DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

# Psychosocial Support Services

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

## I. SERVICE CATEGORY DEFINITION

Psychosocial Support Services provides individual and/or group support and counseling services to address customers' continuing behavioral and physical health concerns. Psychosocial support should be delivered by staff, volunteers, and/or peers to help clients access health and benefits information, develop coping skills, reduce feelings of social isolation, and increase self-determination and self-advocacy, helping improve quality of life for participants. Key activities include:

- Support and counseling activities
- Bereavement counseling
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
- Pastoral care/counseling services
- Caregiver support

## II. INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White customers to maintain proof of eligibility annually. Supporting documentation is required to demonstrate customer eligibility for Ryan White Services.

### A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting viral load.

2. **Residency:** The following are acceptable methods of meeting the burden for residency:

- Current lease or mortgage statement
- Deed settlement agreement
- Current driver's license
- Current voter registration card
- Current notice of decision from Medicaid
- Fuel/utility bill (past 90 days)
- Property tax bill or statement (past 60 days)
- Rent receipt (past 90 days)
- Pay stubs or bank statement with the name and address of the customer (past 30 days)
- Letter from another government agency addressed to customer
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, a written statement from case manager, facility

3. **Income:** Customer income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the customer and any household members for whom customers have legal responsibility. For each income source, the customer must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

   The following are acceptable forms of proof of income:

   - Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub
   - A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
   - Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the customer projecting current annual income must be included
   - Copy of the tenant's lease showing customer as the landlord and a copy of their most recent income tax return
   - SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
   - Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the customer

**B. INTAKE**

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data

13. Documented explanation about the services available within the provider agency and within the Ryan White Program

**C. MAINTENANCE OF ELIGIBILITY**

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency status has changed. RWHAP providers are permitted to accept a customer's self-attestation of "no change" when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

## III. KEY SERVICE COMPONENTS & ACTIVITIES

| ASSESSMENT/SERVICE PLAN/PROVISION OF SERVICES | |
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| **Standard** | **Measure** |
| Prior to the initiation of the psychosocial support service plan, customers are assessed for:<br>● support system and psychosocial support needs<br>● history of accessing primary care and other services and barriers to access— noting psychosocial support barriers in particular | Documentation of intake and assessment in customer's record signed and dated by psychosocial support staff |
| The type and level of psychosocial support services to be delivered must be documented in an existing Ryan White service plan or outlined in a new support plan. The plan for psychosocial support services must include identified problem(s), goal(s) to address problem, and target date for completion. | Psychosocial support service plan, documented in customer record, signed, and dated by the customer and psychosocial support staff |
| Psychosocial support service plan is reassessed every 90 days to review customer's treatment adherence as well as engagement and retention in in primary care and medical case management<br><br>**Exclusions**<br>Funds under this service category may not be used for social/recreational activities or to pay for a customer's gym membership. | Documentation of reviewed and updated of psychosocial support service plan as appropriate signed and dated by customer and psychosocial support staff. Documentation should indicate topics covered, activities conducted, and goals achieved.<br><br>Additional activities in the client record, if applicable, must include:<br>● Progress notes for each contact with client by phone or at face-to-face meetings<br>● Progress notes recording activities on behalf of the client to implement the Support Plan<br>● Progress toward goals<br>● Communications with referring agency (e.g., missed/kept appointments, etc.)<br>● Contacts with client (by phone or face-to-face), depending on client need<br>● Documentation of follow-up for referred services<br>● Documentation of follow-up to missed appointments<br>● Management of emergency situations as they arise<br>● Adjustment to support plan, if necessary<br>● Case conferencing when necessary<br>● Crisis intervention when necessary |
| Customers may receive support counseling in either an individual or group format. Counseling must be | Documentation of counseling services provided in customer record, indicating: |

