

Early Intervention Services

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

I. SERVICE CATEGORY DEFINITION

Early Intervention Services (EIS) includes the identification of individuals at points of entry and access to services and provision of HIV testing and targeted counseling, referral services, linkage to care, and health education and literacy training that enable clients to navigate the HIV system of care.

EIS services must include the following four components (all do not have to be funded by Ryan White)

- 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-positive
 - 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 and directs a client to needed core medical or support services in person or through telephone, written, or other type of communication.
- 3) Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, Substance Use and all other Ryan White Services.
- 4) Outreach Services and Health Education/Risk Reduction: [Refer to Outreach and HE/RR service standards for detailed guidance]
 - a) Outreach Services are:
 - i) Coordinated with local and state HIV prevention outreach programs to avoid duplication of effort.
 - ii) Targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning HIV infection

- and or exhibiting high-risk behavior;
 - iii) Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness.
 - iv) Planned and delivered in processes, to be at disproportionate risk for HIV infection
- b) Health Education/Risk Reduction is related to the education of clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:
- i) Education on risk reduction strategies to reduce transmission such as pre- exposure prophylaxis (PrEP) for customers' sexual partners and treatment as prevention; and ii. Education on health insurance coverage options, health literacy and Treatment adherence education

II. INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White clients to maintain proof of eligibility annually, with recertification every six months. Supporting documentation is required to demonstrate client eligibility for Ryan White Services. However, EIS under DC EMA has a section that is Status-Neutral for those experiencing vulnerability for HIV acquisition.

Depending on the program, refer to Page 6 for Status Neutral Program activities. Requires the same level of service for individuals from focus populations regardless of current HIV status and incorporates a comprehensive harm reduction approach into all activities

A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting CD4 count and viral load. Laboratory results should be within 6 months of the date of certification.
2. **Residency:** The following are acceptable methods of meeting the burden for residency:
 - Current lease or mortgage statement
 - Deed settlement agreement
 - Current driver's license
 - Current voter registration card
 - Current notice of decision from Medicaid

- Fuel/utility bill (past 90 days)
- Property tax bill or statement (past 60 days)
- Rent receipt (past 90 days)
- Pay stubs or bank statement with the name and address of the applicant (past 30 days)
- Letter from another government agency addressed to applicant
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, a written statement from case manager, facility or a letter from landlord that customer is a resident

3. **Income:** Customer income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the applicant and any household members for whom applicants have legal responsibility. For each income source the applicant must indicate the gross amount, how often the income is received, and whether it is your income or a household members from each source.

The following are acceptable forms of proof of income:

- Pay stubs for the past 30 days. The pay stub must show the year-to-date earnings, hours worked, all deductions, and the dates covered by the paystub
- A notarized letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
- Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A notarized statement from the applicant projecting current annual income must be included
- Copy of the tenant's lease showing client as the landlord and a copy of their most recent income tax return
- SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days

- Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the applicant

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of a person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. MAINTENANCE OF ELIGIBILITY

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer’s income and/or residency status has changed. RWHAP providers are permitted to accept a customer’s self-attestation of “no change” when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

III. KEY SERVICE COMPONENTS & ACTIVITIES

ASSESSMENT/SERVICE PLAN/PROVISION OF SERVICES	
Standard	Measure
During initial contact with customers, the early intervention services (EIS) provider must assess: Barriers to medical care Psychosocial needs Health education,	Documentation in customer records of the assessment of identified areas

Targeted HIV Testing	
Standard	Measure
During initial contact with customers, the early intervention services (EIS) provider must assess: Barriers to medical care Psychosocial needs Health education,	Documentation in customer records of the assessment of identified areas
LINKAGE TO MEDICAL AND PSYCHOSOCIAL SERVICES	
a. The EIS provider must link customers to HIV medical care and follow the customer for a minimum of 90 days.	Documentation in customers records of verification of HIV medical care visits. Acceptable methods of verification include: 1. EIS provider physically attended appointment with customer and/or 2. EIS provider confirmed appointment attendance with medical provider.
b. The EIS provider must link customers to health insurance, medication access, and/or AIDS Drug Assistance Program (ADAP) resources.	Documentation in customers' records of being successfully linked to appropriate insurance/medication access resources
c. The EIS provider must link customers psychosocial resources that address barriers to establishing medical care.	Documentation in customer records of being successfully linked to appropriate psychosocial resources
STATUS-NEUTRAL SERVICES	
<p>Scope of Service: Provides status-neutral services to people who experience vulnerability to HIV acquisition, are in an environment with a significantly higher HIV prevalence than the general population, have inconsistent engagement in care and treatment, and/or are at increased risk of disengagement from care/treatment. Requires the same level of service to individuals from focus populations regardless of current HIV status and incorporates a comprehensive harm reduction approach into all activities. Follows the Hi-V (High Five) Service Delivery Model, which consists of five (5) pillars (find ‘em, teach ‘em, test ‘em, link ‘em, and keep ‘em) of customer-centered services that promote equity, whole person health, and eliminate barriers (e.g., employment, housing, and behavioral health) to prevention and/or treatment services.</p>	
Standard	Measure
<p>Outreach (Find ‘em)</p> <ul style="list-style-type: none"> Providers must identify individuals from the focus population(s) who are unaware of their status or who know their status but are not currently in care. Providers may use available regional data or organizational experience as evidenced through current program data to identify this population. Providers must tailor the service model to the specific need(s) of the focus population(s) and use innovative technology, branding, and/or marketing strategies to increase the focus 	<ul style="list-style-type: none"> Definition(s) of the focus population(s) and the data used to substantiate targeting them Evidence demonstrating the effectiveness or promise of tailored approach with the chosen focus population(s) Documentation of the outreach method(s) used (posters, flyers, billboards, social media, TV or radio announcements) Documentation of outreach encounters that includes customer contact information, demographics, risk factors,

