Psychosocial Support Services Standards

Description from Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02:
Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PWH to address behavioral and physical health concerns.

Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Caregiver/respite support (HRSA RWHAP Part D)
- 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

Program Guidance:
May not use funds under this service category to provide nutritional supplements (*See* Food Bank/Home Delivered Meals

HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

May not use HRSA RWHAP funds for social/recreational activities or to pay for a client's gym membership.

For HRSA RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under HRSA RWHAP Part D.

Record service utilization for conducting Ryan White Part B eligibility assessments for an individual not case managed under **Psychosocial Support Services.**

Virginia Ryan White Part B Service Unit Definition:
One 15-minute individual or group Psychosocial Support session (**or**) one 15-minute increment of Unified Eligibility Assessment assistance for clients who are not case managed/receiving case management services.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV (PWH), including the following:

1.0 Intake and Eligibility

As outlined in HRSA HIV/ AIDS bureau (HAB) Policy Clarification Notice (PCN) 21-02 Clarifications on Ryan White Program Client Eligibility Assessments and Recertification Requirements, people are eligible to receive RWHAP services when they meet each of the following factors:

1. HIV Status: A documented diagnosis of HIV. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02.

2. Low- Income: The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL), which can be measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).

3. Residency: The RWHAP recipient defines its residency criteria, within its service area. Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services. RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies.

Standard	Measure
Referral	
1.1) Documentation of self-referral or referral by a Part B provider for Psychosocial Support Services prior to initiation of the service.	1.1) Appointment documented to attend Psychosocial Support Services is present in the client's record.
Eligibility	
1.2) The client's eligibility for Ryan White Part B services must be determined prior to providing the service. To be eligible for this service, clients must: a) Have an HIV diagnosis (one time only) b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Be ineligible for other payer sources covered by Federal or State programs such as Medicare, Medicaid, all other forms of insurance or third-party payers such as private and commercial insurance plans, and other payers that provide the service they are seeking.	1.2) Documentation of the client's eligibility is present in the client's record that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client's Medicaid status verified (gap of services) • Ongoing CARS and complete Continuation Eligibility Assessment every 24 months • Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

• Client Access Reviews (CARs) refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility. • Provide continuation of eligibility every 24 months with proof of income, changes in insurance coverage, or any changes in residency • Client eligibility ensures the use of Part B services as the payer of last resort while vigorously pursuing other funding sources**.** Client must agree to participate in the insurance option that the client is eligible for and that best meets the client's medical needs regardless of preference. Submission of eligibility assessments should be through the Provide Enterprise® data system.	
Intake	
1.3) Complete eligibility screening and intake within 15 days of initial contact with client.	1.3) Documentation of intake and eligibility screening in record signed and dated.
Client Access Reviews/Continuation of Eligibility	
1.4) Client Access Reviews (CARs) refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility and continuation of eligibility conducted every 24 months to continue to receive Ryan White services. There is no grace period.	1.4) Documentation of CARs and continuation of eligibility is present in the client's record.
1.5) For clients not receiving case management services, subrecipients must assist clients with eligibility and perform periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility.	1.5) Documentation of CARs and continuation of eligibility is present in the client's Provide Enterprise® record.
2.0 Key Services Components and Activities	
Standard	**Measure**
Documentation	

2.1) Document provision of all Psychosocial Support Services by type and level of activities.	2.1) Documentation of Psychosocial Support Services conducted by type and level of activities signed by provider of support services.
2.2) When a third-party payer provides service, the subrecipient must maintain a client record. At a minimum, the payer's record must contain: • Referral • Initial assessment • Individualized treatment plan • Documentation of all contacts & dates of service • Reassessment of treatment plan • Referrals and follow-ups • Discharge plan. Must sign and date all reports.	2.2) Documentation of provided services, signed, and dated records.
Assessment/Service Plan/Provision of Services	
2.3) An initial psychosocial assessment of client's needs to be completed prior to the initiation of the service plan.	2.3) Documentation of assessment in client's record signed and dated by the counselor.
2.4) Within fifteen (15) business days after the initial assessment a service plan will be developed and agreed upon by the client and provider outlining service goals, objectives, and interventions. This should include client identified needs as well as plans for continuity of primary medical care and support services, clients are assessed for: • Support system and psychosocial support needs • History of accessing primary care and other services and barriers to access, noting psychosocial support barriers in particular. Staff explains to the client during the first encounter what services are available at the agency based on the client's identified needs.	2.4) Documentation of service plan in client's record, signed and dated by the staff. In addition, review and revise client needs and service plan a minimum of every six months.

