


Using Early Intervention Services to Address Unmet Need

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Welcome and Introductions

- Session Objectives
- Participant questions regarding EIS




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Session Objectives


- Review the intent, and definition of Early Intervention Services
- Re-examine role of EIS in addressing unmet need
- Discuss the steps taken by the Nashville TGA to develop models of EIS
- Work with participants to identify points of entry and methods of using EIS to get individuals into care

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Defining and Identifying the Problem: Unmet Need


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Unmet Review

1. Legislative Requirements
2. HRSA Definition of "unmet need"
3. Estimating Unmet Need
4. Assessing Unmet Need
5. Addressing Unmet Need


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2000 Legislation Required:

- **Secretary of HHS** to develop epidemiologic measures "for establishing the number of individuals living with HIV disease who are not receiving HIV-related health services" and prepare State and national estimates of unmet need as input to Congress
- **Part A and Part B grantees** to assess PLWH service needs and gaps "with particular attention to individuals with HIV disease who know their HIV status and are not receiving HIV-related services" and "disparities in access and services among affected subpopulations and historically underserved communities"


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2006 Legislation Continued Focus on Unmet Need

- No longer “emergency relief” for overburdened health care systems
- Now “Revise and extend the program for providing life-saving care for those with HIV/AIDS”
- “Address the unmet care and treatment needs of persons living with HIV/AIDS by funding primary health care and support services that enhance access to and retention in care”


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Definitions and Distinctions

- **Unmet need** = the unmet need for *HIV-related primary health care* among individuals who know their HIV status but are not in care
- **Service gaps** = *all* needs for *all* PLWH except primary health services for those who know their status and are not in care

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HRSA/HAB Expectations Unmet Need

1. **Provide estimates** of unmet need each year (new estimate at least every 2 years)
2. **Assess unmet need** as part of needs assessment, to learn *who* is out of care, *where* they live, and *barriers* to care
3. **Use information on unmet need** in decision making and planning
4. **Address unmet need:** Find PLWH/A out of care and help them enter primary medical care and stay in care
5. **Monitor progress in addressing unmet need** -- look at changes in unmet need

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HRSA/HAB Working Definition of Unmet Need

An individual with HIV or AIDS is considered to have an **unmet need for care** (or to be **out of care**) when there is no evidence that s/he received *any* of the following three components of HIV primary medical care during a defined 12-month time frame:

1. viral load (VL) testing,
2. CD4 count, or
3. provision of anti-retroviral therapy (ART)

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Population Sizes		Value		Data Source(s)
A	Number of persons living with AIDS (PLWA) as of 12/31/06	2,538		HARS/Ryan White CAREWare
B	Number of persons living with HIV (PLWH)/non-AIDS/aware as of 12/31/06	2,167		HARS/Ryan White CAREWare
C	Total number of HIV+/aware, 1/1-12/31/05	4,705		
Care Patterns		Value		Data Source(s)
D	Number of PLWA who received the specified HIV primary medical care services, 01/01-12/31/05	1,151		HARS/Ryan White CAREWare
E	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care services, 01/01-12/31/05	711		HARS/Ryan White CAREWare
F	Total number of HIV+/aware who received the specified HIV primary medical care services, 1/1-12/31/04	1,862		
Calculated Results		Value	%	Calculation
G	Number of PLWA who did not receive primary medical services	1,387	55%	Value = A - D. Percent = G/A
H	Number of PLWH/non-AIDS/aware who did not receive primary medical services	1,456	67%	Value: B - E. Percent = H/B
I	Total HIV+/aware not receiving specified primary medical services	2,843	60%	Value: G + H. Percent = I/I1


FY 2006 National Estimates: Part A and Part B:

- **Part A EMAs/TGAs:** Aggregate estimated % not in care:
 - ✓ HIV/AIDS: **37%** Nashville - **60%**
 - ✓ HIV/non-AIDS: **47%** Nashville - **67%**
 - AIDS: **27%** Nashville - **55%**
- **Part B States:** Aggregate estimated % not in care:
 - HIV/AIDS: **43%**
 - HIV/non-AIDS: **52%**
 - AIDS: **33%**

Note: Most recent estimates are for FY 2006 and Nashville estimate is for FY 2008

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Unmet Need Interviews



- Compilation of reasons people were Not In Care although they were aware of their status.
- What do you think the reasons were?

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Reasons People Not In Care




- 1) Did not Know Free Low Cost Care Available
- 2) Stigma
- 3) Nashville TGA Results

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What do the Nashville estimates tell us?