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<p>population’s awareness of the program</p> <ul style="list-style-type: none"> • Outreach materials must include explicit and clear links to available RW services Providers must deliver outreach services in coordination with local and state HIV prevention outreach programs to avoid duplicate efforts 	<p>HIV/STI/viral hepatitis testing status & history, engagement in care, referrals & linkages provided, and relevant notes</p>
<p>Health Education/Risk Reduction (Teach ‘em)</p> <ul style="list-style-type: none"> • Providers must educate individuals from the focus population(s) about HIV, STIs, Hepatitis C virus, risk reduction strategies, health literacy, healthcare access, and Undetectable equals untransmittable (U=U) • Providers must integrate U=U into their clinical and non-clinical services and communication with individuals • Providers must address the following core elements: <ul style="list-style-type: none"> ○ Counseling with customers to improve their health status ○ Group-level interventions ○ Healthcare coverage navigation ○ Health literacy training ○ Information about medical and psychosocial support services ○ Sexually transmitted infections (STIs) ○ Treatment as Prevention (TasP), Pre-Exposure Prophylaxis (PrEP), and non- occupational post-exposure prophylaxis (nPEP) information for sexual partners ○ Treatment adherence ○ U=U education/counseling 	<ul style="list-style-type: none"> • Group-level interventions: sign-in sheet, agenda, and curriculum/a • Individual-level interventions: intake form, including customer contact information, checklist of topics discussed, and session notes • Incentive distribution log • Documentation of harm/risk reduction plans in customer record • Documentation of the mechanism used to deliver health education/risk reduction

Standard	Measure
<p>Targeted HIV Testing (Test ‘em)</p> <ul style="list-style-type: none"> ● Sub-recipient must provide targeted HIV testing to help the unaware learn of their HIV status ● Sub-recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts ● Providers must test individuals from the focus population(s) for HIV, STIs, and hepatitis B & C ● Providers may employ evidence-based strategies, including the social network strategy, using individuals to promote testing in their social networks, to encourage testing ● Providers may use outreach service funds for HIV testing when RW resources are available and where the testing would not supplant other existing funding ● Providers must initiate drug therapy either the same day or within 7 days <ul style="list-style-type: none"> ○ PrEP or nPEP (within 72 hours) for individuals who test negative for HIV ○ Rapid Antiretroviral Therapy [ART] for those who are newly diagnosed or treatment naïve. 	<ul style="list-style-type: none"> ● Record of HIV/STI/hepatitis, B & C test(s) indicating test date, type, result, and treatment outcome/timeframe, as appropriate, in customer record

Standard	Measure
<p>Linkage and Navigation Services (Link ‘em)</p> <ul style="list-style-type: none"> ● Providers must provide referrals to and/or link individuals from the focus population(s) to quality culturally competent services as needed. This includes directing individuals who test negative for HIV to risk reduction services, including those that address their priority needs and the social determinants of health that can increase their vulnerabilities to HIV, and eligible PLWH to RW treatment, care, and support services. ● Linkage services for PWH should occur along the following categories: <ul style="list-style-type: none"> ○ Newly Diagnosed ○ receiving RW services but not in primary medical care ○ disengaged from care ○ never in care ● Linkage to care programs must provide PWH with low-barrier, on-demand access to care (e.g., Red Carpet Entry programs) <p>Re-engagement and Retention in Care (Keep ‘em)</p> <ul style="list-style-type: none"> ● Providers should aim to re-engage individuals who are either at-risk of or have fallen out of care ● Providers should engage individuals who receive Ryan White Services but not in primary medical care ● Providers should retain individuals from the focus population through ongoing, active engagement in individualized services designed to eliminate barriers and promote optimal outcomes for overall wellness. 	<ul style="list-style-type: none"> ● Documentation of referrals and linkages in customer record ● Policy outlining the provision of low-barrier, on-demand access to care ● History of contacts and appointments in customer record

