

Texas Department of State Health Services

Protocol-Based
Counseling
Quality Assurance
Standards



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Revised May 2005

Stock#13-11883

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Introduction

This quality assurance (QA) guide was created as part of a Centers for Disease Control and Prevention (CDC) funded project to assess what it takes to create quality assured prevention counseling (PC) in the real world. The project called for tools to be developed to help risk reduction specialists understand and implement the CDC Revised Guidelines for HIV Counseling, Testing, and Referral. As a part of this project, the Texas Department of State Health Services (DSHS) convened a PC Tools Advisory Group to discuss what elements should be included in counseling tools and QA plans, and this guide is a result of their work.

In early 2005, DSHS staff made a series of statewide presentations highlighting the implementation and evaluation of the Protocol-Based Counseling (PBC) project in Texas. In addition, an agency-wide move to PBC was discussed. The presentation is available for review on-line or for download in PowerPoint format at the website listed on the cover page of this guide. Please contact either Jay Todd (jay.todd@dshs.state.tx.us), Jenny McFarlane (jenny.mcfarlane@dshs.state.tx.us), or Ann Robbins (ann.robbins@dshs.state.tx.us) if you have questions about the presentation.

This quality assurance protocol and related forms support the implementation of protocol-based counseling by DSHS contractors. Agencies still providing PCPE should not implement these materials until the switch to protocol-based counseling has been completed.

As you read this document, please keep in mind the following:

- Prevention counseling (PC) is an evidence-based intervention.
- This intervention can be carried out separately from testing and referral.
- There have been replicated studies that show this intervention reduces clients' risk behaviors and new STD infections.
- This intervention focuses on plan-based prevention counseling. Plan-based counseling provides a framework for risk reduction specialists to use during the session that makes it more likely for the essential elements of the intervention to be covered. The essential elements of a prevention counseling session include:
 - Introducing and orienting client to the session
 - Enhancing client's self-perceived risk
 - Exploring client's most recent risk
 - Synthesizing patterns of risks and triggers (putting risk in context)
 - Negotiating a realistic and acceptable risk reduction plan
 - Identifying needed support and referrals
- In Texas, this intervention also includes:
 - Supporting test decision counseling (when appropriate)
 - Providing results simply and supportively
 - Providing partner elicitation (when appropriate)
- QA means actions taken by supervisors and program managers to ensure that the intervention is **consistently implemented across risk reduction specialists and across settings**. It starts with training and development activities for risk reduction specialists, and includes assessment of client satisfaction and client flow, record keeping, and evaluation activities, as well as more traditional elements that include risk reduction specialist observation, feedback, and documentation review.

Defining Quality Assurance for Prevention Counseling, Testing, and Partner Elicitation

Quality assurance (QA) is a way of ensuring that your program delivers prevention interventions as they are intended to be delivered. For prevention counseling, this means ensuring that your risk reduction specialists consistently follow models and protocols of counseling that have been demonstrated to increase the chances that clients will reduce risk behavior. QA activities include observation and feedback, case conferencing, and skill-building opportunities such as training and modeling. QA activities must be on-going and integrated into the functioning of the program.

Protocol-Based Counseling

Intervention Definition

Protocol-Based Counseling (PBC) involves multiple interventions delivered as a set: prevention counseling, testing, referral, and partner services (specifically partner elicitation). Counseling, partner elicitation and/or referral may be provided without testing. This document will emphasize standards associated with prevention counseling.

Prevention counseling is an interactive process in which a risk reduction specialist helps a client identify the specific behaviors and context of behaviors that places him/her at risk for getting or passing on HIV/STD/HCV. The process of counseling also helps a client identify and commit to a specific step designed to reduce the risk for HIV transmission or acquisition and gives a chance to practice skills that go along with that step.

Testing is usually, but not always, a part of the PBC intervention. It is the process through which a client learns his/her infection status and has questions answered about what the test result means.

Referral is the process by which a client's immediate needs for care and supportive services are assessed and prioritized. Clients are provided with assistance in accessing referral services. Referral also includes reasonable follow up efforts necessary to facilitate initial contact with prevention, care, and psychosocial services. **In the context of prevention counseling, referral does not include ongoing support or management of the referral.**

Partner elicitation is an interaction in which the names, locating information and identifying information of the HIV positive- client's sex partners are elicited; this information is also elicited for needle-sharing partners. As outlined in DSHS program guidelines, elicitation should be followed by a discussion of the best method of partner notification: by health department or by contract referral.

Goals of PBC Sessions and Programs

The primary outcome goals of PBC sessions include:

- Increasing clients' self perception of risk;
- Increasing clients' recognition of patterns of risk;
- Creation of risk reduction (RR) steps that:
 - are realistic,
 - address HIV/STD/HCV risks, and
 - address the client's specific risk for HIV/STD/HCV; and
- Provision of appropriate referrals.