<table>
<tr><td>conducted by a qualified individual (professional or peer) and should be structured, with a treatment plan or curriculum, to move clients towards attainable goals.<br><br>Pastoral care/counseling must be available to all eligible customers regardless of religious denominational affiliation and must be provided by:<br>● An institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider, such as a home care or hospice provider<br>● A licensed or accredited provider, wherever such licensure or accreditation is either required or available</td><td>● Date of session<br>● Duration of session<br>● Name and title of the group, if applicable<br>● General topics discussed<br>● Summary of activities conducted<br>● Goals and objectives selected and achieved during the session(s)</td></tr>
<tr><td>Customers may receive nutritional counseling services (e.g., nutrition education, assessment, and counseling) by a non-registered dietitian to assist them in:<br>● Maintaining treatment regimens<br>● Remaining in primary medical care<br>● Using food products in the best way possible to maintain or improve health and maximize health benefits<br><br>Note: A nutritional plan cannot be developed by a registered dietitian under this service category.<br><br>Exclusions<br>● Funds under this service category may not be used to provide nutritional supplements (See Food Bank/Home-Delivered Meals).</td><td>Documentation of nutritional service(s) provided in customer record</td></tr>
<tr><td>Customers may receive bereavement counseling</td><td>Documentation of bereavement counseling provided in customer record</td></tr>
<tr><td>The provider must ensure that referrals and linkages to other services, such as mental health and substance abuse treatment, are made as appropriate and documented with the status of outcomes</td><td>Documentation of referral(s) in customer's record</td></tr>
<tr><th colspan="2">TRANSITION & DISCHARGE</th></tr>
<tr><th>Standard</th><th>Measure</th></tr>
<tr><td>Customer discharged when psychosocial support services are no longer needed, goals have been met, upon death or due to safety issues.<br><br><u>Prior to discharge</u>: Reasons for discharge and options for other service provision should be discussed with customer. Whenever possible, discussion should be occurring face-to-face. If not possible, provider should attempt to talk with customer via phone. If verbal contact is not possible, a certified letter must be sent to customer's last known address. If customer is not</td><td>Documentation of discharge plan and summary in customer's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable.<br><br><u>Documentation</u>: Customer's record must include:<br>● Date services began<br>● Special customer needs<br>● Services needed/actions taken, if applicable<br>● Date of discharge<br>● Reason(s) for discharge</td></tr>
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| present to sign for the letter, it must be returned to the provider.<br><br>Transfer: If customer transfers to another location, agency, or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If customer moves to another area, transferring agency will make referral for needed services in the new location.<br><br>Unable to Locate: If customer cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the customer's last known mailing address within five business days after the last attempt to notify the customer. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made.<br><br>Withdrawal from Service: If customer reports that services are no longer needed or decides to no longer participate in the Service Plan, customer may withdraw from services. Because customers may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the customer's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency customers should be referred to appropriate agencies.<br><br>Administrative Discharge: Customers who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a customer for this reason, the case must be reviewed by the leadership according to that agency's policies. Customers who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the customer's last known mailing address within five business days after the date of discharge, and a copy must be filed in the customer's chart. | ● Referrals made at time of discharge, if applicable |
| **CASE CLOSURE** | |
| **Standard** | **Measure** |
| Case will be closed if customer:<br><br>● Has met the service goals | Documentation of case closure in customer's record with clear rationale for closure |

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| ● Decides to transfer to another agency<br>● Needs are more appropriately addressed in other programs<br>● Moves out of the EMA<br>● Fails to provide updated documentation of eligibility status thus, no longer eligible for services<br>● Fails to maintain contact with the insurance assistance staff for a period of three months despite three documented attempts to contact customer<br>● Can no longer be located<br>● Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan<br>● Exhibits pattern of abuse as defined by agency's policy<br>● Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison, or inpatient program<br>● Is deceased | |

## IV. PERSONNEL QUALIFICATIONS

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance.

