per year for a single client)
A4 Long-term individual counseling/psychotherapy (>24 hours per year for a single client)
A5 Short term group (<24 hours per year for a single client)
A6 Long-term group (>24 hours per year for a single client)
A7 Neuropsych Evaluations
A8 Psychiatric services (evaluations, medication monitoring, etc.)
A9 Case Management
A10 Other (please specify: client-related)

Total Hours Spent Providing:

B1 Crisis (non-M.D.)
B2 Assessment and Triage (non-M.D.)
B3 Short term individual counseling/psychotherapy (<24 hours per year for a single client)(non-M.D.)
B4 Long-term individual counseling/psychotherapy (>24 hours per year for a single client)(non-M.D.)
B5 Short term group (<24 hours per year for a single client)(non-M.D.)
B6 Long-term group (>24 hours per year for a single client)(non-M.D.)
B7 Neuropsych Evaluations (non-M.D.)
B8 Psychiatric services (evaluations, medication monitoring, etc.)
B9 Case Management
B10 Other (please specify: client-related)

WAIT LIST

As of today, does your program have a wait list for non-Psychiatric services? C1 Yes C2 No

If yes, how many people are on the wait list? C3

As of today, does your program have a wait list for Psychiatric services? C4 Yes C5 No

If yes, how many people are on the wait list? C6
**DEMOGRAPHICS**

**PROVIDER:**

**EXHIBIT:**

**TOTAL NUMBER OF CURRENT CLIENTS REPORTED:**

*PLEASE NOTE THAT, UNLESS OTHERWISE SPECIFIED, THE NUMBER OF CLIENTS FOR EACH QUESTION BELOW SHOULD EQUAL THE NUMBER OF CLIENTS ABOVE.*

**GENDER**

_(count each client only once)_

- **Male**
- **Female**
- **Transgender**
- **Unknown**

**AGE**

- **13 Years or Under**
- **13 - 19 Years**
- **20 - 44 Years**
- **45 Years or Older**
- **Unknown**

**CHILDREN**

Number of clients with dependent children (under the age of 18 living with the client): __unknown__

**HIV DIAGNOSIS**

_(count each client only once)_

- **HIV negative**
- **HIV positive (not AIDS) Dg within past year**
- **HIV positive (not AIDS) Dg Over 1 year**
- **AIDS**
- **Unknown**

**RACIAL/ETHNIC HERITAGE**

_(count each client only once)_

- **White (non-Hispanic)**
- **Black (non-Hispanic)**
- **Hispanic**
- **Asian/Pacific Islander (including Filipino/a)**
- **Native American/Aleutian/NaAlaskan/ Eskimo**
- **Other**
- **Unknown**

**LANGUAGE PREFERENCE**

_(count each client only once)_

- **English**
- **Spanish**
- **Tagalog/Ilocano**
- **Mandarin**
- **Other (please specify: Unknown)**

**CURRENT LIVING SITUATION (REQUIRED)**

_(count each client only once)_

If the client has had several different living situations recently, choose the most recent.

- **street, park, car or abandoned building**
- **shelter**
- **emergency housing, not shelter**
- **living with friend or family member and not paying rent**
- **halfway house or drug/alcohol program**
- **single room occupancy hotel room**
- **hospital/institution**
- **jail/incarcerated**
- **renting or own house, apartment or flat**
- **other**
- **unknown**

**LIVING SITUATION LAST 12 MONTHS (OPTIONAL)**

_(specify all that apply)_

- **street, park, car or abandoned building**
- **shelter**
- **emergency housing, not shelter**
- **living with friend or family member and not paying rent**
- **halfway house or drug/alcohol program**
- **single room occupancy hotel room**
- **hospital/institution**
- **jail/incarcerated**
- **renting or own house, apartment or flat**
- **other**
- **unknown**

* Presumptive HIV Positive Status
MONTHLY INCOME FOR INDIVIDUAL CLIENTS (NOT HOUSEHOLD)
(count each client only once)

| 1 | $350 or Below |
| 2 | $350 - $660 |
| 3 | $661 - $1,200 |
| 4 | $1,201 - $2,630 |
| 5 | Above $2,630 |
| 6 | Unknown |

SOURCE OF INCOME
(specify all that apply)

| 1 | GA |
| 2 | TANF |
| 3 | Food Stamps |
| 4 | Salary |
| 5 | Unemployment Benefits |
| 6 | Veteran’s Benefits |
| 7 | SSI |
| 8 | SSDI |
| 9 | State Disability Insur. |
| 10 | SSA Retirement |
| 11 | Long-term Disability |
| 12 | Other |