- More than half of PLWH/A appear to be out of care
- PLWH/non-AIDS more likely than PLWA to be out of care
- Rates typically higher in non-Part A locations – and Nashville estimate is for period before Part A funding
- Actual unmet need may be lower than the estimate – possible data limitations
- Method used may undercount people who are in private care, especially PLWH/non-AIDS


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Need to Look at “Categories” of PLWH/A who are not in Care


- Targeting by category helps in finding people not in care
- Categories:
 1. Newly diagnosed
 2. Receiving other HIV/AIDS services (*often in the Ryan White system*) but not in primary care
 3. Formerly in care – dropped out (*and known to primary care providers*)
 4. Never in care

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To Successfully Assess Unmet Need:


- **Involve Ryan White providers** – some of their current or recent clients may be out of care
- **Involve non-Ryan White providers** – including homeless shelters, drug treatment centers, food banks – they often have clients who are not in primary care
- **Go to “points of entry”** – places where people get tested or referred into care
- **Do interviews** – PLWH/A out of care rarely complete self-administered surveys or attend focus groups
- **Target populations with high rates of HIV/AIDS** – based on your epi data
- **Involve PLWH/A who sit on planning bodies** – they can help find people not in care and design tools to assess their needs



Must “Assess” Unmet Need to Determine:

- **Characteristics** of PLWH/A not in care – e.g., race/ethnicity, gender, age, risk behaviors, co-morbidities – with focus on special needs populations
- **Where they live** within the TGA
- Their **barriers** to care
- Their other **service gaps** – what services are needed and for whom
- **What subpopulations/groups are most likely to be out of care**


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Developing Strategies to Address Unmet Need

- When assessing unmet need, always offer the PLWH/A referrals into care!
- Different strategies needed for helping different groups of PLWH/A enter care
- Strategies must address identified barriers
- Some changes to the continuum of care and its points of entry may be needed
- Strategies extremely varied – Early Intervention Services (EIS) represent one promising and flexible approach


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HRSA Definition and Intent of EIS

- Topics Covered
 - HRSA Definition
 - Legislation
 - Components of EIS
 - Working with Points of Entry
 - Linkage Agreements
 - Referrals


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HRSA Definition of Early Intervention Services

- **Counseling individuals with respect to HIV/AIDS; 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); **referrals**; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

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HRSA Definition of Early Intervention Services

Also includes the following

- **NOTE: EIS provided by Ryan White Part C and Part D Programs should NOT be reported here. Part C and Part D EIS should be included under *Outpatient/Ambulatory medical care*.**


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Ryan White Legislation & EIS

- *Early Intervention Services-*
- (1) *IN GENERAL- For purposes of this section, the term 'early intervention services' means HIV/AIDS early intervention services described in section 2651(e), with follow-up referral provided for the purpose of facilitating the access of individuals receiving the services to HIV-related health services.*

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HRSA Definition of EIS

- Although the definition refers to diagnostic tests, medical evaluation, test on appropriate therapeutic measures, clinical and diagnostic exams --
- HRSA recommends that these be funded and reported under ambulatory outpatient care/primary medical care

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RW Legislation & EIS: Points of Entry

The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities,

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RW Legislation & EIS: Points of Entry, Cont.

...clinics regarding sexually transmitted diseases, homeless shelters, HIV/AIDS counseling and testing sites, health care points of entry specified by eligible areas, federally qualified health centers, and entities described in section 2652(a) that constitute a point of access to services by maintaining referral relationships.

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Components of EIS

- Testing (when CEO certifies that not enough is available)
- Working with Points of Entry
 - Linkage agreements
 - Relationships
 - Information Dissemination
- Counseling
- Referral
- Access to Care

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EIS under Parts A and B

- Services:
 - Do not include primary medical care
 - Do not include prevention
 - Considered a Core Medical Service
 - Focus on testing (if needed)
 - Focus on counseling
 - Focus on referral

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Working With Points of Entry

- Linkage Agreements (MOU/MOA)
- Relationships (referrals and connecting to care)
- Information Dissemination (knowing how and where)




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Linkage Agreements, Relationships, Information Dissemination



- Memoranda of Understanding and Agreement (MOU/MOA)
- Face-to-face contact
- System Monitoring (referral tracking)
- Routine Provider Meetings
- Importance of Non-Ryan White Providers


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Access to Care

- Early Intervention Services Connect Individuals to
 - Primary Medical Care
 - Medical Case Management
 - Case Management
 - Other Core Services


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To Successfully Implement EIS Programs:

- **Involve Ryan White providers** – some of their current or recent clients may be out of care
- **Involve non-Ryan White providers** – including homeless shelters, drug treatment centers, food banks – they often have clients who are not in primary care
- **Go to “points of entry”** – places where people get tested or referred into care
- **Do interviews** – PLWH/A out of care rarely complete self-administered surveys or attend focus groups
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EIS and Nashville

