Early Intervention Services (EIS)[i]

Description:
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

• RWHAP Parts A and B EIS services must include the following four components:

1. Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected
    a. Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
    b. HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
2. Referral services to improve HIV care and treatment services at key points of entry
3. Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Use Disorder Care
4. Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

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 living with HIV, including the following:

1.0 Intake and Eligibility
National Monitoring Standards: Eligibility determination process requiring documentation in patient medical records of low-income status and eligibility based on a specified percent of the FPL and proof of an individual's HIV-positive status, residency. Determination and documentation of patient eligibility every six months.[ii] Documentation that Early Intervention Services funds are used only to support eligible activities, including: a) targeted HIV testing to help the unaware learn of their HIV status; b) referral services to improve HIV care and treatment services at key entry points; c) access to care and treatment services; d) outreach services and health education/risk reduction related to HIV diagnosis.[iii]

Health Resources and Services Administration (HRSA), the funder for Ryan White HIV Services, prohibits continued HIV services, including medications to clients who are not recertified for eligibility of services by their specified date; therefore, if a client has not completed their annual certification or recertification at six months they may not be eligible for Ryan White services.	
Standard	**Measure**
Eligibility	
1.1) The client's eligibility for Ryan White Part B services is determined.	1.1) Documentation of the client's eligibility is present in the client's record.
1.2) To be eligible for this service applicants must: a) Diagnosed with HIV b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Ryan White Part B is the payer of last resort and other funding sources must be vigorously pursued. Providers are responsible to ensure that clients are screened and deemed 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. e) Provide recertification every six months with proof of income, changes in insurance coverage, or any changes in residency f) **Client eligibility ensures Part B services are used as the payer of last resort.** Client must agree to participate in the insurance option client is eligible and that best meets the client's medical needs regardless of preference. *Note:* The Part B Program is the payer of last resort. This is interpreted as "funds received...will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made..." by another payment source.[iv]	1.2) Documentation is present in files verifying that: a) Client is diagnosed with HIV b) Client Lives in Virginia c) Client meets income guidelines d) Client Medicaid status (gap of services) e) eligibility for Part B services every six months f) Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

Apply through the VDH Central Office or through agency's eligibility services.	
2.0 Key Services Components and Activities (include assessment and service plan) ***National Monitoring Standards: EIS Services must include the following four components: 1) targeted HIV testing to help the unaware learn of their HIV status and receiving referral to HIV care and treatment services if found to be HIV-infected; 2) Referral services to improve HIV care and treatment services at key points of entry; 3) Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care; 4) Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.[v]***	
Standard	**Measure**
2.1) Memoranda of understanding (MOUs) will be established with key points of entry into care to facilitate access to care for those who test positive.	2.1) Number of MOUs established with key points of entry.
A. HIV Testing and Targeted Counseling	
2.2) Clients are screened for health insurance, other sources of reimbursement, and/or other benefits	2.2) Completed documentation of client coverage in client's file
2.3) Provision of HIV testing and targeted counseling services that meet CDC and state requirements.	2.3) Documentation to include: • Number of HIV testing and targeted counseling services provided that meet CDC and state requirements. • Number of HIV-positive tests. Where and when Part B-funded HIV testing occurred.
B. Referral Services	
2.4) Referral for EIS services shall be from key points of entry to include, but not limited to public health departments, emergency rooms, substance use disorder and mental health treatment programs, detoxification centers, detention facilities, sexually transmitted disease clinics, homeless shelters, HIV/AIDS counseling and testing centers, community corrections, jails, and federally qualified health centers.	2.4) Number of referrals from key points of entry to EIS programs.
2.5) Except for HIV testing, a referral by a Ryan White Part B provider is made for	2.5) Documentation of the referral by a Ryan White Part B provider is present in the

