Memphis TGA Ryan White Part A & MAI Early Intervention Services Standards of Care

PURPOSE

The purpose of the Ryan White Part A & MAI Early Intervention Services Standards of Care is to ensure that uniformity of service exists in the Memphis Transitional Grant Area (TGA) such that the consumers of a service receive the same quality of service regardless of where or by whom the service is provided. Standards will be used as contract requirements, in program monitoring, and in Quality Management. If an agency is unable to meet a particular standard, the agency must document why the standard was unable to be met and explain the steps it is taking to meet that standard.

The purpose of EIS is to assist Persons Living with HIV/AIDS (PLWHA) in identifying and addressing barriers to the initiation of, participation in and adherence to on-going HIV outpatient/ambulatory medical care. In addition, EIS is to ensure that people testing positive receive necessary HIV related services as early as possible in order to interrupt or delay progression of HIV disease EIS service providers also strive to integrate the complex network of services for their patients and move a client toward self-management.

DEFINITION

Early intervention services (EIS) includes counseling individuals with respect to HIV/AIDS; referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures. HIV education, including risk prevention and adherence counseling are a part of every patient encounter.

EIS:

1. Assists clients with linkage to and follow-up on participation in out-patient HIV medical care (primary focus) and

2. In order to address barriers to care, assist clients in linkage to and follow up on participation in other Ryan White core medical services (e.g., oral health, home health, hospice, ADAP, other prescription care, insurance assistance, mental health, substance abuse, medical case management and nutritional counseling), other Ryan White support services; and other non-Ryan White community services.

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3. Develops formal relationships with "Points of Entry" and informal relationships with other community contacts who are engaged in the provision of HIV testing. Points of Entry are health departments and those entities that have identified at least three (3) HIV+ cases in the last year.

Note: At this time testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures) is not covered under EIS as the TGA has adequate testing resources.

APPLICATION OF STANDARDS

These standards apply to all agencies that are funded to provide Early Intervention Services through Ryan White Part A and/or MAI within the Memphis TGA. These Standards should be used in combination with the Universal Standards of Care that apply to any agency or provider funded to provide any Ryan White Part A and/ or MAI service.

STANDARDS DEVELOPMENT PROCESS

These standards were developed through extensive background research on standards of care, a review of existing standards from other Ryan White Part A Eligible Metropolitan Areas (EMA) and TGAs, meetings of the Evaluation and Assessment Committee of the Memphis TGA Ryan White Planning Council and meetings with the Ryan White Part A Grantee.

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Standard	Measure/Method
I. Policies and Procedures	
A. See Universal Standards of Care	
II. Program Staff	
A. All EIS Specialists hired by subcontractor/provider agencies that are funded in whole or part to provide EIS services with Ryan White Part A funds must possess at a minimum a HS diploma or GED.	• Documentation in client files
B. Ryan White Part A EIS Specialists must have the supervision and guidance of a Master Level Social Worker. Supervision must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting. Supervision will address issues of client care (e.g. boundaries and appropriate interactions with clients), case manager job performance, and skill development (e.g. record keeping). Clinical supervision addresses anything directly related to client care (e.g., supervision in order to address specific client issues), and issues related to job related stress. Administrative supervision addresses issues relating to staffing, policy, client documentation, reimbursement, scheduling, trainings, quality enhancement activities, and the overall running of the program and/or agency. *Note: MSW requirements for clinical supervision may be modified and/or waived. The agency seeking modification and/or waiver must request such in writing to the Part A/ MAI Grantee. Documentation of the request for modification/waiver must include relevant reasons and justification for such action and specific information why the person to provide clinical supervision has sufficient education (Masters Degree in a Health or Human Services field), certification, licensure and clinical experience to merit the modification/waiver.*	• Documentation in personnel files