If testing is included, an additional outcome goal is for the client to learn his/her status. PBC services also ensure that those individuals who wish to learn their disease status through testing are provided with their test results and accurate interpretation of those results. PBC also provides referral services that are responsive to client-identified needs and priorities and are appropriate to the client's culture, sexual identity, language, and gender. For those clients who are infected, PBC must provide active linkage to appropriate medical, psychosocial support, partner and prevention services.¹

DSHS has set performance standards for PBC programs:

- Development of a realistic and appropriate RR step for at least 75% of the clients
- Return rates of at least 75% for all clients who test
- Return rates of at least 95% for all clients who test HIV-positive
- Elicitation of at least one partner for health department referral from at least 80% of the HIV-positive clients who return for results
- Confirmed linkage to medical services and/or case management services for 95% of those HIV-positive clients who return for results

At the time of the submission of each quarterly program report, agencies that fall below these standards must create a plan to address the causes of these shortfalls, or explain the special causes if the results are due to special events.

PBC Quality Assurance Standards

The Risk Reduction Counseling Model

PBC must be provided face-to-face and to one individual at a time. Group education sessions that precede individual-level counseling are acceptable. Counseling should be client-centered, meaning the focus is on developing skills and plans tailored to the client's situation. The counseling should follow the protocol below. Although this section is limited to listing the essential elements of the counseling session in terms of content, the importance of adequate documentation of the session, especially the risk reduction step and referrals, cannot be overemphasized.

¹ Elicitation of partners for health department referral is not required for HCV-positive clients.

Essential Elements of the Initial Counseling Session

- Introduce and orient client to session
- Enhance client's self-perception of risk
- Explore client's most recent risk
- Review risk behavior and risk reduction experiences
- Synthesize patterns of risks and triggers (putting risk in context)
- Negotiate a realistic and acceptable risk reduction step and support development of risk reduction skills
- Identify needed support and referrals
- Support test decision counseling

Essential Elements of the Results Giving Session

- Orient to session and deliver test results
- Partner elicitation, if client is HIV positive
- Review and renegotiate risk reduction step (may not be appropriate for HIV-positive clients)
- Provide referrals for appropriate medical, prevention, and supportive services

Staff Development Requirements

Staff, paid or unpaid, who are responsible for providing PBC services must receive appropriate training and education to ensure that they have the knowledge, skills, and abilities necessary to deliver the model as described above.

Development Requirements for all Staff

- Staff providing prevention counseling must successfully complete the DSHS PBC course.
- Supervisors of risk reduction specialists must successfully complete the DSHS PBC course and successfully complete *Assuring the Quality of Prevention Counseling*.
- Risk reduction specialists and supervisors must participate in DSHS-endorsed updates related to the scientific and public health aspects of HIV/STD/HCV, counseling techniques or special topics at least once every two years.
- Agencies must create a written staff development plan for each paid risk reduction specialist within 3 months of the risk reduction specialist's date of hire. The plan must be developed by the supervisor in consultation with the risk reduction specialist. DSHS recommends that the development plan be reviewed on a semi-annual basis for risk reduction specialists with less than a year of counseling experience, and yearly for risk reduction specialists with a year or more of counseling experience.
- Agencies must maintain a system for recording all staff training. The system must include employee name as well as date, type, source, and duration of training.
- Agencies should provide opportunities for experienced risk reduction specialists to become "lead risk reduction specialists" or mentors to newer risk reduction specialists.
- Case conferences and/or staffings **must** be scheduled at least once a week.
- Staff must be trained on programmatic guidelines and procedures, program plans and goals, the agency's ethical standards and codes of conduct, and reporting requirements. These issues must be reviewed at least annually with staff.

Counseling Proficiency Assessment

The purpose of proficiency assessment is to assure that all staff receive the feedback and support they need to deliver prevention counseling services according to the model described above. The agency must establish a written process for assessment of counseling proficiency. The method for orienting staff to this process should also be described. Agencies must maintain a system for recording proficiency assessments. The record must include: the name of the employee being assessed as well as the name of the person conducting the assessment, the date of the assessment, and the type of assessment (observation of counseling or documentation review).

Observation of Risk Reduction Counseling Sessions

The process for observation must conform to the minimum elements listed here.

- Assessment of counseling skills may be made through direct observation of counseling sessions or review of audio taped sessions. Client permission must be obtained for either method.²
- Supervisors must observe risk reduction specialists with less than 6 months of counseling experience with the protocol at least twice a month. Risk reduction specialists with 6 to 12 months of experience with the protocol should be observed at least once a month. The supervisor must monitor risk reduction specialists with one to two years of experience with the protocol at least quarterly. Risk reduction specialists with more than two years of experience with the protocol must be observed semi-annually.
- Assessments must be documented using the DSHS Session Observation Form, found in Appendix A. Risk reduction specialists may prepare for assessments by completing self-assessments following counseling sessions. The self-assessment forms can be found in Appendix B.
- Risk reduction specialists must receive both verbal and written feedback on the session; the verbal and written feedback does have to be given at the same time, but should be given within three working days. Needed improvements should be documented in an action plan.
- Agencies may supplement supervisor observation with peer and lead risk reduction specialist observations and feedback.