EMPLOYMENT STATUS
(count each client only once)

| 1 | Full time (30 or more hours per week) |
| 2 | Part Time (<30 hours per week) |
| 3 | Not Employed |
| 4 | Unknown |
| 5 | Disabled |

TYPE OF HEALTH CARE COVERAGE
(count only primary coverage)

| 1 | Private Insurance (include HMO’s) |
| 2 | Kaiser |
| 3 | Medi-Cal/Medicaid |
| 4 | Medicare |
| 5 | Other Public Insurance |

Health Insurance for Mental Health Services

| 1 | No coverage |
| 2 | Emergency or short-term only (24 or fewer Sessions per year) |
| 3 | Over 24 sessions per year |
| 4 | Unknown |

MEDI-CAL ELIGIBILITY

What is your current case load for this contract exhibit? Q1
How many of these clients are enrolled in Medi-Cal? Q2

Private Insurance includes HMO’s, Kaiser, Medi-Cal/Medicaid

Counts clients who have applied and who
Awaiting administrative approval as well
As clients who have Medi-Cal through a
Private insurance company.

Other Public Insurance includes CARE funded primary care Clinics, Champus, VA, Wker’s Comp, And HIS

Uninsured
Unknown

- duplicates.
**TYPES OF CLIENTS SERVED AND SEVERITY OF NEED (ALL CLIENTS)**

Please provide information here on all clients seen since January 1, 1998.

**ESTIMATES**

Using the DSM-IV categories, please list the types of diagnosis served by this contract exhibit. (Please do not use diagnostic numbering codes.) Show the number of clients with primary and secondary diagnosis for each diagnostic category listed.

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>PRIMARY NUMBER</th>
<th>SECONDARY NUMBER</th>
<th>DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1</td>
<td>R11</td>
<td></td>
<td>Major Depression R12</td>
</tr>
<tr>
<td>R2</td>
<td>R21</td>
<td></td>
<td>Panic Dx with Agoraphob R22</td>
</tr>
<tr>
<td>R3</td>
<td>R31</td>
<td></td>
<td>Adjustment D.O. R3 - 2</td>
</tr>
<tr>
<td>R4</td>
<td>R41</td>
<td></td>
<td>Adjustment D.O./Anxiety R4 - 2</td>
</tr>
<tr>
<td>R5</td>
<td>R51</td>
<td></td>
<td>Adjustment D.O./Depress. R5 - 3</td>
</tr>
<tr>
<td>R6</td>
<td>R61</td>
<td></td>
<td>Adjustment D.O./mixed R6 - 2</td>
</tr>
<tr>
<td>R7</td>
<td>R71</td>
<td></td>
<td>Depression NOS R7 - 2</td>
</tr>
<tr>
<td>R8</td>
<td>R81</td>
<td></td>
<td>Dysthymia R8 - 2</td>
</tr>
<tr>
<td>R9</td>
<td>R91</td>
<td></td>
<td>Bipolar D.O. R9 - 2</td>
</tr>
<tr>
<td>R10</td>
<td>R10 - 1</td>
<td></td>
<td>Schizophrenic R10 - 2</td>
</tr>
<tr>
<td>R11</td>
<td>R11 - 1</td>
<td></td>
<td>Schizophrenic D.O. R11 - 2</td>
</tr>
<tr>
<td>R12</td>
<td>R12 - 1</td>
<td></td>
<td>Psychotic D.O. NOS R12 - 2</td>
</tr>
<tr>
<td>R13</td>
<td>R13 - 1</td>
<td></td>
<td>Dementia R13 - 2</td>
</tr>
<tr>
<td>R14</td>
<td>R14 - 1</td>
<td></td>
<td>Polysubstance Abuse R14 - 2</td>
</tr>
<tr>
<td>R15</td>
<td>R15 - 1</td>
<td></td>
<td>ETOH Abuse R15 - 2</td>
</tr>
</tbody>
</table>

**SEVERITY INDICATORS**

Specify the number of clients with:

- A mental health impairment so severe as to affect ability to access Primary Care services or adhere to medical treatment for HIV: 51
- History of suicide attempts prior to the preceding year: 52
- Violent behavior within the last year: 53
- History of violent behavior prior to the preceding year: 54
- Homicidal ideation within the last year: 55
- History of physical or sexual abuse: 56

**INTENSITY OF SERVICES REQUIRED**

Specify the number of clients who:

- Need day treatment, sub-acute, or residential mental health treatment to maintain stability and avoid acute care: T1
- Have had one or more psychiatric hospitalizations within the last 12 months: T2
- Have taken psychotropic medications since beginning treatment: T3
- Are considered severely and persistently mentally ill: T4

**GLOBAL ASSESSMENT OF FUNCTIONING (GAF)**

Using the GAF Scale, please indicate the number of clients within each range.

