N-S EMA EARLY INTERVENTION (EIS) SERVICE STANDARDS

Approved by Planning Council May 11, 2017

Service standards outline the elements and expectations a RWHAP Service provider follows when implementing a specific service category. The purpose of service standards are to ensure that all RWHAP service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a RWHAP funded agency or provider may offer within a state, territory or jurisdiction.

N-S HIV Health Services Planning Council
www.longislandpc.org

EARLY INTERVENTION SERVICES (EIS)
SERVICE STANDARDS

Early Intervention Services (EIS) Includes counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, and tests to provide information on appropriate therapeutic measures); counseling referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic measures.

***Note**: At this time testing, including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures, is not covered under this priority as the EMA has adequate testing resources. However, coordination is expected with testing facilities.*

Service Goal: The primary purpose of this service is to identify those who are unaware of their HIV status and those who are aware and out of care, inform them of their status and services available to them, refer them to the appropriate medical supportive services and ensure they are linked to and retained in medical care.

Service Components:

In the Nassau-Suffolk EMA, programs must clearly address each of the four areas: identification, informing, referral, and linkage to care.

*EIS programs must have:

- ⇨ linkages with key points of entry and active relationships/partnerships with counseling and testing providers;
- ⇨ referral services providing access to care; and
- ⇨ health literacy education/training to help clients navigate the HIV/AIDS service delivery system.
- ⇨ Programs may use peers for peer support and mentoring.

As directed by HAB National Monitoring Standards for Ryan White Part A Grantees

Objectives:

1. Service provision focusing on early diagnosis, engagement, linkage, and retention of newly diagnosed PLWHA into primary care, in an effort to improve CD4 count, suppress viral load, improve health outcomes, and reduce disease transmission.
2. To reengage PLWHA who are out of care for over a year, back into care and reinforce retention in care, thereby striving to improve CD4 count, suppress viral load, improve health outcomes, and reduce disease transmission.

Program Outcomes:

- Clients made aware of HIV status

- Clients referred to risk reduction services (HIV+ and HIV -)
- Clients previously out of care are reengaged and retained in care

Indicators:

- Number of clients located and identified as at high risk for HIV
- Number for clients tested for HIV
- Number of clients informed of results of HIV test
- Number of clients referred to risk reduction services and/or HIV medical care
- Number of HIV+ clients referred to Medical Case Management and Outpatient Ambulatory Health Services for treatment of HIV
- Number of identified barriers preventing or delaying entry into Outpatient Ambulatory Health Services
- Number of resolved barriers that prevented entry into Outpatient Ambulatory Health Services
- Retention in Outpatient Ambulatory Health Services defined as receipt of initial viral load and attendance at 2 OAHS visits.

Service Units: Face to face individual and/or face to face group level intervention.

Program Data Reporting:
Part A service providers are responsible for documenting and keeping accurate records of Ryan White Program Data/Client Information, units of service, and client health outcomes. Reporting units of service are a component of each agency's approved workplan. Please refer to the most current workplan, including any amendments, for guidance regarding units of service. Summaries of service statistics by priority will be made available to the Planning Council by the grantee for priority setting, resource allocation and evaluation purposes.

PROGRAM COMPONENTS:

STANDARD	MEASURE
• Initial and Ongoing Assessment of Client Service Needs	• **Documentation of Eligibility** including proof of HIV+ status, Insurance status, Residency-Nassau or Suffolk County, and Income up to 435% of FPL • Documentation of Assessment of Client Service Needs (including access to other resources, payer sources, presenting problem, relevant history, plan including basic medical history, drug usage, mental health status, housing, adequate nutrition etc.)
• Development of Comprehensive and Individual Care or Service Plan with client	• Documented Care Plan or service plan(date of development, problems to be addressed, interventions addressing goals, progress in addressing goals, and mitigation of any identified barriers, planned frequency of contact, start and end date of treatment, staff and client signature)
• Coordination of services to ensure connection to and maintenance in medical care	• Documentation of coordination (agencies must maintain relations with providers in the continuum of care and be able to connect clients to medical care).

• Client monitoring to assess progress	• Documentation that progress is occurring though reassessment of continued linkage to care prior to case transfer and closure.
• Services must be provided by staff knowledgeable about available resources and HIV/AIDS.	• Documentation of training in HIV/AIDS, treatment adherence, cultural competency, substance abuse, mental health, and medical updates in HIV/AIDS and HIV/AIDS confidentiality.
• Services provided in culturally and linguistically competent manner	• Assessment and documentation of language, cultural or other barriers and ways to reduce barriers.
• Clients will sign a contract for services outlining their rights and responsibilities upon admission into the program, as well as a grievance procedure for RWA/MAI services. Clients will be reminded of their Rights and Responsibilities and grievance procedures prior to discharge.	• Signed documents in client chart
• Client records will be contained in a locked file within a secure office space to ensure client confidentiality.	• Verification of locked cabinet and secure storage
OUTCOME	**MEASURE**
• Increase the number of HIV+ unaware individuals who are informed of their newly diagnosed HIV status.	• 2% of HIV+ unaware individuals will be aware of their HIV status
• Increase the number of clients aware of their HIV status, whether newly diagnosed or re-engaged successfully into HIV/AIDS primary medical care.	• 80% of HIV aware clients will enter HIV/AIDS primary medical care.

