RI HIV Provision of Care & Special Populations Unit
RI Medicaid Division

RI EOHHS Early Intervention Services Policy

RI_EIS

RI_EIS Service Category Components

Introduction to this Policy

Let this serve as the RI Executive Office of Health and Human Services, HIV Provision of Care & Special Populations Unit (RI_EOHHS_HIV&SPU) policy and protocol regarding Rhode Island, Ryan White Part B Early Intervention Services (RI_EIS). It is expected this document be functional, so it can become a practice guide for Rhode Island agencies funded for RI_EIS. ***EIS is not a stand-alone project or program.***

It is a series of steps that need to be implemented to make the RI_EOHHS_HIV&SPU goal of ***identifying all high-risk individuals who are unaware of their HIV status***, a reality. There are four documentable components of EIS that have been required by HRSA since the issuance of the **policy notice clarification, PCN 16-02.** Please see this link:

https://hab.hrsa.gov/sites/default/files/hab/Global/service_category_pcn_16-02_final.pdf

Note this PCN supersedes the description of EIS in the 2013 HRSA Part B Monitoring Standards.

The ***ultimate purpose of RI_EIS is to actively seek people (via outreach) who are unaware of their HIV status, find them, test them, educate them. Once positives are found – refer and link to care.***

The four RI_EIS components are (listed in the order that we recommend that they are to be implemented; in a **step by step** (the protocol) fashion:

STEP 1 EIS Targeted Outreach

The goal of **targeted outreach** is to identify individuals who are living with HIV and who may be unaware of their infection to bring them into HIV testing, and to support engagement in HIV care. This includes culturally/linguistically, and appropriate methods associated with the outreach.

More broadly, the Health Outreach Partners (HOP) describes that "Outreach plays a critical role in facilitating access to primary care, case management, health education, and social services to underserved populations. Outreach is about people and trusting relationships with the communities that we serve." In the National Outreach Guidelines for Underserved Populations, HOP defines outreach as the ***process of improving people's quality of life*** by:

- ✓ ***Facilitating access*** to quality health care and social services
- ✓ Providing ***health education***
- ✓ Bringing ***linguistically and culturally responsive*** health care directly to communities
- ✓ Helping people to become ***equal partners*** in their health care
- ✓ Increasing the ***community's awareness*** of the presence of underserved populations"

If you'd like to learn more about HOP and how they approach outreach, go to:

https://outreach-partners.org/2015/10/19/what-is-outreach-2/

Outreach staff's main goal for RI_EIS is to **seek and find** high risk, HIV **unawares.** To do this **they will conduct either what is called active outreach and/or passive outreach. Plus, they will use an assessment screen** attached to this policy to determine **eligibility for Ryan White Part B EIS testing, and screening for PrEP.**

The goal of the attached assessment is to:

a) **Determine high risk status and whether they are eligible for RI_EIS HIV testing**, as indicated by EIS standards,

b) Check for RW eligibility. This is related to the FPL status requirement for Ryan White, yet we encourage agencies to document and to be flexible when an individual cannot verify financial status. ***Since these individuals will ordinarily be known to the agency we are assuming an intake for services and financial eligibility would already be completed***. It is important to know here that RI_EIS will offer individuals a confidential (not anonymous) HIV test.

Again, we are assuming most of the client information regarding such matters as income, and name, will already be known to the agency.

If a client is not known to the agency and is approached by an outreach worker in the field, and a request for anonymous testing is suggested by the client, then, if high risk status is determined, first the agency staff must determine if another HIV testing source (non- Ryan White) is available; and if so, since Ryan White is a payer of last resort, that testing funding must be used.

In some cases, we understand that a client meets all the criteria for RI_EIS as a high-risk individual and if the agency has no means of other testing using other funding, and the client cannot verify financials, then an EIS test can be done without checking for Ryan White fiscal eligibility. However, a confidential test must be offered, and risk determination for high risk, using the attached assessment must be part of the process.

HRSA guidance allows for targeting based on prevalence – e.g. venues serving high risk populations such as behavioral health centers performing Medication Assisted Treatment, and other high prevalence venues. In short, outreach services must "be conducted at times and in places where there is a high probability that people unaware of their status will be identified."

Outreach can happen in clinics, in case management (e.g., for high risk, negative partners) or anywhere the points of entry are conducive to EIS. ***When determining if RI agencies are good candidates for RI_EIS, asking the following questions may help:***

Is Your Agency A Good Fit for RI_EIS??????