<table>
<thead>
<tr>
<th>GAF</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 10</td>
<td>U1</td>
</tr>
<tr>
<td>11 - 20</td>
<td>U2</td>
</tr>
<tr>
<td>21 - 30</td>
<td>U3</td>
</tr>
<tr>
<td>31 - 40</td>
<td>U4</td>
</tr>
<tr>
<td>41 - 50</td>
<td>U5</td>
</tr>
<tr>
<td>51 - 60</td>
<td>U6</td>
</tr>
<tr>
<td>61 - 70</td>
<td>U7</td>
</tr>
<tr>
<td>71 - 80</td>
<td>U8</td>
</tr>
<tr>
<td>81 - 90</td>
<td>U9</td>
</tr>
<tr>
<td>91 - 100</td>
<td>U10</td>
</tr>
</tbody>
</table>

**MULTI-DIAGNOSED**

Number of current clients who have an active substance abuse/dependency problem that warrants treatment or will affect client’s ability to access care along with an active psychiatric illness that warrants treatment or will affect client’s ability to access care: 5

**AIDS DEMENTIA**

Number of clients with diagnosis of:
- HIV-Related Cognitive Impairment: W1
- AIDS Dementia: W2

---

**DEMOGRAPHICS**

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 - 24</td>
<td>D1</td>
</tr>
<tr>
<td>25 - 34</td>
<td>D2</td>
</tr>
<tr>
<td>35 - 44</td>
<td>D3</td>
</tr>
<tr>
<td>45 - 54</td>
<td>D4</td>
</tr>
<tr>
<td>55 - 64</td>
<td>D5</td>
</tr>
<tr>
<td>65 - 74</td>
<td>D6</td>
</tr>
<tr>
<td>75 - 84</td>
<td>D7</td>
</tr>
<tr>
<td>85+</td>
<td>D8</td>
</tr>
</tbody>
</table>
TYPES OF CLIENTS SERVED
AND SEVERITY OF NEED
(LONG-TERM CLIENTS)

Please provide information here only on all clients who have received over 24 sessions per year (long-term clients).

DSM-IV DIAGNOSES
Using the DSM-IV categories, please list the types of diagnosis served by this contract exhibit. (Please do not use diagnostic numbering codes.) Show the number of clients with primary and secondary diagnosis for each diagnostic category listed.

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>PRIMARY</th>
<th>SECONDARY</th>
<th>DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>X1</td>
<td>X1-1</td>
<td>X1-2</td>
<td></td>
</tr>
<tr>
<td>X2</td>
<td>X2-1</td>
<td>X2-2</td>
<td></td>
</tr>
<tr>
<td>X3</td>
<td>X3-1</td>
<td>X3-1</td>
<td></td>
</tr>
<tr>
<td>X4</td>
<td>X4-1</td>
<td>X4-2</td>
<td></td>
</tr>
<tr>
<td>X5</td>
<td>X5-1</td>
<td>X5-2</td>
<td></td>
</tr>
<tr>
<td>X6</td>
<td>X6-1</td>
<td>X6-2</td>
<td></td>
</tr>
<tr>
<td>X7</td>
<td>X7-1</td>
<td>X7-2</td>
<td></td>
</tr>
<tr>
<td>X8</td>
<td>X8-1</td>
<td>X8-2</td>
<td></td>
</tr>
<tr>
<td>X9</td>
<td>X9-1</td>
<td>X9-2</td>
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</tr>
<tr>
<td>X10</td>
<td>X10-1</td>
<td>X10-2</td>
<td></td>
</tr>
<tr>
<td>X11</td>
<td>X11-1</td>
<td>X11-2</td>
<td></td>
</tr>
<tr>
<td>X12</td>
<td>X12-1</td>
<td>X12-2</td>
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</tr>
<tr>
<td>X13</td>
<td>X13-1</td>
<td>X13-2</td>
<td></td>
</tr>
<tr>
<td>X14</td>
<td>X14-1</td>
<td>X14-2</td>
<td></td>
</tr>
<tr>
<td>X15</td>
<td>X15-1</td>
<td>X15-2</td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY OF SERVICES REQUIRED
Specify the number of clients who:

- Need day treatment, sub-acute, or residential mental health treatment to maintain stability and avoid acute care: Z1

- Have had one or more psychiatric hospitalizations within the last 12 months: Z2

- Have taken psychotropic medications since beginning treatment: Z3

- Are considered severely and persistently mentally ill: Z4

GLOBAL ASSESSMENT OF FUNCTIONING (GAF)
Using the GAF Scale, please indicate the number of clients within each range.

