EARLY INTERVENTION SERVICES

Service Category Description

HRSA Definition:

Early Intervention Services (EIS) include identification of individuals at points of entry and access to services and provision of:

- HIV Testing and Targeted counseling
- Referral services
- Linkage to care
- Health education and literacy training that enable participants to navigate the HIV system of care

Denver Part A Implementation clarification:

HIV Testing and Labs will be done in collaboration with existing testing and care programs and will not be funded by Part A EIS

EIS consists of two different programs within the category: Linkage and Reengagement. Each program has its own set of standards.

Unit of Service: 1 Unit = 30 Minutes or less

Early Intervention Services Linkage Program

Requirement	Indicator	Data Source
EIS Linkage will be coordinated with existing services.	Establish linkage agreements with testing sites and Key Points of Entry where Part A is not funding testing but is funding referral and access to care and education, system navigation services. Key points of entry defined in legislation: • Emergency rooms • Substance abuse and mental health treatment programs • Detoxification centers, • Detention facilities • Clinics regarding sexually transmitted disease • Homeless shelters • HIV disease counseling and testing sites Additional points of entry include: • Public health departments • Health care points of entry specified by eligible areas • Federally Qualified Health Centers • Entities such as Ryan White Part C and D grantees • Needle Exchange Programs	**Provider's records** will document linkage agreements.

Requirement	Indicator	Data Source
EIS Linkage is utilized to connect those not in care to the services they need to manage their HIV/AIDS	Participants eligible for EIS Linkage are those who meet one or more of the following: • HIV+ individuals who have never linked to care. • HIV+ individuals who are new to the TGA and need assistance linking to care.	**Participant's file** will demonstrate that the participant is eligible for EIS.
	Participants eligible for EIS Linkage should not be currently engaged in any other Part A funded service or with another medical care provider.	**Participant's file** demonstrates that the participant is not engaged in Part A services or medical care. Exceptions to this restriction must be documented and justified in the file.
	EIS should not last longer than three months unless a barrier is identified and documented that shows services continue past the three month period.	**Participant's file** Shows that services last no longer than three months unless barriers are clearly identified to justify need to continue in EIS.
	Participant will be linked and successfully attend a medical appointment within 90 days of entry into EIS. Best practice will link the participant as soon as possible, preferably within 30 days. As part of this referral, a release of information should be established between the EIS provider and medical provider.	**Participant's file** will document the date of the medical appointment attended by the participant which is within 90 days of entering EIS and contain a release of information with the medical care provider signed by the participant. If a release of information is refused by participant the reason is documented.
	If appropriate, a referral to a medical case management provider will occur within 15 days of entering EIS. As part of this referral, a	**Participant's file** will document linkage referral to medical case management within 15 days and contain a release of information

	release of information should be established between the EIS provider and case management provider.	signed by the participant. If not appropriate for referral or if release of information is refused by participant the reason is documented.
Requirement	**Indicator**	**Data Source**
Every participant shall have an initial screening* to collect data important for proper referrals.	Provider shall schedule an initial screening interview within two business days of a positive diagnosis or within one week of an identified need.	**Participant's file** will demonstrate an initial screening interview was scheduled within two days of a positive diagnosis or within one week of an identified need.
	Initial screening interview will document the referral source/points of entry to the EIS program.	**Participant's file** will document referral source or point of entry to the EIS program.
	During the initial screening interview the staff will work with the participant to gather all eligibility data (income, residency, insurance status, HIV status, and legal name).	**Participant’s file** contains copies of the necessary eligibility data.
	Initial referral screening will include participant’s health (including oral health), mental health, substance abuse, health and system literacy, resources, and insurance eligibility.	**Participant's file** has initial screening interview with all necessary information completed within the first two meetings.