Review of Risk Reduction Counseling Documentation

The agency must establish written procedures for reviewing the documentation of risk reduction specialists. DSHS will accept either of the following approaches to chart sampling:

- Supervisors may conduct quarterly reviews of a random sample of 10% of the charts across risk reduction specialists for clients seen during that quarter.³
- Alternately, supervisors must review a sample of no fewer than 5 charts for a single risk reduction specialist. The review must be conducted at least twice a month for risk reduction specialists with less than 6 months of experience with the protocol, at least once a month for risk reduction specialists with 6 to 12 months of experience with the protocol, at least once a quarter for risk reduction specialists with one to two years of counseling experience with the protocol, and at least semi-annually for risk reduction specialists with more than two years of experience with the protocol.

² DSHS recommends that the risk reduction specialist explain to the client that the observer is directing his/her attention toward the risk reduction specialist's work during the session and not to the issues presented by the participant. The observer should sit so he/she is able to observe the risk reduction specialist without interfering with the session.

³ If there are 700 or more files for clients seen in that quarter, then the agency may take a 5% sample of charts rather than the 10% sample.

- Regardless of the method chosen, the audit should focus on the completeness of the record and the quality of the risk reduction step as documented.⁴ At minimum, the record must contain:
 - The consent form
 - Session documentation, including documentation of client risk-reduction step
 - Lab result
 - Documentation of referrals, including disposition
 - For HIV positive clients, evidence of partner elicitation activities⁵
- The audit must use the DSHS form included in Appendix D, or you may add the elements of the DSHS form to an agency review form currently in use. Risk reduction specialists must be oriented to the procedure for review and the elements to be audited. Written and verbal feedback must be given on adherence to documentation standards.

Special Requirements for Staff New to the DSHS Model of Risk Reduction Counseling

Risk reduction specialists who are just beginning to work with the DSHS protocol require special support. Agencies must provide evidence that before beginning to provide prevention counseling services, risk reduction specialists have:

- Completed required training.
- Been oriented to agency policies and program procedures, goals, standards and requirements, including confidentiality requirements. New staff must also be provided with written copies/given electronic access to these procedures, goals, standards and requirements.
- Been trained on documenting counseling sessions, including procedures for reporting to the counseling and testing data system.
- Been given opportunities to role-play counseling activities with lead risk reduction specialists and his/her supervisor. The more skilled risk reduction specialists should provide both modeling and coaching.
- Completed a preceptorship in which the new risk reduction specialist will observe five initial counseling sessions, five negative results givings, and one session in which a client is receiving positive HIV results. The new risk reduction specialist should observe multiple risk reduction specialists during this preceptorship. Until the observations of each type of session are completed, the risk reduction specialist may not begin to provide observed counseling of that type (i.e., until the risk reduction specialist has observed five negative results giving, the risk reduction specialist may not give a negative test result). The new risk reduction specialist may begin counseling solo after by being observed by more experienced risk reduction specialists doing five initial counseling sessions, five negative results givings, and at least one positive HIV results giving. Multiple risk reduction specialists should observe the new risk reduction specialist. The observing risk reduction specialists should use standard QA forms and procedures while observing the new risk reduction specialist, and should provide detailed verbal and written feedback to the new risk reduction specialist and her/his supervisor (if the supervisor is not conducting the observation) as soon as is feasible. If the supervisor has concern about the risk reduction specialist's skills, the preceptorship may be extended.

Notification of Test Results

To assure that clients who test know their status, at least 75 percent of the clients who test and at least 95 percent of HIV-positive clients must receive their test results. At the time of the submission of each quarterly report, agencies

⁴ If the client tests anonymously, the client's real name cannot be connected with any form in the record.

⁵ Identifying information on partners should not be kept permanently as part of the client record.

that fall below either standard must create a plan to address the causes of these shortfalls, or explain the special causes if there is reason to believe that the return rate is low due to special events. The agency must have written procedures describing specific strategies to provide results and counseling to confidentially tested HIV-positive clients who do not receive their test results, including notification of the local health authority.

Referrals

Key Referral Steps

DSHS PBC contractors must follow the following key steps when making referrals:

- Assess Client Referral Needs
 - Identify key factors that influence the client's ability to adopt/sustain risk reducing behaviors.
 - Examine client's willingness and ability to accept and complete a referral.
 - Document referral needs and priorities in client record.
- Referral Planning
 - Assess factors that might make it difficult to complete a referral (e.g., lack of transportation, work schedule).
 - Identify strategies to facilitate a successful referral.
 - Document referral plan in client record.
- Facilitate Access to Referral Services
 - Provide the client with information necessary to access the service (e.g., contact name, eligibility requirements, location, telephone number).
 - As appropriate, provide assistance with completing the referral (e.g., set appointment, provide or facilitate transportation).
 - Document assistance provided in client record.
 - If client-identifying information is to be shared between providers, written consent must be obtained from the client.
- Document Referral and Referral Follow-Up
 - • Assess if the referral was kept and any difficulties the client experienced.
 - • Document status of referral in client record.

Referral Requirements for HIV-positive Clients

For HIV infected clients, referrals must be made for appropriate medical care and for partner counseling and referral services. The referrals for medical care must be confirmed for at least 95 percent of the HIV-positive clients who return to receive test results.



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