Ryan White Program
Service Area Standards: Outreach
Approved April, 2011

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.

Definitions:

Core medical services: HIV primary medical care--including ambulatory outpatient HIV clinic services, AIDS Drug Assistance Program, oral health care, outpatient mental health care, outpatient substance abuse treatment, medical nutritional therapy, medical case management including treatment adherence, early intervention services, home health care services and specialty medical care referrals.

Non-medical support services: Services that address barriers to people living with HIV/AIDS accessing and remaining in primary medical care.

Outreach services: Programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status and are out of care so that they may become aware of, and enrolled in, care and treatment services.

Contact: An approach made to an individual to talk about her or his HIV status, risk, and/or access to services.

Encounter: Engagement of an individual in conversation about his or her HIV risk, status, and access to services.

Assessment: Individual evaluation of an HIV positive individual's medical care and risk status, knowledge of disease, barriers to accessing medical care and awareness of resources.

Eligible for Ryan White Outreach Services: Individuals who are assessed to be at risk and unaware of their HIV status or HIV positive and out of care, who also meet financial eligibility requirements and are in need of assistance to access testing and/or HIV medical care. Do not include clients currently receiving Medical Case Management or HIV primary medical care services.

Linkage: Successful engagement of a client into primary HIV medical care, with the understanding that current barriers to returning to care at recommended intervals are addressed; client is assessed as being likely to keep HIV medical appointments in the near future.

Hard to reach populations: People not accessing care due to barriers that may include poverty, health insurance gaps, substance abuse, or mental health problems. Other co-factors such as fear and stigma, low health literacy, and lack of readiness also create barriers to care.

High risk populations: Populations known through local epidemiologic data to be at disproportionate risk for HIV infection.

In care: A person is considered to be in care when he or she is receiving primary HIV medical care (clinical evaluation and clinical care) at a minimum of every six months. This medical care should meet U.S. Public Health Service guidelines for the treatment of HIV/AIDS.

Out of care: An individual that has not accessed primary HIV medical care within the last six months.

Partnerships: An arrangement with another service provider that will help advance the goal of care outreach.

Coordination: Working with other service providers to ensure efficiency and eliminate duplication of efforts.

Early intervention services: A mix of services limited to 1) targeted testing and counseling of individuals with respect to HIV/AIDS; 2) formal relationships with key points of entry that facilitate follow-up 3) referral services providing access to care, and 4) health education and literacy training enabling clients to navigate the HIV system of care. Note: All four program components must be present for a program to be considered an early intervention services program.

Points of entry: Health care and human services access points used frequently by traditionally underserved HIV-positive individuals to help meet their medical and social service needs. They are therefore key access points for referring such individuals into the HIV care system.

Standard	Intervention	Measure	Data Source
Individual Client Focused Standards			
1. Sites	1.1. Direct service staff will conduct outreach at sites where "hard to reach" and high risk individuals are known to congregate. These may include: • Correctional facilities • Homeless centers • Bars • Social clubs • Streets and Parks • Online internet sites Sites can not be at a Ryan White funded provider unless justified and approved by Contract Manager. 1.2 Client identification and outreach activities will occur at hours and sites where targeted populations are likely to be encountered.	1.1.-1.2. Outreach programs report staff visits to specific sites, times, and outreach activities that are conducted.	1.1.-1.2 Outreach field notes, quarterly reports, and client level data system (CLD) document activities planned to recruit into services individuals unaware of their HIV status and/or out of care. Outreach calendar that includes sites, times and populations is submitted to contract manager as part of the quarterly report.
2.Contacts and Encounters	2.1. Program staff will make sufficient contacts with people in the community to meet program goals for initiating eligible individuals into Ryan White Outreach services.	2.1. Programs will track outreach contacts, encounters, and activities.	2.1. Program files and quarterly reports will document the number of outreach contacts, encounters, and activities conducted to identify and recruit individuals eligible for outreach services.
3. Assessment	3.1. Outreach staff will utilize a brief screening tool to assess clients' risk behaviors, knowledge of their HIV status, care status, and other immediate needs. 3.2. Assessment will include identification of needs and a follow-up plan.	3.1. Client assessment results including HIV knowledge, risk, HIV status, date of last HIV test (if at-risk status identified) date of last medical appt (if positive) and services needs. 3.2. A follow-up plan will be	3.1.- 3.2. Field notes completed; assessment in individual client files and quarterly reports.