<table>
<thead>
<tr>
<th>GAF</th>
<th>Number of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 - 10</td>
</tr>
<tr>
<td>2</td>
<td>11 - 20</td>
</tr>
<tr>
<td>3</td>
<td>21 - 30</td>
</tr>
<tr>
<td>4</td>
<td>31 - 40</td>
</tr>
<tr>
<td>5</td>
<td>41 - 50</td>
</tr>
<tr>
<td>6</td>
<td>51 - 60</td>
</tr>
<tr>
<td>7</td>
<td>61 - 70</td>
</tr>
<tr>
<td>8</td>
<td>71 - 80</td>
</tr>
<tr>
<td>9</td>
<td>81 - 90</td>
</tr>
<tr>
<td>10</td>
<td>91 - 100</td>
</tr>
</tbody>
</table>

MULTI-DIAGNOSED
Number of current clients who have an active substance abuse/dependency problem that warrants treatment or will affect client’s ability to access care along with an active psychiatric illness that warrants treatment or will affect client’s ability to access care. B81

AIDS DEMENTIA
Number of clients with diagnosis of:
- HIV-Related Cognitive Impairment CC1
- AIDS Dementia CC2
Mental Health Medi-Cal Eligible Clients Estimate, Based on Two Clinics

<table>
<thead>
<tr>
<th></th>
<th>Multi- Diagnosis Project-CHN</th>
<th>CMHC/CSP AIDS Mental Health Case Mgmt</th>
<th>Long &amp; Short Term Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Caseload, or Unduplicated Clients</td>
<td>126 (100%)</td>
<td>142 (100%)</td>
<td>268 (100%)</td>
</tr>
<tr>
<td>Current Total, Medi-Cal Enrolled</td>
<td>42 (33%)</td>
<td>107 (75%)</td>
<td>149 (56%)</td>
</tr>
<tr>
<td>Current Total, Diagnosis Included</td>
<td>33 (79%)</td>
<td>83 (78%)</td>
<td>116 (78%)</td>
</tr>
<tr>
<td>Current Total, Diagnosis Excluded</td>
<td>9 (27%)</td>
<td>24 (29%)</td>
<td>33 (22%)</td>
</tr>
<tr>
<td>Total Non-Medical</td>
<td>54 (67%)</td>
<td>35 (25%)</td>
<td>119 (44%)</td>
</tr>
</tbody>
</table>
COMMUNITY MENTAL HEALTH WORKGROUP
MINUTES

July 22, 1998

Present: Jim Dilley, AHP; Laura Feren, Family Svcs Agency; Joe Neislen, New Leaf; Wayne Clark, DPH; Melissa, HIV Ctr for Special Problems; Mike Lipp; HC #1; MH Center; Estella Garcia, Instituto Familiar de la Raza, Maria Martinez, CHS; Russ Zellers

Absent: Russ Zellers

Announcements: The CARE Council is holding population targeted community meetings as part of their outreach efforts. The first is Mon, July 27 @ Mission Neighborhood Health Center, 10:00AM - 2:00PM.

Dick Pabich/Bill Barnes have been invited to attend these meetings. Jim Dilley sent Dick minutes from the last meeting.

I. MEDI-CAL DISCUSSION

Maria discussed the possibility of following the lead of the city's children's services in using city dollars to leverage Medi-Cal monies. With support of the CARE Council, the AIDS office and DPH, a similar plan may be successful for us. This plan would involve supplanting mental health CARE dollars with General Fund monies going to the AIDS Office to contract for the services with existing providers. These providers would, in turn, bill for services that are reimbursable under MediCal. If this scenario "works", it's possible that this would offer a way to essentially "double" the funds "invested" by the CARE council. CARE would still pay a portion of the services; General Fund would pay another portion and the final portion would be from MediCal. Maria will report back at next meeting about the possibility of this plan.