2.5) Counseling Services Staff may provide counseling related to: • Child abuse and neglect counseling • Bereavement counseling • Nutrition counseling (provided by non-registered dietitian) Psychosocial Support staff will make appropriate referrals.	2.5) Documentation of Psychosocial Support Services conducted by type and level of activities signed by provider of support services.
2.6) Support Groups HIV support groups include, but not limited to, caregiver and HIV support. Staff or volunteers providing psychosocial support through group facilitation will include discussions on: • Treatment adherence • Access and engagement in primary care • Access and engagement in case management, if appropriate.	2.6) Evidence of client progress toward meeting established goals through documentation of activity including sign-in sheets, progress notes, group curricula, etc.
2.7) Virginia Ryan White Part B Eligibility (non-case managed clients) Staff will conduct Virginia Ryan White Part B Eligibility for non-case managed clients. Record eligibility assessments for non-case managed clients as a Psychosocial Support Service.	2.7) Documentation of eligibility assessment submitted in Provide Enterprise® data system.
2.8) Reassess service plan every 90 days to assess progress and identify emerging needs.	2.8) Documentation of review and update of the plan as appropriate, signed and dated by staff. Progress notes should include documentation that a copy of the service plan was provided to the client.
2.9) Refer client to other services as appropriate, e.g., mental health, substance use disorder treatment.	2.9) Documentation of referrals made and status of outcome in client's record.
Transition and Discharge	
2.10) Client discharged when Psychosocial Support Services are no longer needed, goals	2.10) Documentation of discharge plan and summary in client's record with clear

have been met, upon death or due to safety issues. (*see 2.11*) Prior to discharge: Discuss with client reasons for discharge and options for other service provisions. Whenever possible, discussion should occur face-to-face. If not possible, provider should attempt to talk with client via phone. If verbal contact is not possible, a certified letter* must be sent to client's last known address. Must return letter to provider, if client is not present to sign for it. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.* Documentation: Client's record must include: a) Date services began b) Special client needs c) Services needed/actions taken, if applicable d) Date of discharge e) Reason(s) for discharge f) Referrals made at time of discharge, if applicable.	rationale for discharge within 30 days of discharge, including certified letter*, if applicable. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*
Transfer: If client 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 client moves to another area, transferring agency will make referral for needed services in the new location.	Discharge summary and other records send with the patient
Unable to Locate: If a client cannot be located, the subrecipient 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. The three attempts should start no later than three months prior to the due date. A certified letter* must be mailed to the client's last known mailing address within five business days after	Document attempts made

the last attempt to notify the client. The letter will state case closure within 30 days from the date on the letter if no appointment is made with the provider. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.* <u>Withdrawal from Service:</u> If client reports no need of services or not participate in the Service Plan, client may withdraw from services. Because clients 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 client's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. <u>Administrative Discharge:</u> Clients who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a client for this reason, agency leadership must review the case according to that agency's policies. Provide clients discharged for administrative reasons written notification of and reason for the discharge and notify of possible alternative resources. A certified letter* that notes the reason for discharge and includes alternative resources must be mailed to the client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the client's chart. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*	

Case Closure	
2.11) Case will be closed if client: a) Has met the service goals; b) Decides to transfer to another agency; c) Needs are more appropriately addressed in other programs; d) Moves out of state; e) Fails to provide updated documentation of eligibility status thus, no longer eligible for services; f) Fails to maintain contact with the Psychosocial Support Services assistance staff for a period of three months despite three (3) documented attempts to contact client; g) Can no longer be located; h) Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; i) Exhibits pattern of abuse as defined by agency's policy; j) Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program; or k) Is deceased.	2.11) Documentation of case closure in client's record with clear rationale for closure.
3.0 Client Rights and Responsibilities	
Standard	**Measure**

3.1) Services are available and accessible to any individual who meets program eligibility requirements. Each provider shall assist clients with conducting Ryan White Part B eligibility, regardless of whether they receive other Part B services at your agency. All providers shall comply with all applicable federal, state, and local anti-discrimination laws and regulations, including but not limited to the American's with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering services based on the fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or HIV/AIDS diagnosis. Each provider shall make available to clients a process for requesting interpretation services, including American Sign Language.	3.1) Written eligibility requirements and non-discrimination policy on file.
3.2) Each agency should have a Client's Rights and Responsibilities policy, which requires each client to sign & date indicating they has been offered: a) explanation of the policy, and b) copy of *'Client's Rights and Responsibilities* and to communicate client's understanding of the policy.	3.2) Written policy on file.
3.3) Explanation of *Client's Rights and Responsibilities* is provided to each client. Client rights include: • Be treated with respect, dignity, consideration, and compassion; • Receive services free of discrimination; • Be informed about services and options available. • Participate in creating a plan of services;	3.3) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the rights and responsibilities.