- ☐ Is the agency clinical in nature and do they have a high-risk group of patients circulating in and out?
- ☐ Is the agency non-clinical in nature (e.g., non-medical case management organizations) that performs some behavioral health clinical services without operating as a clinic – for example clinical social workers that perform non-medical, targeted HIV case management services?
- ☐ Is the agency non-clinical in nature, performing work with people who are at high risk for HIV, and do they know their clients by name, so that a confidential HIV test can be seamlessly offered within this environment?
- ☐ Is the agency either a clinical or non-clinical provider, performing work with people who are at high risk for HIV, and is a Medicaid provider that has the capacity to also request and handle such matters as Medicaid enrollment, RW eligibility and possibly other insurance?

REMEMBER: Confidential testing is an integral part of RI_EIS testing. That means a client/patient name is necessary, so your agency can receive reimbursement by the Ryan White Part B.

✓ If you answered yes to one or more of the above questions, your agency may be a good candidate for confidential, HIV testing and can easily incorporate all of the components of RI_EIS.

Since the initial goal in RI-EIS Outreach is to **seek and find** unawares, the agency approach needs to detail how all assigned EIS staff can perform the pre-testing assessment. Both **Passive** *(e.g., a client/patient comes to a facility and the staff outreach worker or case manager or clinician universally asks the person to be assessed for EIS)* and **active Outreach** *(e.g., you send someone outside of the building into community "hot spots" to find unawares – you still have to assess for EIS eligibility)* can occur, unless you are doing anonymous testing under a different funding source, then no risk assessment screening is needed, but that testing cannot be billed to RI_EIS.

STEP 2 Targeted HIV Testing

Once Outreach/Risk Assessment happens and the risk assessment given then HIV testing under RI-EIS can occur. So, what is **Targeted HIV Testing** under RI_EIS???

Targeted HIV testing is the practice of *directing HIV testing to high-risk populations and settings where high-risk people can be risk accessed, HIV tested and identified if they are unaware of their HIV status.* ***"You can think about targeted HIV testing as gathering all of your resources and directing them to areas that have individuals who are at greatest risk for contracting HIV." Some say this is a more efficient way to target those at risk for HIV.***

Reference: C4H, Capacity for Health. http://www.capacity4health.org/resource/targeted-hiv-testing-template/

HIV Targeted Testing
Case Examples

#1: Clinica Esperanza finds an individual that is high risk for HIV as part of a routine office visit. They are a clinic and offer clinical services. Testing here for HIV is integrated into routine care and RI_EIS offers the clinic opportunities to screen for high risk unawares. The **individual in this case that takes the risk assessment** qualifies for testing under RI_EIS (the Denver Risk Factor screen), and also completes a RW fiscal screen. The client/patient name is recorded in the medical record regarding EIS testing.

#2: An AIDS Care Ocean State case manager finds that their client, a person living with HIV, is in a new relationship with a person who is negative. The case manager determines that the negative partner is at high risk due to the person living with HIV is not virally suppressed. The case manager works with the client who is living with HIV and works to have their negative partner come in for a test. After the case manager performs the assessment (performs a fiscal intake for Ryan White, a Denver high risk assessment for RI_EIS eligibility), the negative client comes in, and then the negative partner is given EIS testing. *If the high-risk negative partner of your client living with HIV can access another HIV testing option, they should be referred out or the agency may perform a non-EIS test.*

This method of testing requires that the agency is carefully screening people who are at high risk and who may be unaware of their HIV status. To repeat, it is based upon the risk assessment screening tool. It is different than universal, anonymous HIV testing where no pre-risk screening is needed.

- ☐ Recipient **agencies doing RI_EIS testing must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts** being particularly aware of Ryan White as payer of last resort.
- ☐ **HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources**.

☐ For an agency performing RI_EIS, ***referral services to improve HIV care and treatment services are necessary***. Referral services must be integrated into this approach for both high risk negatives, and for those who take an HIV test and have a reactive result (Refer and Link to HIV care). Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Use Care must be immediate and a function of EIS testing.