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TRANSITION & DISCHARGE	
Standard	Measure
<p>Customer discharged when EIS services are no longer needed, goals have been met, upon death or due to safety issues.</p> <p><u>Prior to discharge</u>: Reasons for discharge and options for other service provision should be discussed with customers. Whenever possible, discussion should be face-to-face. If it is not possible, provider should attempt to talk with customer via phone. If verbal contact is not possible, a certified letter must be sent to the customer’s last known address. If a customer is not present to sign for the letter, it must be returned to the provider.</p> <p><u>Transfer</u>: If a customer 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 a customer moves to another area, the transfer agency will make referral for needed services in the new location.</p> <p><u>Unable to Locate</u>: If customer 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 customer’s last known mailing address within five business days after the last attempt to notify the customer. The letter will state that the case will be closed within 30 days of the date on the letter if an appointment with the provider is not made.</p> <p><u>Withdrawal from Service</u>: If a customer reports that services are no longer needed or decides to no longer participate in the Service Plan, the customer may withdraw from services. Because customers may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure</p>	<p>Documentation of discharge plan and summary in customer’s record with clear rationale for discharge within 30 days of discharge, including a certified letter, if applicable.</p> <p>Documentation: Customer’s record must include:</p> <ul style="list-style-type: none"> • Date services began • Special customer needs • Services needed/actions taken, if applicable • Date of discharge • Reason(s) for discharge • Referrals made at time of discharge, if applicable

<p>reasons for withdrawal are understood or identify factors interfering with the customer's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency, customers should be referred to appropriate agencies.</p> <p>Withdrawal from Service: If a customer reports that services are no longer needed or decides to no longer participate in the Service Plan, the customer may withdraw from services. Because customers 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 customer's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency, customers should be referred to appropriate agencies.</p> <p>Administrative Discharge: Customers who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a customer for this reason, the case must be reviewed by the leadership according to that agency's policies. Customers who are discharged for administrative reasons must be provided with 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 customer's last known mailing address within five business days after the date of discharge, and a copy must be filed in the customer's chart</p>	
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CASE CLOSURE	
Standard	Measure
<p>Case will be closed if customer:</p> <ul style="list-style-type: none"> • Has met the service goals • Decides to transfer to another agency • Needs are more appropriately addressed in other programs • Moves out of the EMA • Fails to provide updated documentation of eligibility status thus, no longer eligible for services • Can no longer be located • Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participate 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 • Is deceased 	<p>Documentation of case closure in customer's record with clear rationale for closure</p>

IV. PERSONNEL QUALIFICATIONS

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance. Agencies are also responsible for maintaining documentation of the appropriate education, qualifications, training, and experience in personnel files.

A. EARLY INTERVENTION SERVICE COORDINATOR

1. Associate's/Bachelor's degree in health or human services related field preferred. High School diploma or GED required
2. A minimum of 2 years of past experience working with persons living with HIV or at high risk of HIV acquisition preferred
3. Ongoing education/training in HIV related subject
4. Agency will provide new hires with training regarding confidentiality, customer rights and the agency's grievance procedure

B. COMMUNITY HEALTH WORKER

1. Para-professional with a High School diploma or GED preferred and two years of experience working with persons living with HIV and/or health care training, such as certified medical assistants and medical clerks.
2. Ability to read, write, understand and carry out instructions
3. Knowledge of community resources
4. Sensitivity towards persons living with HIV
5. Bi-lingual preferred when appropriate
6. Ongoing education/training in HIV related subjects

C. ELIGIBILITY/INTAKE SPECIALIST

1. Para-professional with a High School diploma or GED preferred and two years of experience working with persons living with HIV and/or health care training, such as certified medical assistants and medical clerks.
2. Ability to read, write, understand and carry out instructions

3. Knowledge of community resources
4. Sensitivity towards persons living with HIV
5. Bi-lingual preferred when appropriate
6. Ongoing education/training in HIV related subjects

All EIS Providers, Community Health Workers, Eligibility/Intake Specialists must complete a minimum training regimen within one year of hire date that includes:

1. ADAP requirements and application
2. Overview of Medicaid, Medicare, SSI, SSDI
3. EIS/REIS Service Standards
4. National Standards for Culturally and Linguistically Appropriate Services (CLAS)
5. Ryan White eligibility criteria

If newly hired, EIS Coordinators, Community Health Workers, Eligibility/Intake Specialists have previously obtained all of the required training, they do not need to repeat it. Documentation of completion of required trainings must be kept in the EIS Coordinators, Community Health Workers, Eligibility/Intake Specialist's personnel file.

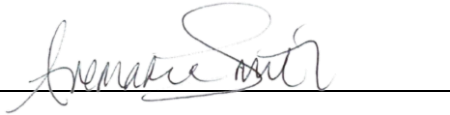
Sixteen hours of training/education in HIV/AIDS is required annually. Ongoing training on changes to benefit programs and their eligibility, such as Medicare, Medicaid, SSI, SSDI, Ryan White etc. is also required annually. Documentation for completion of required trainings must be kept in the EIS Coordinators, Community Health Workers, Eligibility/Intake Specialist's personnel file.

IX. CLINICAL QUALITY MANAGEMENT

A continuous Clinical Quality Management Program for HIV patient care. Please refer to Policy Clarification Notice (PCN) #15-02 (updated 09/01/2020).

X. APPROVAL & SIGNATURES

This service standard has been reviewed and approved on January 2, 2024.
The next annual review is July 31, 2025.



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