EARLY INTERVENTION SERVICES

I. DEFINITION OF SERVICE
Support of Early Intervention Services (EIS) that include identification of individuals at points of entry and access to services and provision of:

1. HIV Testing and Targeted counseling
2. Referral services
3. Linkage to care
4. Health education and literacy training that enable clients to navigate the HIV system of care

All four components must be present, but Part A funds to be used for HIV testing only as necessary to supplement, not supplant, existing funding.

II. DESCRIPTION OF SERVICE

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>PERFORMANCE MEASURE/METHOD</th>
<th>MONITORING STANDARD</th>
<th>LIMITATIONS</th>
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<tbody>
<tr>
<td>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 • Health education and literacy training that enables clients to navigate the HIV system of care</td>
<td>Documentation that: 1. Part A 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. Individuals who test positive are referred for and linked to health care and supportive services 3. Health education and literacy training is provided that enables clients to navigate the HIV system 4. EIS is provided at or in coordination with documented key points of entry 5. EIS services are coordinated with HIV prevention efforts and programs</td>
<td>1. Establish memoranda of understanding (MOUs) with key points of entry into care to facilitate access to care for those who test positive 2. Document provision of all four required EIS service components, with Part A or other funding 3. Document and report on numbers of HIV tests and positives, as well as where and when Part A-funded HIV testing occurs 4. Document that HIV testing activities and methods meet CDC and state requirements 5. Document the number of referrals for health care and supportive services 6. Document referrals from key points of entry to EIS programs 7. Document training and education sessions designed to help individuals navigate and understand the HIV system of care 8. Establish linkage agreements with testing sites where Part A is not funding testing but is funding referral and access to care and education, system navigation services 9. Obtain written approval from the grantee to provide EIS services in point of entry not included in original scope of work</td>
<td>Part A funds used for HIV testing only as necessary to supplement, not supplant, existing funding</td>
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III. EIS SERVICE COMPONENTS

Program Outcomes:

- Clients made aware of HIV status
- Clients referred to risk reduction services (HIV+ and HIV-)

Indicator:

- Number of clients located and identified as at high risk for HIV
- Number of 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 Ambulatory Outpatient Medical Care for treatment of HIV.
  - Time from referral until medical care entry
- Number of identified barriers preventing or delaying entry into Ambulatory Outpatient Medical Care
- Number of resolved barriers that prevented entry into Ambulatory Outpatient Medical Care
- Retention in Ambulatory Outpatient Medical Care defined as receipt of initial viral load and attendance at 3 AOMC visits

Service Unit(s):

- Clients made aware of HIV status
- EIS Plan to link client to care is documented
- Successful entry of HIV+ clients into ambulatory outpatient medical care for HIV treatment

Performance Measure (Scope of Work):

#1: Number of HIV tests administered by EIS staff
#2: Number or Percentage of clients testing positive for HIV for HIV tests administered by EIS Staff
#3: Number of clients testing negative for HIV that receive counseling on risk reduction and/or are referred to services to reduce risk
#4: Number or percentage of clients testing HIV positive referred to ambulatory outpatient medical care for treatment of HIV
#4b: Existence of EIS Plan to link clients testing HIV positive to ambulatory outpatient medical care for treatment of HIV
#5: Number of clients testing positive for HIV that are successfully linked to ambulatory outpatient medical care (at least 3 visits)
#6: Number of clients testing HIV positive successfully retained in AOMC (track at 3, 6, 9 and 12 months post-entry)
#7: Number of clients (HIV positive or negative) with documented health literacy assessment
<table>
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<tr>
<th>Standard</th>
<th>Measure</th>
<th>Narrative Fraction</th>
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</table>
| **1.** US (Unaware Specialist) will **locate and identify** persons at high risk for HIV in community settings, such as homeless shelters, substance abuse treatment facilities, emergency rooms and other location. | Review of EIS client files with focus on roster of persons identified with outreach setting, HIV counseling & testing, seropositivity and referrals. | # of High Risk Clients Identified
# of Estimated High Risk Clients |
| **2.** US (Unaware Specialist) will work with HIV testing sources (traditional and non-traditional) to modify process for **informing** those tested of result, services required and impact in a manner that is most confidential, respectful and yet moves newly diagnosed into service(s). | Review of EIS client files. Detail by demographic/ risk factors of individuals and results of test, process for informing. | 1) # of HIV tests by EIS staff
2) # of HIV counseling upon testing
3) # of HIV+ tests |
| **3.** US (Unaware Specialist) will work with HIV testing sources (traditional and non-traditional) to **refer** newly diagnosed HIV positive clients to HIV medical care and high risk but HIV negative individuals to needed services to reduce risk for HIV. | Review of EIS client files Detail by location of HIV test, services that were referred and location and demographic/ risk factors of individuals | 1) # of individuals referred to services that are HIV+
2) # of individuals referred to services that are not HIV+.
3) Documented EIS Plan to link HIV+ clients to HIV medical care |
| **4.** US (Unaware Specialist) will **link** clients with HIV primary 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 behavior, and provide emotional support. | Review of client files or roster of persons identified documenting specific activities related to engaging in HIV medical care. | # of Clients linked to Care* 
Total # of Clients Referred

* Linked = validate attendance at HIV medical care with CD4/Viral Load confirmation

Time from HIV diagnosis to entry HIV medical |
| **5.** Primary care outreach workers will help clients **overcome the barriers** that prevent them from accessing care on a regular basis and refer clients to appropriate support services including evaluation of HEALTH LITERACY. | Review of client files or, roster of persons identified with documentation of linkage to support or other services aimed at reducing barriers to care entry or re-entry. | # of Clients with identified barriers
Total # of EIS clients

# Clients with identified barriers resolved thru referral
Total # of EIS clients

# Clients evaluated for Health Literacy
Total # of EIS Clients |
| **6.** Primary care outreach workers will follow-up with clients and referral agencies regarding **retention in care (attachment)** at 3, 6 and 9 month intervals post-linkage | 100% of sampled client files document referrals and follow-up on all referrals | # of Client identified, referred, with case findings
Total # of EIS Clients |
### GOALS OF THE NATIONAL HIV/AIDS STRATEGY

<table>
<thead>
<tr>
<th>NO.</th>
<th>GOAL</th>
<th>NEW HAVEN EMA MEASURES</th>
<th>DATA SOURCE 1</th>
<th>DATA SOURCE 2</th>
<th>SOC by SERVICE</th>
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<tbody>
<tr>
<td>1</td>
<td>Reducing New HIV infections</td>
<td># of new HIV infections in EMA</td>
<td>CT DOH Epidemiology</td>
<td>US/EIS STAFF CHART AUDITS FOR PRIOR YEAR</td>
<td>EIS</td>
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<td></td>
<td>a</td>
<td>• By 2015, lower the annual number of new infections by 25% (from 56,300 to 42,225).</td>
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<td>2</td>
<td>Increasing Access to Care and Improving Health Outcomes for People Living with HIV</td>
<td># newly diagnosed in EMA</td>
<td>Numerator: 1a Denominator: CT DOH Epidemiology</td>
<td></td>
<td>EIS</td>
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<td>b</td>
<td>• Reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30% (from 5 persons infected per 100 people with HIV to 3.5 persons infected per 100 people with HIV).</td>
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<td>EIS</td>
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<td>• By 2015, increase from 79% to 90% the percentage of people living with HIV who know their serostatus (from 948,000 to 1,080,000 people).</td>
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<td>EIS</td>
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#### 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 work plan. Please refer to the most current work plan, 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.

*The Chart Audit Tool for Early Intervention Services is attached on the next page*