Minnesota Ryan White HIV/AIDS Program
Service Area Standards: Outreach Services

HRSA Description: The Outreach Services category has as its principal purpose identifying people with HIV 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 Ryan White HIV/AIDS Program 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 linkage.

Outreach Services must:

1. Use data to target populations and places that have a high probability of reaching people with HIV who:
    a. Have never been tested and are undiagnosed
    b. Have been tested, diagnosed as HIV positive, but have not received their results
    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 people with HIV will be identified
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.

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

Standard	Measure	Data Source
Individual Client Focused Standards		
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" andhigh-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 immediateneeds. 2.2 Screening will include identification of immediate needs and a plan for referral and follow-up.	2.1. Client screening assessmentwill 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 addressclient'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 extensive follow-up should be referred to medical case management.	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 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.

Standard	Measure	Data Source
3.2.a. Coordination of referrals will include thosethat address clients' barriers to care. 3.2.b Linkage to HIV-related medical care should bea priority for those out of care. 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. 3.3.b. When information is to be shared, clients willsign a release of information (ROI) allowing the outreach program to follow up, as appropriate, withreferral 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. 3.4. Outreach programs will develop and utilize alist of referral sources with which program staff have established a relationship to better ensure successful linkage to services.	3.3.a. Documentation includes plans for follow-up to referrals. 3.3b Documentation includes current release of information.	Documentation of medical care linkage in client file. 3.3. Client record has dated, signed release of information forms that areno more than one year old. 3.4. Program records willdocument list of referral sources and formal agreements and other working relationships/communications.
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 refusesservices or contact is lost.	4.1. Individual client files will include documentation of referrals, coordination, follow-ups and completion of linkagesto services.	4.1 – 4.2. Individual client files, quarterly reports, andclient level data.

Standard	Measure	Data Source
Program Focused Standards		
5. **Provider Qualifications** 5.1. Outreach staff will have the knowledge, skill, and ability to: • Engage high risk and hard to reach clientsin discussions concerning sexual health, HIV risks, HIV status, and the importance of testing and treatment. • Coordinate linkages to primary care andother Ryan White system resources aimed at reducing barriers to care.	5.1.- 5.2. Position descriptionsexplain the knowledge, skills and experience required for Outreach.	5.1.- 5.2. Program file contains documentation of current program service staff including position description and resume.
5.2. Outreach safety protocol. Programs will develop, implement, and train staff on an approvedoutreach safety protocol.	5.2. Safety protocol will be developed, implemented, and easily accessible.	5.2. Program file will include safety protocol. Staff completion of safetyprotocol training will be documented in program file.