PERSONNEL:

Staff Qualifications	Expected Practice
Staff providing care and/or counseling services to clients participating in the EIS program must be trained to provide these services to both recently diagnosed PLWHA ***and*** to PLWHA who know their status but are out of care. All agency staff who provide direct care services shall possess: • Training/experience in the area of HIV/AIDS • Skills and abilities as evidenced by training, certification, and/or licensure • Demonstration of skill level to work with health care professionals, medical case managers, and interdisciplinary personnel • A minimum of a high school diploma, GED/TASC preferred.	Personnel records/resumes/applications for employment reflect requisite experience/education. Documentation of training on file.
Trainings in cultural competency, HIV confidentiality and at least 1-2 HIV specific trainings annually.	Documentation of training on file.

CLIENT VERIFICATION OF ELIGIBILITY:

As required by HRSA/HAB Policy Notice #13-02, Ryan White Eligibility and proof of documentation are required at intake/assessment and must be updated every 6 months. Please refer to the N-S EMA's Ryan White Client Eligibility Guidelines for specific Information and acceptable forms of documentation.

Standard	Provider/Sub-grantee Responsibility
Eligibility determination of clients to determine eligibility for Ryan White services within a predetermined timeframe	**Initial Eligibility Determination Documentation Requirements:** • HIV/AIDS Diagnosis (at initial determination); • Proof of residence (Nassau or Suffolk); • Proof of Income- 435% of the Federal Poverty Level; • Proof of Insurance Status- Uninsured or underinsured status (insurance verification as proof); • Determination of eligibility and enrollment in other third party insurance programs including Medicaid, Medicare; • For underinsured, proof this service is not covered by other third party insurance programs including Medicaid and Medicare; • Viral Load CD4

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
INTAKES					
An appointment will be scheduled no later than **3 working days** of a referral/request to Early Intervention Services.	Documentation in client's file on referral date and appointment date scheduled.	Number of clients with less than or equal to 3 working days documented between client request and appointment	Number of clients referred to Early Intervention Services	Client Files CAREWare	90% of clients will have an appointment scheduled within 3 working days of request for Early Intervention Services.
ASSESSMENTS					
A comprehensive assessment is to be completed within **2 week**s of intake to Early Intervention Services.	Comprehensive assessment in client chart containing: • Medical history • Health resources • Potential barriers to care • Substance abuse concerns • Mental health concerns • Housing stability • Financial resources • Partner notification needs • Other service needs	Number of client charts with assessment completed within 1 week of intake	Number of clients accessing Early Intervention Services	Client Files CAREWare	90% of clients will have comprehensive assessments completed within 2 weeks of intake.
TREATMENT PLANS					
A treatment plan will be signed between EIS staff and client within **2 weeks** of assessment date.	Documentation of ***client signed***/dated treatment plan which includes: • List of service needs • Establishment of short and long term goals • Objectives and action steps to meet short-term goals • Any identified	Number of client charts with signed treatment plans completed within 2 weeks of assessment	Number of clients accessing Early Intervention Services	Client Files CAREWare	90% of clients will have treatment plans signed within 2 weeks of assessment.

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
	barriers to goals • Indication of who is responsible for action steps and objectives (i.e. staff, client) • Goal Completion dates				
Referrals, Linkage, and Retention in Care					
EIS staff will ***refer*** newly diagnosed or out of care clients to HIV primary medical care/outpatient ambulatory health services within 1 week of comprehensive assessment	Documentation in client file of: referral source, date of referral, service coordination, and client acknowledgement	Number of clients receiving a referral to HIV primary medical care/Outpatient Ambulatory Health Services	Number of clients accessing Early Intervention Services	Client Files CAREWare	90% of clients will be referred to HIV primary medical care/outpatient ambulatory health services within 1 week of comprehensive assessment
EIS staff will ***link*** clients with HIV Primary Medical care and medical case management, offer appointment reminders, accompany clients on health care and case management appointments, help clients understand HIV disease, treatment options, and risk reduction behaviors.	Documentation in client file of: linkages, dates of service, and care coordination	Number of clients attending appointments to primary medical and other supportive services.	Number of clients linked to Early Intervention Services	Client Files CAREWare	85% of clients will receive care linkages to medical and supportive services while enrolled in EIS program.
EIS clients will be ***retained*** in care as evidenced by attendance at 2 HIV Primary Medical Care/Outpatient Ambulatory Health Services appointments	Documentation in client chart of verification of client attendance (i.e. follow up call to provider) Copy of lab work documenting viral load and CD4	Number of clients who have attended two HIV primary care appointments and have a documented Viral Load and CD4.	Number of clients linked to Early Intervention Services	Client Files Copies of labs CAREWare	85% of clients will be retained in care while enrolled in the EIS program.

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
Discharge/Case Closure					
EIS staff will work with clients for a ***maximum*** of 6 months to facilitate linkage to care	Documentation in client file of time frames for service coordination, referrals to medical case management prior to discharge from program.	Number of clients receiving services for no more than a six month time frame.	Number of clients retained in Early Intervention Services	Client Files CAREWare	90% of clients will receive EIS services for a maximum of six months.
EIS staff will complete a client-centered discharge plan which includes connection to other resources needed to support client's retention in care.	Documentation of client discharge plan indicating summary of services, outcome report, and transition to other services within the community to maintain care.	Number of clients with a comprehensive discharge plan on file.	Number of clients are retained in Early Intervention Services	Client Files CAREWare	90% of EIS participants will receive a client-centered discharge plan, inclusive of resources needed to maintain their medical care.