Minnesota Ryan White HIV/AIDS Program
Service Area Standards: Early Intervention Services

HRSA Definition: 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 Abuse Care
4. Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

Universal Standards: All subrecipients must meet universal standards requirements in addition to service area standards for which they are funded.

Definitions:

Assessment: Individual evaluation of an HIV positive individual's medical care and risk status, knowledge of disease, barriers to accessing medical care and awareness of resources.

Contact: An approach made to an individual to talk about her or his HIV status, risk, and/or access to services.

Coordination: Working with other service providers to ensure efficiency and eliminate duplication of efforts.

Core medical services: HIV primary medical care--including ambulatory outpatient HIV clinic services, AIDS Drug Assistance Program, oral health care, outpatient mental health care, outpatient substance abuse treatment, medical nutritional therapy, medical case management including treatment adherence, early intervention services, home health care services and specialty medical care referrals.

Early intervention services (EIS): A mix of services limited to 1) targeted testing and counseling of individuals with respect to HIV/AIDS; 2) formal relationships with key points of entry that facilitate follow-up 3) referral services providing access to care, and 4) health education and literacy training enabling clients to navigate the HIV system of care. Note: All four program components must be present for a program to be considered an early intervention services program.

Eligible for Ryan White EIS Services: Individuals who are assessed to be at risk and unaware of their HIV status or HIV positive and out of care, who also meet financial eligibility requirements and are in need of assistance to access testing and/or HIV medical care. Does not include clients currently receiving Medical Case Management or HIV primary medical care services.

Encounter: Engagement of an individual in conversation about his or her HIV risk, status, and access to services.

Hard to reach populations: People not accessing care due to barriers that may include poverty, health insurance gaps, substance abuse, or mental health problems. Other co-factors such as fear and stigma, low health literacy, and lack of readiness also create barriers to care.

Health education and literacy training: services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission as well as how to navigate the system of care.
- Provision of information about available medical and psychosocial support services
- Counseling on how to improve their health status and reduce the risk of HIV transmission to others

High risk populations: Populations known through local epidemiologic data to be at disproportionate risk for HIV infection.

In care: A person is considered to be in care when he or she is receiving primary HIV medical care (clinical evaluation and clinical care) at a minimum of every six months. This medical care should meet U.S. Public Health Service guidelines for the treatment of HIV/AIDS.

Linkage: Successful engagement of a client into primary HIV medical care, with the understanding that current barriers to returning to care at recommended intervals are addressed; client is assessed as being likely to keep HIV medical appointments in the near future

Medical Case Management: Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Non-medical support services: Services that address barriers to people living with HIV/AIDS accessing and remaining in primary medical care.

Out of care: An individual that has not accessed primary HIV medical care within the last six months.

Partnerships: An arrangement with another service provider that will help advance the goal of care EIS. *Written referral agreement with HIV medical provider.*

Points of entry: Health care and human services access points used frequently by traditionally underserved HIV-positive individuals to help meet their medical and social service needs. They are therefore key access points for referring such individuals into the HIV care system. Examples are health departments, emergency rooms, substance abuse programs, mental health programs, detention facilities, STD clinics, homeless shelters, counseling and testing sites, federally qualified health centers, and other healthcare points of entry that have established referral relationships/agreements with Part A funded Early Intervention Services providers.

Referral: The recommendation of a medical, paramedical professional, and other service providers.

Testing and Counseling: Refer to current Centers for Disease Control and Prevention guidelines for HIV test and counseling. Counseling includes HIV prevention, transmission, and the importance of early diagnose and treatment.

Standard	Measure	Data Source
Individual Client Focused Standards		
1. Sites Program staff will identify sites (including social networking sites) and make contacts with people in the community to meet program goals for initiating eligible individuals into Ryan White EIS. 1.1 Sites will be identified to reach individuals out of care and unaware of their HIV status. 1.2 Program will continuously explore new opportunities and sites for reaching individuals out of care and unaware of their HIV status.	1.1.-1.2 Program will track sites, opportunities, and rate of finding individuals out of care and unaware of their HIV status.	1.1.-1.2 Program files and quarterly reports will document sites, opportunities, and rate of finding individuals out of care and unaware of their HIV status.
2. Testing 2.1 Ryan White funds are used for HIV testing only where existing federal, state, and local funds are not adequate, and Ryan White funds will supplement and not supplant existing funds for testing	2.1. Program documents Ryan White Part funds as the payer of last resort.	2.1. Documentation filed.
3. Health education and literacy training is provided that enables clients to navigate the HIV system. 3.1 Program staff will utilize a screening tool to assess clients' risk behaviors, knowledge of their HIV status, care status, other immediate needs and knowledge of HIV and other medical and social services available. 3.2 Assessment will include identification of needs and a follow-up plan. 3.3 Client will receive HIV risk reduction counseling and on the benefits of early detection and treatment of HIV infection.	3.1-3.3. Client screening will include HIV knowledge, risk, HIV status, date of last HIV test (if at-risk status identified), date of last medical appt (if positive) and services needs. 3.2. A follow-up plan will be in place to address client's identified needs.	3.1.- 3.3. Field notes completed; screening in individual client files and number of screenings in quarterly reports.
4. Rapid ART: To engage and link those newly diagnosed with HIV into care and treatment within 7 days of diagnosis.	4.1. – 4.2. Number of referrals, coordination activities, follow-ups, and	4.1.-4.2. Individual client records and client level data reflect referrals, and follow-up to confirm linkage to care. Quarterly reports document the