		in place to address client's identified needs.	
4. Linkage	4.1. Direct service staff will work individually with clients until linkages to testing, care and other needed services are confirmed. Staff will provide information on available HIV services, referral and coordination to ensure clients are linked to HIV-related medical care and other services. 4.2.a. Coordination of referrals will include addressing clients' barriers to care such as transportation, mental health issues, chemical health needs, or basic needs such as housing and nutrition. 4.2.b. Referrals to medical case management, mental health, and outpatient substance abuse treatment services should be made when needs are identified. 4.2.c. Referral, coordination, and follow-up to HIV-related medical care should always occur for individuals out of care. Linkage to needed care will be confirmed with primary care provider. 4.3.a. Direct service staff will develop a plan with individual clients for how they will follow up with them post referral. 4.3.b. When information is to be shared, direct service staff will request a signed release of information from the client to allow them to follow up, as appropriate, with referral resources. Staff must confirm linkage to primary HIV care and/or medical case management with provider agency. 4.4.a. 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.	4.1. – 4.2. Number of referrals, coordination activities, follow-ups, and confirmed linkages. 4.3.a. Documentation includes plans for follow-up to referrals. 4.3.b. Documentation includes current release of information if information is to be shared or note that client declined and linkages made. 4.4. Documentation of referral sources and formal agreements.	4.1.-4.2.Individual client records and client level data reflect referrals, and follow-up to confirm linkage to care. Quarterly reports document the number of clients initiated into outreach services, the number of services provided, and the number of clients linked to care and needed services. 4.3. Client record has dated, signed release of information forms that are no more than one year old if information has been or will be shared and notation of confirmation of linkages. 4.4. Program records will document list of referral sources and formal agreements and other working relationships /communications

	4.4.b. Each provider agency must have formal and written referral agreements with at least one of each of the following provider types: HIV medical care, HIV-testing site if testing is not offered by outreach provider, early intervention services, mental health, and outpatient substance abuse services.		
5. Multiple Co-factors	5.1 Clients that present with multiple co-factors or barriers to accessing care that require extensive follow-up should be referred to a medical case management program along with HIV medical care. 5.2 Clients with unmet mental health needs and expressed readiness should be immediately referred to a mental health provider along with MCM and HIV-related medical care. 5.3 Clients with unmet chemical health needs and expressed readiness should be immediately referred to a substance abuse assessment along with HIV-related medical care.	5.1.-5.3. Documentation of referrals, coordination, follow-ups, and confirmed linkages to MCM, mental health services and/or substance abuse outpatient services.	5.1.-5.3. Individual client records document assessment of co-factors or barriers, referrals made, and follow-up. Quarterly reports reflect numbers of clients referred to medical and behavioral health services and to Medical Case Management
6. Length of Service	6.1. Outreach services will be provided for clients until linkages to HIV medical care or medical case management are established. 6.2. Outreach services shall not replace medical case management, mental health, and outpatient substance abuse treatment.	6.1. Individual client files will include documentation of referrals, coordination, follow-ups and completion of linkages to services.	6.1 – 6.2. Individual client files, quarterly reports, and client level data.
Program Focused Standards			
7. ProviderQualifications	7.1. Direct Service Providers will have the knowledge, skills and abilities to: 7.1.a. Engage high risk and hard to reach clients in dialogue about their sexual health, HIV risks, HIV status, and the importance of testing & treatment. 7.1.b. Coordinate linkages to primary care and/or early intervention services for clients. 7.1.c. Coordinate access to services to meet client needs which may include medical case management, mental health, chemical health, and support services.	7.1.- 7.2. Programs are staffed with personnel with knowledge of HIV and skills and experience to work with populations most impacted by HIV.	7.1.- 7.2. Program file contains documentation of all current direct service staff including resume, education, work experience, skills, and training needs/plans.

	7.1.d. Utilize motivational interviewing techniques to engage clients. 7.2. Program Supervisors will have two years of related work experience (as listed in 7.1) and have completed training on the topics listed in 7.3. 7.3. Training 7.3.a. Staff is required to attend and document a minimum of 24 hours of training on HIV 101, treatment basics, counseling and testing, HIV system of care, resources and accessing services, motivational interviewing, sexual health, gender and sexual orientation competency, contract requirements, safety protocol, and consent laws. 7.3.b. Staff is required to attend a minimum of 16 hours of annual ongoing training on topics that include confidentiality, HIPAA, sexual health, chemical health (including sensitivity), mental health, domestic violence, STDs, partner notification, bereavement, cultural and linguistic competency, gender sensitivity, boundaries, safety, HIV epidemiologic and treatment trends, treatment adherence, and nutrition. Confidentiality and HIPAA training are required annually. 7.4. Outreach safety protocol. Programs will develop, implement and train staff on an approved outreach safety protocol.	7.3. Training attendance will be confirmed and documented by program supervisor. 7.4. Safety protocol will be developed, implemented, and easily accessible.	7.3. Program file contains documentation of all completed training. 7.4. Program file will include safety protocol. Staff completion of safety protocol training will be documented in program file.
8. Documentation	8.1. Complete, current, secure individual record is maintained for each client receiving outreach and linkage services.	8.1. Each client has a separate, individual record that documents assessments, referrals, coordination of follow-ups and completed linkage to	8.1. Client record has dated, signed hard copy or electronic documentation as specified for each individual standard.

	8.2. Ryan White funded Outreach activities are accurately entered into the client level data reporting system (Minnesota CAREWare).	care. 8.2. Outreach clients (those who are identified during encounters as eligible and willing to receive Ryan White funded Outreach services) have each service accurately entered into CAREWare including subservices of ""case finding, referral and care coordination and linkage to care.".	8.2. Client level outreach data are consistent with numbers of clients reported in invoices and quarterly reports.