

Ryan White Program Service Area Standards: Outreach

Vision. People living with HIV (whether aware or unaware of their status) who are not connected to HIV medical care will receive contacts, education, and brief services that result in their connection to that care.

HRSA Description: The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities:

- 1) identification of people who do not know their HIV status and/or
- 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options. Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must:

- 1) use data to target populations and places that have a high probability of reaching PLWH who
 - a. have never been tested and are undiagnosed,
 - b. have been tested, diagnosed as HIV positive, but have not received their test results, or
 - c. have been tested, know their HIV positive status, but are not in medical care;
- 2) be conducted at times and in places where there is a high probability that PLWH will be identified; and
- 3) be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Program Guidance: Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.

Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding.

All subrecipients must meet universal standards requirements in addition to service area standards for which they are funded.

| Standard | Intervention | Measure | Data Source |
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| Service Components | | | |
| 1. Sites, Contacts and Encounters | 1.1. Outreach programs conduct outreach at a variety of sites, including social media, that are demonstrated to encounter “hard to reach” and high-risk individuals. | 1.1.-1.2. Outreach programs report visits to specific sites, times of visits, outreach activities that occurred and include the number of encounters that are conducted. | 1.1.-1.2 Quarterly reports, and client level data system (CLD) document activities including outreach contacts, encounters, and activities. Outreach calendar that includes sites, times and populations reached is included in quarterly report. |
| 2. Screening Assessment | 2.1. Each outreach client will receive a screening assessment to determine their risk behaviors, knowledge of HIV status, care status, and immediate needs. 2.2. Screening will include identification of immediate needs and a plan for referral and follow-up. | 2.1. Client screening assessment will include documentation of HIV knowledge, understanding of risk, HIV status, date of last HIV test (if at-risk status identified) date of last medical appointment (if positive) and service needs. 2.2. A referral and follow-up plan will be in place to address client’s identified needs. | 2.1. - 2.2. Case notes completed; screening in individual client file. |
| 3. Linkage | 3.1. Outreach programs will work with clients until linkages to testing (if needed), health care and referrals to other needed services have occurred. Programs will provide information on Ryan White HIV services, referral and coordination to ensure clients are linked to HIV-related medical care and other needed services. Clients who require | 3.1. – 3.2. Number of referrals, coordination activities, follow-ups, and confirmed linkages to health care. | 3.1.-3.2 .Individual client records and client level data reflect referrals, and follow-up to confirm linkage to care. Quarterly reports document the number of |

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| | <p>extensive follow-up should be referred to medical case management</p> <p>3.2.a. Coordination of referrals will include those that address clients' barriers to care.</p> <p>3.2.b Linkage to HIV-related medical care should be a priority for those out of care.</p> <p>3.3.a. Outreach programs will develop a plan with each client explaining how the outreach program will follow up with the client post referral.</p> <p>3.3.b. When information is to be shared, clients will sign a release of information (ROI) allowing the outreach program to follow up, as appropriate, with referral resources. Outreach programs making referrals within the clinical/health system of which they are also a part, will follow their clinic/health system's guidance around ROI's.</p> <p>3.4. Outreach programs will develop and utilize a list of referral sources with which program staff have established a relationship to better ensure successful linkage to services.</p> | | <p>clients enrolled into outreach services, the number of services provided, and the number of clients referred to medical case management, medical care and behavioral health.</p> <p>Documentation of medical care linkage in client file.</p> <p>3.3. Client record has dated, signed release of information forms that are no more than one year old.</p> <p>3.4. Program records will document list of referral sources and formal agreements and other working relationships /communications.</p> |
| 4. Length of Service | 4.1. Outreach services will be provided until linkages to HIV medical care or medical case management are established or until client refuses services or contact is lost. | 4.1. Individual client files will include documentation of referrals, coordination, follow-ups and completion of linkages to services. | 4.1 – 4.2. Individual client files, quarterly reports, and client level data. |
| Provider Qualifications | | | |
| 5. Provider Qualifications | 5.1. Outreach staff will have the knowledge, skill and ability to: | 5.1.- 5.2. Position descriptions explain the knowledge, skills | 5.1.- 5.2. Program file contains documentation of |

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| | <p>5.1.a. Engage high risk and hard to reach clients in discussions concerning sexual health, HIV risks, HIV status, and the importance of testing and treatment.</p> <p>5.1.b. Coordinate linkages to primary care and other Ryan White system resources aimed at reducing barriers to care.</p> <p>5.2. Outreach safety protocol. Programs will develop, implement and train staff on an approved outreach safety protocol.</p> | <p>and experience required for Outreach.</p> <p>5.2. Safety protocol will be developed, implemented, and easily accessible.</p> | <p>current program service staff including position description and resume.</p> <p>5.2. Program file will include safety protocol. Staff completion of safety protocol training will be documented in program file.</p> |
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