OUTREACH SERVICES

(Approved by the Executive Committee 2/14/2020)

I. DEFINITION/OVERVIEW

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.

II. 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 a person living with HIV, but have not received their test results, or
    c. Have been tested, know they are living with HIV, 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 efforts.

Outreach services should be continually reviewed and evaluated in order to maximize the probability of reaching individuals who know their HIV status but are not actively in treatment. Quantified program reporting is required to assist local planning and evaluation efforts. HIV prevention education, counseling and testing are not allowable activities under this service category.

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.

III. ELIGIBILITY

Outreach services pertain to linking PLWH into care and services and linking persons not living with HIV into care testing, risk reduction activities, and education. This shall only require that the individual being served is a resident of the EMA. (See Universal Standards, Verification of Eligibility sections 1.1 and 1.3)

IV. SECTIONS

In this document you will find:

- → Personnel
- → Referral to Part A services
- → Coordination and Referral
- → Discharge/Transition

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualification**	
1.11	Service providers will employ staff who are knowledgeable and experienced regarding HIV outreach and the HIV continuum of care (i.e. care and clinical resources).	Documentation in employee's file.
1.2	**Training**	
1.21	Training in HIV outreach and counseling is required for all staff funded under this initiative. Training services are offered through Louisiana Office of Public Health HIV/STD Program.	Documentation in personnel file or training log
1.22	Ongoing training for staff must be provided to appropriate staff to maintain current knowledge about outreach.	Documentation in personnel file or training log
2.0	**REFERRAL TO PART A SERVICES**	
2.1	People living with HIV who are identified will be referred to a Part A Early Intervention	A written referral process (such

#	Standard	Measure
	Services or Medical Case Management provider or directly to a Primary Medical Care provider to facilitate transition to Primary Medical Care. Outreach providers shall follow-up with agencies to which clients were referred.	as a referral log or client specific documentation) and documentation of follow-up to agencies to which clients were referred, as well as follow-up with clients. Written client consent must be obtained and kept on file in order to follow-up with referral. A good faith effort to obtain such consent must be documented.
3.0	**COORDINATION AND REFERRAL**	
3.1	Providers should establish formal referral relationships and linkages to HIV primary care, case management, and other services in the HIV continuum of care as appropriate. Outreach should work to expand the provider network to include relationships with local points of entry, both short and long term. Outreach providers will partner with community-based access points to identify and refer people living with HIV who are not in care/not in Ryan White Care into the health care system and/or into the Ryan White services system, as applicable.	MOU and other formal documentation of linkages between primary care, case management and Outreach sites will be kept on file with appropriate updates and signatures.
4.0	**DISCHARGE/TRANSITION**	
4.1	Client will be considered discharged upon successful referral to EIS or case management provider or primary care provider	1. With client consent, documentation of client contact with EIS or case management or primary medical care. OR 2. Written note indicating that

#	Standard	Measure
		client expressly refused referral services OR 3. Documented attempts at multiple follow-up attempts through data management system