To achieve this goal, several issues need to be addressed: one is that DPH would need to buy into the proposal, assuring Gen. Fund dollars as the basis of the matching funds, another is that existing CARE funded mental health providers will need to be certified as MediCal providers and then be prepared (trained) to do the billing--not a small task.

Other issues which need consideration include the question of Medical reimbursement rate versus our existing cost/UOS. Current reimbursement to agencies is very low from MediCal. Given that most of the clients we see are complex, we would argue that the higher reimbursement given to support care for the persistently mentally ill should be assigned to people with HIV and mental health disorders.

Also, note that the idea of referring our clients to ACCESS is problematic. ACCESS is already besieged with clients and CMHS has already approached the Health Commission with the idea that the previously proposed "single standard of care" for both insured (MediCal) and uninsured (medically indigent), may need to be revised since CMHS only received $1M of the $5M requested to provide for this level of care.
II. Recommendations to the CARE Council

On 8/5 CARE council wants from us recommendations re: the role of CARE in providing for mental health services. Some discussion was had re: the council’s responsibility to provide services to the “underinsured” as well as the “uninsured”. More specifically they want to know what we would recommend if 10% of our funds would be cut?

Maria suggested information should be collected and presented to the CARE council, showing how many and to what extent our current population of clients could be served:

- Qualify - but can’t get Access------>
- Don’t qualify -------->(primary SA/OBS, etc.)
- Not CARE appropriate

Discussion of CARE Council - Priorities -- How should CARE spend its mental health dollars?

Seriously emotionally disturbed vs. in serious emotional crisis. Or,

1. Chronic, persistently mentally ill vs:
2. Hard to have AIDS, not persistently mentally ill - council may say not appropriate for CARE funds.

Long Term strategic plan for CARE dollars over next 5 years

Psych consultation >
Case Management >
Psychotherapy >

We did sample, 30% of the client base is Medi-Cal reimbursable. 70% uninsured - not Medi-Cal insured.

The council is putting more money in housing, cutting MH from point of view of the client. MH and Case management is a priority.
# Mano a Mano Assessment Form

<table>
<thead>
<tr>
<th>Date</th>
<th>ID #</th>
<th>Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Intake Date** / / Month **Update Due** Yearly

Please check if true. All checked responses need to be explained in the narrative.

### Risk Factors:
- Suicidal ideation/ gesture
- Hx of suicide attempt
- Family Hx of suicide
- Violent Behavior
- Hx of violent behavior
- Homicidal ideation
- Alcohol & substance use
- Family substance abuse
- Physical or sexual abuse
- Other at-risk behavior
- Psychiatric symptoms
- Change in health or status

### Problems with:
- Primary social support group
- Social environment
- Educational concerns
- Occupational concerns
- Housing concerns
- Economic concerns
- Access to health care
- Legal system / crime
- Other psychosocial & environmental problems

### GAF ______

## Client Description & Behavioral Observations:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

## Presenting Problems/ Symptoms:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

## Mental Status:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

## History (e.g. relevant family, social, cultural, educational, career, psychiatric, etc.):

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Confidential
Purpose of Mental Health Workgroup

(1) Design questionnaire to determine “Who Is Being Served?”:
   • Describe client population for Planning Council
   • Triage for contracting purposes
   • Reductions for FY 98-99 (?)

(2) How can clients be effectively transferred when $850,000 reduction made in July 1998? Where can clients be referred after that date?

(3) Recommendations for next Planning Council prioritization process
Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health–illness. Do not include impairment in functioning due to physical (or environmental) limitations.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Superior functioning in a wide range of activities; life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.</td>
</tr>
<tr>
<td>99</td>
<td>Absent or minimal symptoms (e.g., mild anxiety before an exam; good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally with life, no more than everyday problems or concerns (e.g., occasional argument with family members)).</td>
</tr>
<tr>
<td>90</td>
<td>Some mild symptoms (e.g., depressed mood and mild insomnia; OR some difficulty in social, occupational, or school functioning (e.g., occasional truanting, or theft within the household), but generally functioning pretty well.</td>
</tr>
<tr>
<td>80</td>
<td>Moderate symptoms (e.g., flat affect and circumstantial speech; occasional panic attacks; OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).</td>
</tr>
<tr>
<td>70</td>
<td>Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting; OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).</td>
</tr>
<tr>
<td>60</td>
<td>Some impairment in reality testing or communication (e.g., speech at times illogical, obscure, or overly tangential; OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently neglects homework, runs away from home, tends to lie).</td>
</tr>
<tr>
<td>50</td>
<td>Behavior is considerably influenced by delusions or hallucinations; OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriate, suicidal preoccupation; OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).</td>
</tr>
<tr>
<td>40</td>
<td>Some danger of hurting self or others (e.g., suicide attempt with clear expectation of death; frequently violent; manic excitement); OR occasionally fails to maintain minimal personal hygiene (e.g., shaves face); OR gross impairment in communication (e.g., largely incoherent or mute).</td>
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<tr>
<td>30</td>
<td>Persistent danger of severely hurting self or others (e.g., recurrent violence); OR persistent inability to maintain minimal personal hygiene; OR serious suicidal act with clear expectation of death.</td>
</tr>
<tr>
<td>20</td>
<td>Inadequate information.</td>
</tr>
</tbody>
</table>