STEP 3 EIS Health Education Risk Reduction

Culturally appropriate/sensitive Health Education Risk Reduction (HE/RR) always happens as part of EIS. This is a must. HIV counseling and testing regulations for the state also apply, but the nature of EIS is a bit different than universal, anonymous HIV testing, and a series of effective educational components must be covered regarding minimizing high risk behaviors, using condoms as protection, PrEP, nPEP, etc. In these sessions being sensitive to all aspects of the known client and their cultural and linguistic needs is paramount. Topics covered under HE/RR may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention;
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage);
- Health literacy; and
- Treatment adherence education.

One limitation of Health Education/Risk Reduction services is they cannot be delivered anonymously. Other activities of Health Education/Risk Reduction include, but are not limited to:

- Provision of information about available medical services, psychosocial support, and counseling services;
- Education on HIV transmission and how to reduce the risk of transmission; and
- Risk reduction counseling on how to improve their health status and reduce the risk of HIV transmission to others.

HRSA defines **Health Education/Risk Reduction** as *"the provision of education to 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."*

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH under HE/RR:

Standard	Performance Measure
Health Educational Assessment and Service Plan: HE/RR staff will complete a health/HIV educational evaluation and plan that will indicate how the client's educational needs will be met. Plan must address: • Methods of HIV transmission • How to reduce risk of HIV transmission • Medication adherence • Available resources to meet needs for recently incarcerated • Available resources to meet client needs • Health literacy	Percentage of clients with documented evidence in the client's primary record of a completed health/HIV education evaluation and plan. Percentage of clients with documented evidence in the client's primary record of a completed plan addressing methods of HIV transmission, risk reduction education, and resources available to meet client's needs.
Health Education/Risk Reduction: HE/RR staff will provide health education/risk reduction curriculum regarding: • Methods of HIV transmission and how to reduce the risk of transmission HE/RR staff will provide health education/risk reduction counseling regarding: • How to improve their health status and reduce their risk of transmission to others.	Percentage of clients with documented evidence in the client's primary record of HE/RR curriculum regarding methods of HIV transmission and how to reduce risk of transmission. Percentage of clients with documented evidence in the client's primary record of HE/RR counseling regarding how to improve health status and reduce risk of transmission.
Resources: HE/RR staff will provide information regarding available medical and psychosocial support services to reduce barriers to care.	Percentage of clients with documented evidence in the client's primary record of HE/RR education provided regarding available medical and support services in the community.
Evaluation of health education/risk reduction counseling: HE/RR staff will administer pre and post-tests to each client to assess changes in knowledge/attitudes as a result of the health education/risk reduction counseling. HE/RR Staff will ask each client to complete a brief program evaluation after each completion of a	Percentage of clients with documented evidence in the client's primary record of a pretest to assess client's understanding of disease process. Percentage of clients with documented evidence in the client's primary record of a post-test to assess client's understanding of disease process.

Standard	Performance Measure
course/service plan to assess effectiveness of program.	Percentage of clients with documented evidence in the client's primary record of increased knowledge of disease process and risk reduction methods. Percentage of clients with documented evidence of participation in course/service plan satisfaction survey.

References for HE/RR section

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 30-31.

HRSA Policy Notice 16-02. Eligible Individuals & Allowable Uses of Funds.

STEP 4 EIS Referral and Linkage to Care

Agencies must be equipped to handle immediate **referrals and linkage to care** once a reactive HIV test appears.

- If after HIV testing, **a negative test result** is presented, then referrals happen to other providers (SU, MH, recovery, housing, etc.). At this time the EIS staff must determine where to send the individual still at high risk for HIV, but because they are negative at this time --- an appropriate testing plan should be in place that speaks to how often the individual should test and where they should go for testing.
- ***As a rule, agencies must decide that EIS testing that reveals negative responses should be referred to prevention HIV testing services,*** and this participant is probably not suited for EIS testing. If, in this case the individual is not willing to take PrEP, or fiscally cannot afford to take PrEP, then a referral to a prevention program is best.
- A "schedule" of testing for this high-risk individual should be discussed with the EIS staff. Keep in mind because EIS is seeking unawares a lifetime of EIS testing may not be in order may not be appropriate for this person. PrEP may be suggested and if taken, the client can assume a less aggressive testing schedule with their physician or seek a prevention testing site for further testing.
- Next, if a **reactive test** result appears, under the state's rules, a report must be submitted to DOH and a reactive requires a confirmation test. The agency must make the appropriate arrangements for connection to care at this time. In short, immediate referral and linkage to care must occur.

