Early Intervention Services (EIS)

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02:
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 with HIV.
    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.

Virginia Ryan White Part B Service Unit Definition:
All four components must be completed to receive one unit:

1. Completing one targeted HIV testing effort,
2. One referral to HIV medical care,
3. One linkage to HIV care or treatment, **and**
4. One outreach and health education/risk reduction unit.

(Note: If any of the four conditions are not present, each component must be billed to the appropriate service category. A client should receive only one EIS unit.)

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, including the following:

1.0 Intake and Eligibility

As outlined in HRSA HAB Policy Clarification Notice 21-02 Clarifications (PCN) on Ryan White Program Client Eligibility Determinations 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. 2 (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) Self-referral or referral by a Part B provider for Early Intervention Services is documented prior to initiation of the service.	1.1) Appointment documented for qualifying Early Intervention Services is present in the client's record.
Eligibility	
1.2) The client's eligibility for Ryan White Part B services is determined. To be eligible for this service applicants must: a) Be diagnosed with HIV (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. • Client Access Reviews (CARs) - refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility.	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 Medicaid status verified (gap of services) • Ongoing CARS and complete Continuation Eligibility Determination every 24 months • Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

• Provide continuation of eligibility every 24 months with proof of income, changes in insurance coverage, or any changes in residency • Client eligibility ensures Part B services are used as the payer of last resort and other funding sources must be vigorously pursued**.** 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.
2.0 Key Services Components and Activities	
Standard	**Measure**
2.1) Subrecipients will establish Memoranda of understanding (MOUs), with key points of entry to care, to facilitate care access 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 assessment of 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 tests 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 initiation of services. No referral is required if HIV testing is performed as part of EIS.	2.5) Documentation of the referral by a Ryan White Part B provider is present in the 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) As necessary, refer client to other appropriate services, 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 engaged in HIV medical care until the client is 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	2.12) 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 a service plan with the client, to be assessed every 90 days for evaluation of progress and 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 2.20)* EIS	2.19) Documentation of discharge plan and summary in client's record with clear rationale

may be called upon to re-engage the client if falls out of care. Prior to discharge: Conduct discussion with client over 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. If client is not present to sign for the letter, return to the provider. *Exception: If the client has noted during the intake or at any other time to the VA MAP staff that sending mail is not permitted, no letter will be sent. If this is the case, VDH will document this in progress notes and discharge summary. Documentation: Client's record must include: a) Date services start 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. Transfer: If client transfers to another location (state), 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. Unable to Locate: 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. The three attempts should start no later than three months prior to the due date. A certified	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. Discharge summary and other records send with the patient Document attempts

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 case closure within 30 days from the date on the letter if no appointment is schedule 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 longer needing services 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 understanding reasons for withdrawal, or if client still needs services identify factors interfering with the client's ability to fully participate. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. <u>Administrative Discharge:</u> Discharge clients who engage in behavior that abuses the safety or violates the confidentiality of others. Prior to discharging a client for this reason, agency leadership according to that agency's policies must review the case. 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	
2.20) Case will be closed if client: • Has met the service goals; • No longer meets eligibility criteria; • Decides to transfer to another agency; • Needs are more appropriately addressed in other programs; • Moves out of state; • Fails to provide updated documentation of eligibility status thus, no longer eligible for services; • Fails to maintain contact with the ADAP 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	
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.	3.1) Written eligibility requirements and non-discrimination policy on file.

All providers shall comply with all applicable federal, state, and local anti-discrimination laws and regulations, including but not limited to the Americans with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering any service because of 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. Each provider shall make available to clients a process for requesting interpretation services, including American Sign Language.	
3.2) Each agency should have a Client's Rights and Responsibilities policy, which requires each client to sign & date a form indicating they have 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; • 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;	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.

• 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 and • Avoid 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 requires each client to sign & date indicating they have been offered: a) explanation of the policy, b) copy of *Grievance Procedure* and c) communication of client's understanding of the policy.	4.1) Written grievance procedure on file, available in languages and formats appropriate to populations served.

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.	
4.2) Provide explanation of *Grievance Procedure* to each client. Clients may file a grievance if denied their request for services, 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 of grievance policy yearly with client signature.	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) Staff shall have knowledge and understanding of HIV testing, HIV education, the criminal justice system, services for PWH, and medical systems. Staff shall have experience working with people experiencing homelessness, mental health conditions, substance use disorder issues, and developmental delays.	5.1) Personnel records contain documentation of completed disease intervention specialist or HIV testing training, as appropriate. 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 clients and to	5.2) Evidence of training will be documented in the staff personnel records

PWH 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; • Early intervention HIV skills and abilities as evidenced by training, 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: 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, 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 from date of signature.
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 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 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 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*

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