Who Is Being Served by Long and Short-term Psychothapy Providers?

Develop 5 or 6 key factors/categorias. These factors may be assessed differently by different agencies. Use language we have in common (not DMS categories).

Suggested at February 2, 1998 meeting.

Option I
- Functional level
- Clinical risk factors (e.g., suicidal behavior)
- Psychosocial risk factors

Option II
"Acute, reoccuring, or chronic mental health problems or the presence of psychosocial stressors."

Option III
GAF score < or = to 60
Symptomatology and effects on social, occupational or school functioning.

Option IV
Clinicians assessment of symptomatology and effects on social, occupational or school functioning.

Option V
Mental health problems so significant as to interfere with the activities of daily living or with the ability of a client to obtain HIV treatment.

Option VI
DMS IV--Axis I and II (includes substance abuse)
Does this include Personality Disorders?
From: Harrison, George (2/9/98)
To: Dilley, James
CC: Rinaldi, Joanna

5 Question Survey to ID Patients 02-09-98 13:21 -0800

I am faxing you some suggested material that I got from Jill Daly.

One is the SCL - 90 - R (Symptom check list 90, revised), the other is the Brief Symptom Inventory.

These are my ideas for the items to reflect who we serve and what their acuity is.

1). DSM IV Axis I, II, and V Dx
2). Date of last use of any substance (including alcohol) which would meet criteria for abuse or dependence.
3). A scale to assess the severity of psychosocial stressors. (I don't know of one but we should be able to consult with someone from psychology for suggestions.)
4). Using a GAF like scale rewritten for the lay public, patients will self rate their functioning.

Also, I am faxing you the results of the chart review of PCS and Crisis. I also will fax a copy of this to Joanna.

George
FAX COVER SHEET

Date: 2-26-98

To: [Name]
From: [Name]

Fax #: 502-7271

Comments:

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
AIDS OFFICE
25 VAN NESS AVENUE, SUITE 500
SAN FRANCISCO, CA 94102-6033
PHONE: (415) 554-9000
FAX: (415) 431-7547 -- GENERAL
FAX: (415) 431-7154 -- DIRECTOR'S OFFICE