- If the client agrees, the EIS staff should begin the process of verifying things as insurer, home stability, physician, or medical provider, and any other risk factors that may impede care and treatment (behavioral health screen, etc.).
- *Finally, at this step, when a positive, reactive is found---- a RW case manager should also be called ASAP.*

Note, many agencies also may find at this time that the reactive test was no surprise to the client. Specifically, this is when the individual had at least one HIV test that was reactive or even confirmed. Sometimes our clients in this situation are in disbelief and want to verify that the diagnosis and/or the reactive test was accurate. In sum, they had been diagnosed with HIV previously and needed to confirm it by having another test – or they may have forgotten they were positive.

At this time an agency may find themselves assisting with the re-engagement to care when they find someone who is aware of their status, but out of care. ***That is a part of EIS and can be part of the referral plan.*** For this scenario a solid plan of action to re-engage the person in care is necessary.

Operational definitions

☐ Referral – Some referrals are passive, others are active. In passive one may provide information but not necessarily aid in accessing the service and may not require follow-up for the purpose of determining the outcome of the referral (passive).

In Ryan White, if a client is reactive positive after the test we recommend active referral where the testing agency makes an actively assists the client with the referral ---e.g., makes phone calls, provides transportation for linkage to care.

"Studies highlight the limited value of passive referral practices and the increased effectiveness of active referral and linkage practices. Numerous studies on linkage to HIV care suggest that case management approaches, cultural-linguistic concordance between linkage staff and clients, and structural features such as colocation facilitate timely linkage to care. Integration of other medical and social services such as family planning and alcohol screening services into STD settings may be optimal but resource-intensive. Active referral practices such as having a written referral protocols and agreements, using information technology to help transfer information between providers, and making appointments for clients may offer some benefit." Linkage and Referral to HIV and Other Medical and Social Services: A Focused Literature Review for Sexually Transmitted Disease Prevention and Control Programs.

Carter MW[1], Wu H, Cohen S, Hightow-Weidman L, Lecher SL, Peters PJ.

☐ Linkage to medical care - process of assisting HIV-diagnosed clients into medical care with an HIV primary care provider (authorized to prescribe ARVs medications) following the

receipt of a HIV diagnosis. Linkage to medical care requires follow-up and documentation.

☐ Linkage to supportive services – process of assisting HIV-diagnosed clients in accessing critical needs for supportive and ancillary medical services that may impede (are barriers) to HIV primary medical care. Linkage to supportive services requires follow-up and documentation.

☐ Newly diagnosed – Diagnosed within the previous 12 months.

☐ Previously diagnosed – Previous HIV diagnoses, NOT within the past 12months.
☐ Newly engaged – Previously diagnosed, but never having entered into medical care.
☐ Lost to care – Previously diagnosed, without a visit for routine HIV medical care in the preceding 12 months.
☐ Lost-to-follow-up (designates linkage attempts) - three (3) unsuccessful attempts to contact the client within a 90-day period.

Summary Points for RI-EIS

- Targeted Outreach – Can be passive (e.g., in agency, routinized) or active (e.g., go out and find them).
- Confidential Testing - Usually this will depend on how the agency does business with clients/patients and how they are set up to receive names and perform intake for such things as eligibility.
- Agency Point of Entry Ability and Capability to Perform EIS - the agency must be prepared to handle all the components of EIS and to organize their staff around the services to be performed.
- Assessment of Client for EIS and for Ryan White – High Risk Negative determined by Assessment Tool for High Risk – Assessment determines eligibility and then we enroll in EIS. If found reactive, positive, agency connects client to care, enrolls in case management and other service categories as needed. Intake will perform eligibility for such things as Ryan White, Medicaid and other possible program services. Here we are concerned that a person is financially eligible to participate in the Ryan White program.
- All HIV test kits are to be purchased with RW Part B funds – Intermingling with anonymous, universal testing kits not recommended so the Ryan White program can track effectiveness of RI_EIS.
- All four EIS components must be done by the agency and agency will use RW Part B funds to fund EIS as a package.

Interested in integrating high risk HIV case management for unawares for Medicaid beneficiaries? Go to the manual online:
http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/MA%20Reference%20Guides/HIV%20Providers/HIV_TCM_Manual.pdf

#

RI_EOHHS_RI_EIS_6.20.2019.Final Revised.pgl