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C. Agencies providing EIS services must document efforts to assist EIS Specialist and clinical supervisory staff in securing ongoing education and training to better perform their respective job duties.	• Documentation in personnel files • Policy on file
D. Individuals who hold certification and/or licensure as a part of their job duties must maintain that in good standing with the respective governance bodies.	• Documentation in personnel files
E. It is mandatory that participate in annual training for at least five (5) hours per year on one or more of the following topics: • HIV 101 Updating • HIV/AIDS Medical Management Updating • Treatment Adherence • Cultural Issues / Competency • Community Resources / Services (health, housing, income….) • CM Skills Building (documentation, interviewing) • Client Retention Training • Particular Client Issues/Needs (MH, A&D, poverty….)	• Documentation in personnel file
III. Access to Services	
A. Agency is accessible to desired populations. Accessibility includes: ✓ Proximity to community ✓ Proximity to mass transit (where applicable) ✓ Proximity to low-income individuals ✓ Proximity to underinsured or uninsured individuals ✓ Proximity to individuals living with HIV	• Documentation provided in funding application • Site visit observation of facility and its location within the community • Client data report showing client profile consistent with contract requirements
IV. Eligibility Determination/Intake/Screening	
A. Provider determines client eligibility for services based on Part A guidelines and	• Client records documenting eligibility

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reassesses eligibility every 6 months. The process to determine client eligibility is completed in a time frame that ensures that screening is not delayed. Eligibility assessment includes at least the following: ✓ Proof of HIV Status - In instances where the client is a person affected by HIV, such as a caregiver, partner, family, or friend, verification of HIV status of the infected person is required. ✓ Proof of income using approved documentation as provided by the grantee ✓ Proof of residence in the TGA	and required reassessment, with copies of appropriate documents or evidence that eligibility information was provided by another provider, consistent with TGA policy • Policy and procedures on file • Documentation that all staff involved in eligibility determination have participated in required training provided by the Grantee to ensure understanding of the policy and procedures • Agency client data report consistent with funding requirements
B. EIS services are specifically designed to be provided to: • PLWHA who are newly diagnosed; OR • PLWHA who are pregnant; OR • PLWHA who are being released from incarceration (up to 90 days prior to release); OR • PLWHA who are in medical care, but have identified issues that adversely impact retention in care; OR • PLWHA who are out of care.	Client's file includes: • Documentation of new diagnosis, pregnancy, history of incarceration, identified barriers to retention in care, or out of care status
V. Assessment/ Plan of Care	
A. While the assessment of each client may require the selection from a variety of assessment tools, the assessment(s) should gather information from the many areas in which the client functions. In each area the EIS Specialist is focused to identifying the specific barriers the client/patient has /may experience in accessing	• Policy and procedures related to EIS assessment on file • Documentation in client file

Standard	Measure/Method
medical care, remaining in care and/or adhering to medical treatments. These areas include are not limited to: ○ Medical history/physical health. The persons beliefs and response to his/her HIV/AIDS, Opportunistic Infections (OIs), other medical conditions, medication(s) and adherence, medical providers / settings, hospitalizations, etc. ○ Health Resources. Identification of resources and ability to access those to support/diminish a person's ability to be/remain connected to care) ○ HIV/ AIDS (Safer Sex Practices). Knowledge and awareness of and/or beliefs about HIV and medical treatments that support/diminish a person's ability to be/remain connected to care. ○ Psychosocial. Emotional, substance use/abuse and mental health issues that support/diminish a person's ability to be/remain connected to care. ○ Housing. Stability of housing as it support/diminish a person's ability to be/remain connected to care. ○ Financial resources. Employment, income, access to entitlement/ public assistance that support/diminish a person's ability to be/remain connected to care. ○ Social Network. People and systems that are a resource / support and those who diminish the person's ability to be/remain connected to care. ○ Practical resources. Transportation, child care and nutrition that support/diminish a person's ability to be/remain connected to care. ○ Service needs	
B. Agency may use previous assessments (i.e. medical and nursing) may be used in determining client needs if applicable.	• Documentation in client file
C. Results of assessments are kept in client's file.	• Documentation in client file
D. A written plan of care must be developed within 30 calendar days from assessment date and with the participation and agreement of the client or guardian and must be free of ambiguity with clearly defined priority areas and time frames. The purpose of	• Documentation in client file