At minimum, all psychosocial support service staff and volunteers must have a high school diploma or GED plus one year of social service experience. Qualifying life experience may substitute educational and professional requirements. They must be able to provide linguistically and culturally appropriate services for people living with HIV, and complete documentation as required by their positions. Staff will be sensitive to the needs of persons of diverse life experiences, including customers with substance use disorder, mental illness, with co-occurring disorders and, ideally, will have prior experience working with the target population. Staff and volunteers will also be trained in or have relevant experience in core competencies:

- Active listening and other one-on-one support skills
- Group facilitation, if applicable
- Conflict de-escalation/resolution
- Roles and responsibilities of peer emotional support
- Client assessment skills, including:
    - Conducting an initial needs assessment (as appropriate to job function)
    - Identifying an individual at imminent risk who is in need of a higher level of support
- Awareness of resources for appropriate referral

All newly hired psychosocial support services staff and volunteers must complete the following trainings:

a. HIV 101, including impacted communities, disease process, co-morbidities, and psychosocial effects of the virus
b. HIV counseling and testing
c. HIV care system, resources, and access
d. Motivational interviewing
e. Information and techniques for working with substance use disorder
f. Sexual health and risk

g. Gender competency
h. Names reporting
i. Cultural Awareness, sensitivity, and competency
j. Consent laws, client confidentiality, Health Insurance Portability and Accountability Act (HIPAA), client rights, and agency grievance procedures
k. Entitlement programs, benefits to clients, and community resources/support services

In addition to attending the above, all psychosocial support services staff and volunteers are required to attend ongoing annual training on topics related to their position, including, but not limited to:

a. Sexual health
b. Substance use disorder, sensitivity and cultural approaches and related issues
c. Mental health
d. Domestic violence
e. Sexually transmitted infections (STIs)
f. Partner notification
g. Bereavement
h. Cultural and linguistic competence
i. Nutrition

Pastoral Care Counselor

- All pastoral care counselors must have appropriate and valid licensure as required by their jurisdiction.

Psychosocial Support Services Supervisor

- All non-professional staff delivering psychosocial support services must be supervised by a licensed professional.
- The supervisor of psychosocial support staff must be appropriately trained, knowledgeable and highly competent in the areas of HIV/AIDS, substance use disorder, community referrals, educational services, general computer skills, and the areas of competence and training expected of psychosocial support staff.
- Supervisors will have at least two years of work experience with related populations or issues.
- Supervisors will also complete the trainings required of new psychosocial support service staff, as noted in this section.

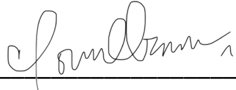
## V CLINICAL QUALITY MANAGEMENT

A continuous Clinical Quality Management Program for HIV patient care. Please refer to Policy Clarification Notice (PCN) #15-02 (updated 09/01/2020).

Every agency that provides Ryan White supported Substance Abuse services must develop and implement a Quality Management (QM) Plan. The QM Plan should be actively supported and guided by the formal agency leadership and senior administration, and appropriate resources should be committed to support continuous quality improvement activities. Agencies with multiple funded service categories must integrate the Substance Abuse QM Plan into their broader QM Plan and specifically address HIV-related services. The QM Plan must be in writing. At least once a year, the QM Plan must be reviewed and updated routinely by the QM committee. Staff from all levels of the agency, as well as patients should serve on the QM committee. Each member of the committee should be aware of the QM infrastructure. However, all agency staff regardless of their participation on the committee must understand their role in the agency's/program's quality improvement activities.

## VI. APPROVAL & SIGNATURES

This service standard has been reviewed and approved on April 26 2021. The next annual review is April 2022.



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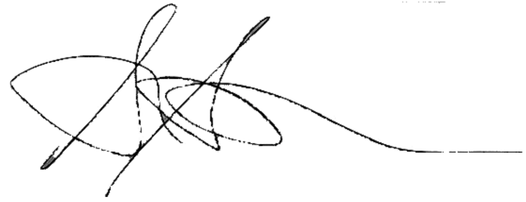

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Sarcia Adkins
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