Standard	Measure	Data Source
• Agencies shall have a written policy for RRT, expediting care and treatment for referral of newly diagnosed and out of care clients. Coordination and referral including HIV appointments, labs, and treatment within 7 days. • Agencies shall have memorandums of understandings with Ryan White Funded Outpatient Health Services (OHS) providers (and other local HIV care and treatment providers.) • Agencies shall develop and maintain relationships with Ryan White Funded OHS providers. 4.1 Program staff will work individually with clients until linkages to testing, care and other needed services are confirmed. Staff will provide information on available HIV services, including referral and coordination to ensure clients are linked to HIV-related medical care and other services. Individuals who test positive are referred and linked to health care and supportive services 4.2.a Coordination of referrals will include addressing clients' barriers to care such as transportation, mental health issues, chemical health needs, or basic needs such as housing, financial assistance, and nutrition. 4.2.b Referrals to medical case management, mental health, and outpatient substance abuse treatment services should be made when needs are identified. 4.2.c Referral, coordination, and follow-up to HIV-related medical care should always occur for individuals out of care. Linkage to needed care will be confirmed with primary care and core medical services providers. 4.3.a Program staff will develop a plan with individual clients for how program staff will follow up with them post	confirmed linkages. 4.2.c Written referral agreement with HIV medical provider(s). 4.3.a. Documentation includes plans for follow-up	number of clients initiated into outreach services, the number of services provided, and the number of clients linked to care and needed services. 4.3. Client record has dated, signed release of information forms that are no more than one year old if information has been or will be shared and notation of confirmation of linkages. 4.4. Program records will document list of

Standard	Measure	Data Source
referral. 4.3 .b When information is to be shared, direct service staff will request a signed release of information from the client to allow them to follow up, as appropriate, with referral resources. Staff must confirm linkage to primary HIV care and/or medical case management with provider agency. 4.4 Program staff will develop and utilize a list of referral sources with which program staff have established a relationship to better ensure successful linkage to services.	to referrals. 4.3.b. Documentation includes current release of information if information is to be shared or note that client declined and linkages made. 4.4. Documentation of referral sources and formal agreements.	referral sources and formal agreements and other working relationships /communications.
5. Points of Entry 5.1 EIS is provided at or in coordination with documented key points of entry. 5.2 Each provider agency must have formal and written referral agreements with at least one of each of the following provider types: HIV medical care, HIV-testing site if testing is not offered by EIS provider, medical case management, mental health, and outpatient substance abuse services.	5.1-5.2 Program document points of entry and formal written referral agreements.	5.1-5.2 Program charts and points of entry reported in quarterly reports.
6. Length of Service 6.1 EIS services will be provided for clients until linkages to HIV medical care (and medical case management, if needed) are confirmed by the provider of such services.	6.1. Individual client files will include documentation of referrals, coordination, follow-ups and completion of linkages to services.	6.1 – 6.2. Individual client files, quarterly reports, and client level data.
Program Focused Standards		
7. Provider Qualifications 7.1 Direct Service Providers will have the certification, knowledge, skills and abilities to provide the four mandatory components of EIS as outlined in standards 1-4. 7.2 Program Supervisors will have a Master of Social Work or equivalent in a related field. Supervision must occur a minimum of 2 hours per month for a total of 24 hours per	7.1 - 7.3 Programs are staffed with personnel with knowledge of HIV and skills and experience to provide EIS to populations most impacted by HIV.	7.1 - 7.3 Program file contains documentation of all current direct service staff including job description, resume, education, certification, licensure, work experience, skills, and training needs/plans.

Standard	Measure	Data Source
year in either a group or individual setting. Supervision will address issues of client care (e.g. boundaries and appropriate interactions with clients), job performance, and skill development (e.g. record keeping). 7.3 Licensed medical care clinicians will address anything directly related to client medical care beyond HIV testing and counseling. Community based organizations without an onsite licensed clinician must have a formal referral agreement with HIV clinics. 7.4 Training Staff is required to attend a minimum of 8 hours of annual ongoing training on topics may include HIV testing and counseling, sexual health, chemical health, mental health, domestic violence, STDs, partner notification, bereavement, cultural and linguistic competency, gender sensitivity, boundaries, safety, HIV epidemiologic and treatment trends and treatment adherence. Additionally, confidentiality and HIPAA training are required annually.	7.4 Training attendance will be confirmed and documented by program supervisor.	7.4 Program file contains documentation of all completed training.
8. Documentation 8.1 Complete, current, secure individual record is maintained for each client receiving EIS and linkage services. 8.2 Ryan White funded EIS activities are accurately entered into the client level data reporting system (Minnesota CAREWare).	8.1. Each client has a separate, individual record that documents assessments, referrals, coordination of follow-ups and completed linkage to care. 8.2. EIS clients (those who are identified during encounters as eligible and willing to receive Ryan White funded EIS services) have each service	8.1. Client record has dated, signed hard copy or electronic documentation as specified for each individual standard. 8.2. Client level EIS data are consistent with numbers of clients reported in invoices and quarterly reports.

Standard	Measure	Data Source
	accurately entered into CAREWare including subservices of "case finding, referral and care coordination and linkage to care.".	