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the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. The written plan also serves as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.	
E. Information to be documented in the plan of care include: ✓ List of client service needs ✓ Establishment of short and long term goals ✓ Objectives and action steps to meet short-term goals ✓ Formal and informal resources to accomplish goals ✓ Collaboration with all currently available Public Health Strategies ✓ Gaps in services ✓ Alternatives to meet client goals ✓ Resources to be used to meet client goals ✓ Criteria for determination of completion of goals	• Documentation in client file
F. Documentation of the client's participation in the planning process is done with signature by the client and/or legal guardian. If the client is unable to sign written plan, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).	• Documentation in client file
G. Services must not be routinely rendered without a written plan of care.	• Documentation in client file
H. The Written Plan of Care must evidence on-going involvement and review by the EIS staff with the client. Minimally, this must be quarterly with contact and review within 3 months of intake and/or re-assessment.	• Documentation in client file
I. Non-scheduled care plan meetings may occur as the need arises.	• Documentation in client file
J. Work collaboratively with all currently available Public Health Strategies, in the care of newly diagnosed clients. Public Health Strategies for use with newly diagnosed clients, as defined by the CDC, include partner services, Anti-Retroviral Treatment and Access to Services (ARTAS) intervention, and Social Network Strategy (SNS).	• Documentation in client file

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VI. Monitoring/ Reassessment/ Termination of Treatment Plan	
✓ The needs and status of each client receiving EIS services will be monitored on a regular basis. The purpose of this stage is to allow the client and EIS Specialist to observe the progress of the plan of care in order to make revisions. The intervals between monitoring may vary among clients but must reflect necessity and consistency with the written plan. However, monitoring is an ongoing process.	• Documentation in client file • Policy on file
✓ Each client must be reassessed every six (6) months minimally or as the need arises. The purpose of the reassessment is to address the issues noted during the monitoring phase. Reassessment will include but is not limited to the original assessment areas. The client and EIS Specialist work together to reevaluate the course of the plan of care. Reassessment also allows for client readmission to programs, assignment to another level of service, and the termination of services. The elements of the reassessment should include: • Updating/revising written plan of care per stated standards. • Communication with client regarding services. • Topics to be addressed in the reassessment may include: a) Appointment, status and referrals; b) Special intervention activities; and c) Special needs • Entries in the written plan of care. • Client acknowledgment of changes resulting from the reassessment	• Documentation in client file
✓ Documentation of service/ written care plan implementation/monitoring/review, client participation, success, barriers and/or failures should be documented in the client chart (written plan and/or progress notes).	• Documentation in client file

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✓ Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or case manager. Conditions which result in a client's termination from services may include: ✓ Attainment of goals ✓ Non-compliance with stipulations of written plan ✓ Change in status which results in program ineligibility ✓ Client desire to terminate services ✓ Death	• Documentation in client file
VII.. Service Coordination/ Referral	
A. Providers must demonstrate strong linkages with HIV/AIDS medical providers, other EIS agencies and points of entry. This must be in the form of a written Memorandum of Agreement.	• Agency documentation of MOUs with Part A HIV medical providers, points of entry and other EIS agencies.
B. Providers must coordinate with medical case managers and must demonstrate strong linkages with these entities.	• Agency documentation of MOUs with medical case managers.
VIII. Client Rights and Responsibilities	
A. See Universal Standards of Care	
B. A client may refuse agreement to the identification of any or all problems, goals and/or action steps. In such cases the client chart (written plan and/or progress notes) must reflect the refusal, reasons and if appropriate, client signature.	• Documentation in client file • Policy on file

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C. The client must be instructed to notify EIS Specialist of any change in status or if any problems are found with the services provided.	• Documentation in client file • Policy on file
D. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the agency's written Grievance Policy.	• Documentation in client file • Policy on file
E. If terminated, client must be afforded information regarding transfer to an outside agency.	• Documentation in client file • Policy on file