initiation of services. No referral is required if HIV testing is performed as part of EIS.	client's record, signed and dated, except for HIV testing.
2.6) Linkage agreements in place with Outpatient Ambulatory Health Services and HIV Prevention services	2.6) Copies of Memorandum of Understanding (MOU) are available. Referrals are documented in the client chart.
2.7) For persons who test negative, refer to HIV prevention services, including Pre-exposure prophylaxis (PrEP).	2.7) Number of referrals for prevention services for persons who tested HIV-negative.
2.8) For persons who test positive, refer and link to health care and supportive services, such as outpatient/ambulatory health services, medical case management and substance use disorder care.	2.8) Number of referrals for health care and supportive services for persons who tested HIV-positive.
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.
C. Linkage to care	
2.10) HIV positive clients are referred to a primary medical care provider or an infectious disease provider for initial lab work	2.10) Referral date and date of initial lab work are documented in the client chart.
2.11) Follow-up with clients who are not in HIV medical care until the client is engaged in care. Providers must prioritize clients who have been recently diagnosed or have been out of medical care for longer than six months and who experience barriers to care such as: a) Active or recent substance use disorder issues b) Active or recent mental health issues c) Recent or chronic incarceration d) Homelessness or unstable housing e) Recent change in income	2.11) Follow up date and date in the client chart.
2.12) As necessary, HIV positive clients are referred to medical case management, substance abuse treatment and other core medical services	2.13) Referral date and provider documented in client chart.
2.13) Care will be coordinated across the HIV care team and specifically address engagement in care.	2.13) Documentation of consultation with medical staff, mental health and other support services, as appropriate.

2.14) Develop with the client a service plan to be reassessed every 90 days to evaluate progress and identify emerging needs.	2.14) Documentation of initiated service plan signed and dated by client and support counselor.
D. Health Education and Literacy Training	
2.15) Conduct an individual assessment of client's knowledge of HIV risk and transmission, disease progression and the health care delivery system	2.15) Completed assessment filed in client chart.
2.16) Based on the results of the assessment, Provide health education, risk reduction and literacy training to help individuals understand the HIV diagnosis and navigate the HIV system of care.	2.16) Documentation of education provided in client's record.
2.17) Service plan is reassessed every 90 days to assess progress and identify emerging needs.	2.17) Documentation of review and update of the plan as appropriate signed and dated by client and support counselor.
2.18) Assess if health education and literacy training to staff support both HIV positive and negative clients to meet their needed health goals.	2.18) Health education sessions outcomes are documented in client chart.
Transition and Discharge	
2.19) Client discharged when EIS services are no longer needed, goals have been met, upon death or due to safety issues *(see 2.14)* EIS may be called upon to re-engage the client if falls out of care. Prior to discharge: Reasons for discharge and options for other service provision should be discussed with client. 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. If client is not present to sign for the letter, it must be returned to the provider. Documentation: Client's record must include: • Date services start • Special client needs • Services needed/actions taken, if applicable	2.19) Documentation of discharge plan and summary in client's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable.

• Date of discharge • Reason(s) for discharge • Referrals made at time of discharge, if applicable. <u>Transfer:</u> 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. <u>Unable to Locate:</u> If client 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 client's last known mailing address within five business days after the last attempt to notify the client. 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. <u>Withdrawal from Service:</u> If client reports that services are no longer needed or decides to no longer 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, the case must be reviewed by leadership according to that agency's policies.	

Clients 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 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.	
Case Closure	
2.20) Case will be closed if client: • Has met the service goals; • Decides to transfer to another agency; • Needs are more appropriately addressed in other programs; • Moves out of state; • Fails to maintain contact with the other EIS staff; • Fails to maintain contact with the insurance assistance staff for a period of three months despite three (3) documented attempts to contact client; • Can no longer be located; • Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; • Exhibits pattern of abuse as defined by agency's policy. • 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 • Is deceased.	2.20) Documentation of case closure in client's record with clear rationale for closure.
3.0 Client Rights and Responsibilities *National Monitoring Standards: Provision of Part B funded HIV primary medical care and support services, to the maximum extent, without regard to either: the ability of the individual to pay for such services, or the current or past health conditions of the individuals served.*[vi]	
Standard	**Measure**

3.1) Services are available and accessible to any individual who meets program eligibility requirements. All providers shall be in compliance 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 on the basis of 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) Clients Rights and Responsibilities policy exists which requires each client to sign & date a form 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: o Be treated with respect, dignity, consideration, and compassion; o Receive services free of discrimination; o Be informed about services and options available. o Participate in creating a plan of services; o Reach an agreement about the frequency of contact the client will have either in person or over the phone. o File a grievance about services received or denied; o Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; o Voluntary withdraw from the program;	3.3) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record.