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# ADULT SERVICES

## Medical Necessity and Service Intensity Guidelines

<table>
<thead>
<tr>
<th>Medical Necessity DSM-IV</th>
<th>Medical Necessity DSM-IV (cont)</th>
<th>Medical Necessity DSM-IV (cont)</th>
<th>Intensity of Service</th>
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</thead>
<tbody>
<tr>
<td><strong>A. Must have 1 of the following disorders:</strong></td>
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<tr>
<td>Pervasive Dvt Disorder except Autism; Attn Deficit Disorder, Disruptive Behav Disorder, Feeding &amp; Eating Disorder, Elimination Disorder, Other Disorders of Infancy, Childhood, &amp; Adolescence; Schizophrenia &amp; Other Psychotic Disorders, Mood Disorders, Anxiety Disorders, Somatoform Disorder, Factitious Disorders, Dissociative Disorder, Paraphilias, Gender Identity Disorder, Eating Disorders, Impulse Control Disorder not elsewhere classified, Adjustment Disorders, Personality Disorders except Antisocial; Med-Induced Mvmt Disorders</td>
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<tr>
<td><strong>Plus</strong></td>
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<tr>
<td><strong>B- Impairment Criteria</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>And</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>C. Intervention Related Criteria</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>B. Impairment Criteria</strong></td>
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<tr>
<td>Must meet at least 1 of 3 impairment as a result of the mental disorder:</td>
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<tr>
<td>1. A significant impairment in an important area of life functioning</td>
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<tr>
<td>2. A probability of significant deterioration in an important area of life functioning</td>
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<tr>
<td>3. Children also qualify if there is a probability the child will not progress developmentally as appropriate.</td>
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<tr>
<td><strong>C. Intervention Related Criteria</strong></td>
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<tr>
<td>Must meet all: 1, 2, &amp; 3 below:</td>
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<tr>
<td>1. The focus of proposed intervention is to address the condition identified in Impairment Criteria B, and</td>
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<tr>
<td>2. The intervention will significantly diminish the impairment, or prevent significant deterioration in an important area of life function, and/or, for children, the child will progress developmentally as individually appropriate, and</td>
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<tr>
<td>3. The condition would not be responsive to physical health care based treatment.</td>
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<tr>
<td><strong>Service Intensity:</strong> over 72 hours annually</td>
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<tr>
<td>Must meet at least 3 of 5:</td>
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<tr>
<td>1. Needs services from more than 1 site*</td>
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<tr>
<td>2. Need day tx, sub-acute, residential tx to maintain stability, avoid acute care.</td>
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<tr>
<td>3. Cost of care exceeds $20,000 in last 12 months</td>
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<td>4. 2 psych hosps in last 12 mos.</td>
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<td>5. 2 crisis visits in last 12 mos.</td>
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<tr>
<td><strong>Service Intensity:</strong> under 72 hours annually</td>
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<td></td>
</tr>
<tr>
<td>Does not need services from more than 1 site*</td>
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<td>-and-</td>
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<tr>
<td>at least 2 of 3:</td>
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</tr>
<tr>
<td>1. Cost of care of &lt;$20,000</td>
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<tr>
<td>2. &lt;2 psych hosps in last 12 mos.</td>
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<td></td>
</tr>
<tr>
<td>3. &lt;2 crisis visits in last 12 mos.</td>
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Note: Victims of a declared natural disaster in need of focused treatment are considered authorized for high intensity services.

* Exception: 2 providers are allowed if individual is receiving socialization services and/or MHS/CMB services in a shelter, supportive housing, residential care facility or co-ops.
Mayor’s HIV Health Planning Council
Mental Health Work Group
Minutes of Meeting
March 4, 1998

Members present:
Russ Zellers-AIDS Office
George Harrison-AIDS Health Project
Melissa Bloom-DPH, Center for Special Problems
Wayne Clark-DPH, CMHS
Victoria Lee-Iris Center
Don Bliss-New Leaf
Laura Feren-Medically Indigent Adults
Ali Riker-CARE Council
Estella Garcia-IFR, Mano a Mano Program

(Note: The following minutes are not complete. They begin with a discussion regarding a draft provided to the group entitled: Types of Clients Served and Severity of Need.)

George asked for clarification of item (I) DSM-IV Diagnoses, asking what the DSM-IV diagnoses referred to would be. He noted that the draft referenced the attached “Exhibit A: Medical Necessity Criteria for the San Francisco Mental Health Plan,” which lists both included and excluded diagnoses. Russ explained that Exhibit A includes the DSM-IV diagnostic categories Access 1 and 2 (but not 3, 4, or 5), and the GAF scores, recorded in item (IV) on the second page of the draft.

Laura proposed the following scale for interpreting the range of specifications requested with regard to GAF scores: 0-30 fairly acute; 30-50 serious symptoms; 51-70 mild symptoms; and 71 or above, symptom-free. Melissa expressed the concern that the proposed scale is too broad, and suggested that it be broken down further to recognize symptoms that are mild to moderate. Estella recommended that the standard blueprint for measuring the GAF be adopted, noting that the goal is to elicit specific information with regard to the range of functioning of clients.

Although it was acknowledged that the blueprint measure incorporated ten groupings as opposed to the four suggested, it was agreed that the standard measure would be easier to interpret, as well as more accurate. Laura also noted the option to design fewer categories based on acuity later using the blueprint information collected. It was therefore determined that the standard measurement would be utilized in the assessment of GAF scores.

Estella requested that clarification of the diagnostic categories to be used in item (1) DSM-IV Diagnoses (i.e., Access 1, Access 2, and the GAF), be indicated on the form. Laura suggested that the reference to Exhibit A should
be dropped. Russ replied that the list being reviewed was included to depict the categories that would be used, and would be omitted when the form is typed up.

Laura noted that using only a primary diagnosis would include instances such as secondary substance abuse in the Access 1 category. George agreed that important information would most likely be missed, because clinicians are used to trying to get billing and rarely document a diagnosis centered around substance abuse issues.