Requirement	Indicator	Data Source
Every participant shall have a Referral Plan* which guides their EIS.	The Referral Plan will demonstrate how the participant's needs (identified in their initial screening interview), will be met through Part A and other service providers.	**Participant's file** contains Referral Plan which demonstrates connections to proper services.
	The plan will be completed within one week of the initial screening.	**Participant's file** contains Referral Plan that is completed within the required timeframe.
	The Referral Plan will document referrals made to medical care provider, medical case management and supportive services, and outcomes of the referrals.	**Participant's file** contains Referral plan which documents referrals made and outcomes of the referrals.
	If health and system literacy needs are identified in the initial screening, the Referral Plan will contain a plan for health education designed to help individuals navigate and understand the HIV system of care.	**Participant's file** contains Referral plan which documents Health literacy, education, and/or navigation plan, as needed.
	If at the end of three months, EIS services are continued, a new Referral Plan should be established for existing needs.	**Participant's file** contains a revised Referral Plan with documented progress and new referrals if necessary.
Progress notes shall be completed after every significant contact with participant. (Significant contact is defined as contact over 15 minutes or that is significant to care)	Progress notes demonstrate that the Referral Plan is being implemented and followed or revised to meet the participant's changing needs.	**Participant's file** contains progress notes related to the Referral Plan.

Requirement	Indicator	Data Source
EIS will ensure that participant has engaged with medical care six months after close date from EIS.	EIS staff will follow-up with medical provider six months after closing out EIS to ensure participant has engaged in medical care.	**Participant's file** demonstrates participant is engaged in medical care six months after EIS close date.
	If participant has not engaged in medical care, EIS staff will coordinate with medical care provider and/or Medical Case Manager to assure that outreach to participant is taking place. If needed, EIS staff will work to reengage participant in EIS.	**Participant's file** documents outreach coordination efforts and demonstrate who will work to engage participant. If needed, file will demonstrate that participant is re-enaged in EIS if they have fallen out of medical care. If participant refuses to reengage the file documents the participant's reason.
EIS Linkage Quality Measures	85% of participants determined eligible for EIS will have attended a medical appointment within 90 days of becoming a participant of an EIS program.	**Participant's file** documents a medical appointment for those within 90 days.
	85% of participants determined eligible for EIS will be assigned to a Medical Case Manager within 90 days of becoming a participant of an EIS program if appropriate.	**Participant's file** documents an assignment of a Medical Case Manager within 90 days or a reason that a Medical Case Manager is not needed.
	75% of EIS participants will still be engaged in medical care six months after their close date.	**Participant's file** will document engagement in medical care six months after close date.

Early Intervention Services Reengagement Program

Requirement	Indicator	Data Source
EIS Reengagement is utilized to identify and reengage participant who have fallen out of medical care.	Participants eligible for EIS are those who meet one or more of the following: • Not had a medical care appointment for over eight months. • Have a high degree of medical concerns and have not been seen within the prescribed timeframe set by their physician. • Have been identified by another professional to have intense issues that would likely prevent them from continuing to engage in healthcare.	**Participant's file** will demonstrate that the participant is eligible for EIS.
EIS Reengagement providers should have strategies and protocols in place to search for participants who have disengaged from care.	Providers have a documented set of procedures they utilize to find and reengage EIS Reengagement participants.	**Provider's procedures** demonstrate their protocol for reengaging participants. **Participant's file** will demonstrate reengagement efforts in progress notes.
Length of EIS Reengagement	EIS are reengaging participants with medical care and other needed services and follow up to ensure these services are implemented. EIS should not last longer than three months after the participant is found unless a barrier is identified and documented that shows services continue past the three month period.	**Participant's file** will demonstrate that referrals are made in a timely manner or documentation exists to explain why services continue past three months.