○ 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 and ○ Avoid to subject 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, and 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.	4.1) Written grievance procedure on file, available in languages and formats appropriate to populations served.

Policy shall be available in languages and formats (e.g. for persons with disabilities) appropriate to populations served.	
4.2) Explanation of *Grievance Procedure* is provided to each client. 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.
4.3) Grievance process shall be fair and expeditious for resolution of client grievances. Review of grievance policy yearly with client signature.	4.3) Documentation of client grievances, status and resolution.
5.0 Personnel Qualifications (including licensure) ***National Monitoring Standards: Documentation of appropriate and valid licensure and certification as required by the State.***[vii]	
Standard	**Measure**
5.1) Staff shall have knowledge and understanding of HIV testing, HIV education, the criminal justice system, services for PLWH/A, and medical systems. Staff shall have experience working with people experiencing homelessness, mental health conditions, substance use disorder issues, and developmental delays.	5.1) a) Personnel records contain documentation of completed disease intervention specialist or HIV testing training, as appropriate. b) Personnel records contain documented training/experience in working with people with substance use disorder/addiction, issues of poverty, mental illness, developmental delays, and criminal justice system.
5.2) Staff qualifications: a) Staff providing care and/or counseling services to clients participating in the Early Intervention program must be trained to provide these services to recently diagnosed HIV/AIDS clients and to PLWHs who know their status and are not in care. b) All agency staff that provide direct-care services shall possess: • Advanced training/experience in the area of HIV/infectious disease • HIV early intervention skills and abilities as evidenced by training,	5.2) Evidence of training will be documented in the staff personnel records

certification, and/or licensure, and documented competency assessment • Skills necessary to work with a variety of health care professionals, medical case managers, and interdisciplinary personnel.	
5.3) Staff Training: a) Within three (3) months of hire, all staff must complete a minimum of sixteen (16) hours of training regarding the target population and the HIV service delivery system in the service area, including but not limited to: • The full complement of HIV/AIDS services available within the selected areas • How to access such services [including how to ensure that particular subpopulations are able to access services (i.e., undocumented individuals)] • Eligibility for other sources of funding under entitlement and benefit programs other than Ryan White services. Each staff will complete a minimum of 12 hours of training annually to remain current on HIV care. Evidence of training will be documented in the staff personnel records	5.3) Evidence of training will be documented in the staff personnel records
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: • Experience with providing services to the diverse ethnic, linguistic, sexual or cultural populations targeted;	6.1) Documentation of cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.

• Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services; • List of cultural competency trainings completed by staff	
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.[viii]	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: 1) 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) Each client file is stored in a secure location. Electronic client records are 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 ***National Monitoring Standards: Implement a Clinical Quality Management Program (CQM) to include: a) written QM plan; b) quality expectations for providers and services; c) method to report and track expected outcomes; d) monitoring of provider compliance with HHS treatment guidelines and Part B Program's approved Standards of Care.***[ix]	
Standard	**Measure**
8.1) Measure and report client health outcomes using Early Intervention Services measures approved by VDH.	8.1) Performance measurement data on the following indicators: • Percentage of people enrolled in RW Part B-funded Program living with HIV regardless of age and receiving EIS

	services, who will have at least one care marker* in a 30 day period. ** 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*

[i] HRSA/HAB Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice #16-02 (Revised 10/22/18).
[ii] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards for Part A and B Grantees: Universal (April, 2013), p. 4.
[iii] HRSA/HAB Ryan White HIV/AIDS Program Services: Clarifications on Ryan White Program Eligibility Determinations and Recertification Requirements Policy Clarification Notice #13-02, p. 9.
[iv] Public Health Service Act; Sections 2605(a) (6), 2617 (b) (7) (F), 2664 (f) (1), and 2671 (I).
[v] HRSA/HAB Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice #16-02 (December 5, 2016).
[vi] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April, 2013), pp. 61-62.
[vii] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April, 2013), p. 42.
[viii] National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Available at:
https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf
[ix] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April, 2013), p. 71.