The group first considered including all diagnoses that apply in the DSM-IV category, and then looked at using both a primary and secondary diagnosis on Access 1. Wayne asked if satisfactory information could be gathered if a primary and secondary diagnosis using Access 1 and Access 2 categories was requested. George replied that if clinicians were specifically instructed to list the primary and secondary diagnosis, which could either be Access 1 or Access 2, the result would be two solid diagnoses, which would be sufficient.

The group then discussed what the most effective format would be for eliciting and interpreting the results accurately. A checklist was proposed that would correspond to the specifications listed in Exhibit A. Laura expressed the view that asking clinicians to adapt their diagnoses to a prefabricated checklist could result in confusion. She suggested that clinicians simply be plainly asked to give a DSM-IV diagnosis which the group could then categorize themselves according to the criteria that has been established. The group agreed to participate in sorting the information once it has been gathered.

Don asked Russ whether the AIDS Office had met with CMHS to determine if CMHS is going to be able to serve clients who are going to become mentally ill. Russ responded that a meeting took place on the issue, but that the situation was still unresolved. Don explained that, due to their inability to serve them, New Leaf presently turns away approximately 600 clients a year from their mental health services. He explained that when the agency approached CMHS for an increase in funding for their general mental health program, it was made clear that funding was not available for people who have been cut out of mental health services that rely on CARE funds. Don expressed a deep concern with regard to the willingness of CMHS to consider picking up some of the clients that New Leaf is unable to currently serve.

Don noting the RFA deadline on Friday, also inquired about the deadline for agencies interested in becoming a part of the provider network, should CMHS later locate additional funding. Wayne explained that there is both and RFA and an RFP, and that both of those deadlines are imminent. Wayne stated that Joë had suggested that Mitch Katz may not have been aware of the $850,000 cut in mental health services in the AIDS Office. In turn, DPH was not informed of the need to request an additional $850,000 as part of the budget process.
He stated that one of the things that the DPH is trying to do with regard to the situation, is to look at the number of the clients eligible for medi-cal that are currently being served by the system to determine whether any of the programs who serve them have completed the RFA.

Wayne also proposed that the group work with the Contractor’s Association in raising the issue with the Planning Council as a cut to the AIDS budget. He stated that he thought organizations would be much more effective in their appeal if they approached the Council jointly rather than one by one. Russ agreed that the level of coordination between agencies needed to be improved, but stated that the most pressing issue was to figure out a way to

Wayne stated that the goal was to establish continuity of care for clients, which means insuring that providers receive continued funding from some source past June 30. His view was that this effort needs to happen contractually, and that the negotiation process needs to include the consideration that some agencies, such as the AIDS Health Project are not part of CMHS’s system. He explained, however, that the first step is to identify where the money will come from.

Laura expressed the opinion that the Contractors Association has focused on trying to aid its group to respond to the AIDS Office RFPs. She said that the Association had gone before the CARE Council and were able to extend the deadline which the AIDS Office had established for incorporating changes in RFPs. Laura also explained that she felt that there has not been enough time to mobilize and address mental health, and offered to present the issue at the next Contractors Association meeting.

Don added that since the decision to cut funding had come out of the prioritization process, the Contractors Association had made the effort to educate the Council regarding the effects of cutbacks in mental health services. His feeling was that the mental health group itself was meeting as a result of the Association’s efforts in this area.

Estella reminded the group that the system is the last safety net for many people, and that they are mandated to insure that services be made available. She expressed the opinion that, regardless of the politics involved, decision-makers need to be held accountable for getting resources restructured.

Wayne requested that the other members of the group call him with the number of their clients who are active, as well as the percentage of their clients who are on medi-cal. He suggested that part of the solution might be a general fund allocation that covers 50% of the federal medi-cal match, which would enable DPH to cover the other $850,000. Laura informed Wayne that most of these clients are uninsured, as CARE money is focused on clients who have no other
means of paying for services. Wayne explained that what he expected to find is
that some clients are may not covered in the mental health benefit because
they don't meet the severe need criteria, but that they may nevertheless be
eligible for medi-cal after April 1.

Russ agreed that finding a way to leverage money would help solve the
problem, and suggested that Wayne's proposal be pursued. He then
suggested that the group meet one more time After April 1 to deal with the
transition of clients issue.

Meeting adjourned at 9:50 am.

The next meeting of the Mental Health Work Group will be held on Wednesday, April 8 at
9:00 am.