Requirement	Indicator	Data Source
When a re-engagement participant is found they shall have an initial screening* interview to collect data important for proper referrals.	Provider will assess the reasons why the participant disengaged from care and identify barriers that might cause disengagement in the future.	**Participant's file** complete in initial screening interview identifying reason for current and possible future disengagement
	During the initial screening interview the staff will work with the participant to gather all eligibility data (income, residency, insurance status, HIV status, and legal name).	**Participant's file** contains copies of the necessary eligibility data.
	Initial referral screening will include participant's health (including oral health), mental health, substance abuse, health and system literacy, resources, and insurance eligibility.	**Participant's file** has initial interview screening with all necessary information completed within the first two meetings.
When a participant is found the EIS provider will create Reengagement Plan* with the participant on how they will stay engaged in care.	The Reengagement Plan will demonstrate how the participant's needs (identified in their initial screening interview), will be met through Part A and other service providers to prevent further disengagement.	**Participant's file** contains Reengagement Plan which demonstrates connections to proper services.
	The plan will be completed within one weeks of the screening.	**Participant's file** contains Reengagement Plan that is completed within the required timeframe.
	The Reengagement Plan will document referrals made to healthcare, medical case management and supportive services, and outcomes of the referrals.	**Participant's file** contains Reengagement Plan which documents referrals made and outcomes of the referrals.
	If health and system literacy needs are identified in the Initial screening, the Reengagement Plan will contain a plan for health education designed to help	**Participant's file** contains Reengagement Plan which documents Health literacy, education, and/or navigation plan, as needed.

	individuals navigate and understand the HIV system of care.	
	If at the end of three months, EIS Reengagement services are continued, new plan should be established for existing needs	**Participant's file** contains a revised Reengagement Plan with documented progress and new referrals if necessary.
Requirement	**Indicator**	**Data Source**
Progress notes shall be completed after every significant contact with participant. (Significant contact is defined as contact over 15 minutes or that is significant to care)	Progress notes demonstrate that the Reengagement Plan is being implemented and followed or revised to meet the participant's changing needs.	**Participant's file** contains progress notes related to the Reengagement Plan.
If the participant is located, EIS will ensure that participant has engaged in services with medical care six months after the close date from EIS.	EIS staff will follow-up with medical provider six months after EIS close date to ensure participant has engaged in medical care.	**Participant’s file** demonstrates participant is engaged in medical care six months after EIS close date.
	If participant has not engaged in medical care, EIS staff will coordinate with medical care provider and/or Medical Case Manager to assure that outreach to participant is taking place. If needed, EIS staff will work to reengage participant in EIS.	**Participant’s file** documents outreach coordination efforts and demonstrate who will work to engage participant. If needed, file will demonstrate that participant is reengaged in EIS if they have fallen out of medical care. If participant refuses to reengage the file documents the participant’s reason.

Requirement	Indicator	Data Source
EIS Reengagement Quality Measures	65% of participants determined eligible for EIS will be found.	**Participant's file** shows that the participant was contacted successfully by the provider.
	75% of participants found will have attended a medical visit within 90 days of being found.	**Participant's file** documents a medical visit.
	75% of EIS participants will still be engaged in medical care six months after their close date.	**Participant's file** will document engagement in medical care six months after close date.

Scenarios to assist with clarifying the intent of this service category:

1) Person contacts medical care on their own (self-linked), unless a barrier has been identified requiring additional assistance, this person is not eligible for EIS Services.
2) Person is new to Denver, but was actively engaged in care somewhere else. Eligible, but may not need 3 months of EIS service. Connect person to services and evaluate if there are other needs that will be addressed on the Referral Plan. Needs on Referral plan would determine how long the person stays in EIS.
3) EIS staff from DH connect a person to EIS staff from CHIP. Assure ROI exists (if possible). Transfer EIS to CHIP, discharge from DH. At 6 months, DH would call CHIP to assure the person stayed in service. Both DH and CHIP can count this participant as EIS, but not all standards requirements would apply (to DH—like screening and referral plan).
4) Person is due for an appointment next month and provider calls to remind patient of their visit. Although this is a legitimate "Retention" effort, this is not an EIS Reengagement effort because the person was not out of care.
5) Person has missed their regularly scheduled appointment and it has now been 8 months since their last appointment and has a history of no-shows. The patient does have a re-scheduled appointment set for next month. This person may qualify for EIS Reengagement if there are known barriers to accessing care (Systemic, eligibility, insurance, psychosocial, etc.). This will be a judgment call for the EIS provider.
6) Person has been in jail or prison and is not connected to medical care. This person could be a linkage client if they tested positive in the jail or prison system or a reengagement client if the person was once connected but has fallen out of care.

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*Tools available to assist with meeting above requirements:

1. Initial Screening Screening and Referral Form

2. Substance Abuse and Mental Illness Symptom Screener.