- Discussion of Nashville and EIS
- Pam Sylakowski, Nashville Part A Grantee

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Challenges for Nashville

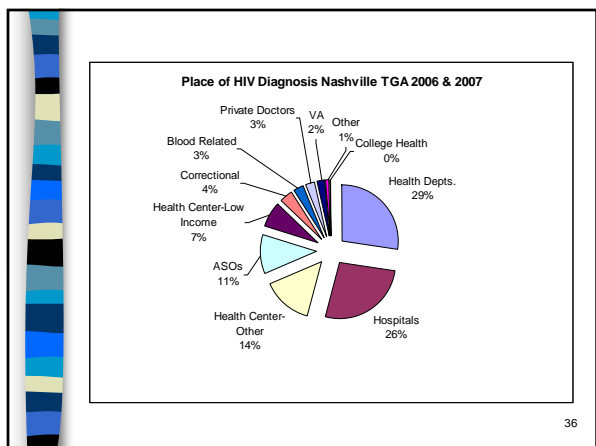
- New Part A Program under the 2006 Legislative Changes
- Need for Integration of Part A system of care with already existing mix of HIV/services
- High unmet need in the area
- HIV/AIDS not openly discussed or addressed often


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Need to Understand EIS

- Confusion regarding EIS among grantee office, providers, and Planning Council
 - Difference between prevention, outreach & EIS
 - What is a “point of entry” versus “a contact”
- Desire to Get It Right
- Realization of its potential to get and keep individuals in care
- Role of peer providers

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Creation of an EIS Summit

- Discussion/Meeting with Providers
 - Review the Legislation and HRSA's intent
 - Discuss the activities of all contracted EIS providers in the TGA
 - Discuss the effectiveness of these activities
 - Develop a process for the development of standards of care for EIS


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EIS Summit (Background Principles)

- Meeting to foster open, honest dialogue
- Held at neutral site
- Used an outside facilitator
- Not punitive in nature
- Corrections to some models would be made in future
- Client centered and focused

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EIS Models Used in Nashville

- By Service Location
- Urban Versus Rural Coverage
- Coordination Between EIS Providers
- Linkage Between EIS & Medical & Support Providers

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What Did We Learn?



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What Did We Learn


- Many providers needed reassurance regarding this service
- Some providers are better structured to integrate EIS within their service system
- Recognize strengths of providers who have successful history of working with hard-to-reach population
- More work could be done to identify and work with points of entry
- More coordination needed between EIS providers
- The relationship between EIS, medical case management and primary care requires more thought and work than anticipated
- Will also look at relationship of EIS and other core services (long term)

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What Did We Learn (cont.)

- Relationship building occurs with consumers and between organizations
- Information dissemination is a necessary component many points of entry do not know how to refer a client into Ryan White services
- EIS Summit is part of an on-going dialogue


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Results

- Creation of a working group to develop standards of care for EIS
- There will be changes to the scopes of work for providers of EIS
- Various models can and do exist including activities where providers work within the points of entry as well as train non-Ryan White providers how to refer clients into our system
- Examining how EIS works with medical case management/case management and primary care
- Exploring use of readiness scales to help target intervention (stages of change, motivational interviewing)


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Results (cont.)

- Learned that many of our consumers do not have good experiences with medical community upon learning their diagnosis
 - May be a contributing factor to those out of care
 - Barrier that EIS has to work to overcome

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Results (cont.)

- EIS Summit/HIV Continuum of Care Meeting (2009)
 - Will include Ryan White Providers
 - Also invite non-Ryan White Providers who serve those with HIV/AIDS
 - Continues the dialogue on unmet need
 - Allows relationship building
 - Refining our system for referrals into care

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**Activity – Group Discussion–
Harold Phillips**

In your community:

- Do Ryan White and non-Ryan White providers know what to do when they find someone who is positive?
- What are your “points of entry?”
- Are referrals monitored and how?


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Activity – Connection To Care

- Define Connected to Care?
 - Is it time in the system?
 - Is it behavior?
 - Is it number of visits?


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EIS Connection To Care

- Contract Language Should Allow:
 - Providers to educate Ryan White and non-Ryan White Providers
 - Referrals to be tracked and monitored
 - Connection to care more than one visit to primary care
 - Enhanced relationship between EIS, primary medical care and medical case management/case management


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Summary

- EIS can be part of a strategy to address unmet need
- EIS focuses on getting individuals in care
- Emphasis on working with points of entry
- EIS is a core service
- Work with consumers and providers to develop models


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Summary

- Connection between EIS, medical case management/case management and primary medical care
- Models should focus on
 - Linkage Agreements
 - Relationship building
 - Information dissemination
 - Getting individuals into care (Referrals)


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Resources for EIS


- HIV Treatment Modernization Act
- Ryan White Service Definitions
- CAEAR Coalition Document on Establishing Formal Linkages
 - www.caeear.org
- HRSA Technical Assistance

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Questions

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Wrap Up and Evaluation

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