• Reach an agreement about the frequency of contact the client will have either in person or over the phone. • File a grievance about services received or denied; • Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; • Voluntary withdraw from the program; • Have all records be treated confidentially; Have information released only when: • A written release of information is signed; • A medical emergency exists; • There is an immediate danger to the client or others; • There is possible child or elder abuse; or • Ordered by a court of law. Client responsibilities include: • Treat other clients and staff with respect and courtesy; • Protect the confidentiality of other clients; • Participate in creating a plan of service; • Let the agency know any concerns or changes in needs; • Make and keep appointments, or when possible, phone to cancel or change an appointment time; • Stay in contact with the agency by informing the agency of change in address and phone number, respond to phone calls and mail • Not subjecting the agency's staff to physical, sexual, verbal and/or emotional abuse or threats.	
4.0 Grievance Process	
Standard	**Measure**

4.1) Grievance policy exists which requires each client to sign & date indicating they has been offered: a) explanation of the policy, b) copy of *Grievance Procedure* and c) communication of client's understanding of the policy. Policy shall describe the process for resolving client grievances, including identification of whom to contact and applicable timelines. Policy shall be available in languages and formats (e.g., for persons with disabilities) appropriate to populations served.	4.1) Written grievance procedure on file, available in languages and formats appropriate to populations served.
4.2) Provide to each client an explanation of *Grievance Procedure*. Clients may file a grievance if their request for services is denied or if they have any complaint or concern about the services received.	4.2) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.
4.3) Grievance process shall be fair and expeditious for resolution of client grievances.	4.3) Documentation of client grievances, status, and resolution.
4.4) Review the *Grievance Procedure* yearly.	4.4) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the client's grievance procedure.
5.0 Personnel Qualifications (including licensure)	
Standard	**Measure**
5.1) All psychosocial and pastoral care counselors will have appropriate and valid licensure if required by the Commonwealth of Virginia.	5.1) Copy of current licensure in personnel file.
5.2) All staff who deliver non-professional counseling services or group facilitation must have a high school diploma or General Equivalency Diploma (GED) and one year of experience working with people with HIV,	5.2) Documentation of qualifications in personnel file.

providing counseling services or additional health care training.	
5.3) Newly employed psychosocial counselors, including individual practitioners, must complete orientation within 2 weeks of hire and the following training within 180 days of hire: • HIV 101; • HIV testing (through VHARCC); • Cultural competency; • Legal ramifications, including confidentiality; • Counseling & referral; and • Prevention (through VHARCC).	5.3) Documentation of training completed in personnel file.
5.4) All staff and volunteers providing will be trained in the following 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 and the difference between this service and other services • Client eligibility assessment skills • HIV co-morbidities, symptoms, medications, interactions and side effects. Train program staff conducting nutritional counseling to perform nutritional assessments.	5.4) Documentation of training completed in personnel file.
5.5) All psychosocial counselors must complete 6 hours of continuing education in counseling or HIV/AIDS annually.	5.5) Documentation of continuing education credits in personnel file.
5.6) Required supervision of all non-professional staff delivering psychosocial support services by a licensed professional.	5.6) Documentation of supervision according to agency policy.
6.0 Cultural and Linguistic Competency	
Standard	**Measure**

6.1) Health services are culturally and linguistically competent, client-guided and community based. At a minimum, provider's documentation should include: a) Experience with providing services to the diverse ethnic, linguistic, sexual or cultural populations targeted; b) Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services; c) List of cultural competency trainings completed by staff.	6.1) Documentation of cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.
6.2) Easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area shall be available.	6.2) Culturally and linguistically appropriate materials and signage accessible.
7.0 Privacy and Confidentiality (including securing records)	
Standard	**Measure**
7.1) Client confidentiality policy exists which include: a) Release of information requirements, and b) Health Insurance Portability and Accountability Act.	7.1) Written client confidentiality policy on file at provider agency.
7.2) Client's consent for release of information is determined.	7.2) Current *Release of Information Form* signed and dated by client and provider representative and located in client's record. Each release form indicates who may receive the client's information and has an expiration of not more than 12 months.
7.3) Store each client's file in a secure location with electronic client records protected from unauthorized use.	7.3) Files stored in locked file or cabinet with access limited to appropriate personnel. Electronic files are secure with password protection and access is limited to appropriate personnel.

7.4) Annual submission of *Verification of Receipt of Assurance of Key Requirements* document by all staff that handle client identifying information.	7.4) Documentation of signed *Verification of Receipt of Assurance of Key Requirement* forms.
8.0 Quality Management	
Standard	**Measure**
8.1) Measure and report client health outcomes using Psychosocial Support Services measures approved by VDH.	8.1) Performance measurement data on the following indicators: • Percentage of people with HIV and receiving Outpatient Ambulatory Health Services, regardless of age, with at least two care markers in a 12-month period that are at least 3 months apart. ▪ Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date. • Percentage of people enrolled in RW Part B-funded Program with HIV and receiving Psychosocial Support Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

References

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