

Ryan White Planning Council/MCDPH Ryan White Title I Services  
Quality Management  
STANDARDS OF CARE

**Outreach Services**

**Service Definition**

Outreach Services are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Provides a range of client-centered services that link clients with primary HIV medical care, psychosocial, and other services to insure timely, coordinated access to medically-appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and a linkage that expedites discharge, as medically appropriate, from inpatient facilities. Key activities include initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic reevaluation and revision of the plan as necessary during the life of the client. Services may include client-specific advocacy. Following the assessment of individual need, advice and assistance in obtaining medical, social, community, legal, financial, benefits counseling and assistance, and other needed services are provided.

**Goals**

The goals of the Outreach service category are to:

- Conduct community-level canvassing to locate individuals with known or unknown HIV positive status not receiving medical care for the purpose of educating them on the HIV disease process and available treatment services
- Facilitate access linkage to medical care or community services

STANDARD	MEASURE/EVIDENCE
<b>Client Level</b>	
1. <b>Intake:</b> All clients are screened to determine the need for linkages into primary medical care or community services  2. <b>Linkage to medical care</b>	1. Client's chart contains documentation of the intake within 10 working days of the first contact.  2. Client chart will document access to primary medical care within 3 months of initial Outreach intake and assessment

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<p>2. <b>Assessment:</b> Upon establishing need for services, client's assessment provides the foundation for service planning and delivery</p>	<p>1. Client chart will contain documentation of assessment within 10 working days of intake.            2. Client assessment will review at a minimum the following areas:</p> <ul style="list-style-type: none"> <li>▪ medical;</li> <li>▪ dental;</li> <li>▪ mental health;</li> <li>▪ substance abuse;</li> <li>▪ financial;</li> <li>▪ social support;</li> <li>▪ legal needs;</li> <li>▪ transportation;</li> <li>▪ housing;</li> <li>▪ risk reduction;</li> <li>▪ cultural factors;</li> </ul>
<p><b>Referral to Medical Care</b></p> <p><b>Case manager for Care Plan development:</b> All clients must participate in the development of a care plan based on the findings of initial assessment.</p>	<p>1. Chart will document referral to medical care within 3 months of initial outreach intake and assessment            2. Chart will document referral to Case Manager for care plan development within 10 days following client's initial Outreach assessment.</p>
<p><b>Identification of resources and referrals:</b> Based on assessment, Outreach worker will identify applicable resources, inform client of those resources, and encourage client to make the initial contact</p>	<ul style="list-style-type: none"> <li>▪ Documentation of applicable resources and referrals are in the client chart.</li> </ul>
<p><b>Follow-up</b></p>	<ul style="list-style-type: none"> <li>▪ Client chart includes documentation of Outreach workers activities to encourage client to make the initial contact for all existing and applicable services.</li> <li>▪ Client chart includes documentation of two monthly contacts or attempts to locate client regarding attendance of two medical appointments within the first 120 days after initial Outreach assessment</li> </ul>
<p><b>Case closure:</b> Upon client's death, or client's choice, chart will be moved to inactive/closed status</p>	<ul style="list-style-type: none"> <li>▪ Client chart includes documentation of a closure note within ten working days of case closure/inactive status.</li> </ul>
<b>Vendor Level</b>	
<p>Agency follows established Phoenix EMA Ryan White Part A Standards of Care and agency-specific policies and procedures.</p>	<p>Agency has policies describing:</p> <ol style="list-style-type: none"> <li>1. procedures on how to conduct appropriate Outreach</li> <li>2. how to conduct an assessment;</li> <li>3. grievance procedures.</li> </ol>

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STANDARD	MEASURE/EVIDENCE
<b>System Level</b>	
OUTCOMES	MEASURES/EVIDENCE
<p>Improve clients' health by increasing access to primary medical care</p>	<ul style="list-style-type: none"> <li>▪ 75% of clients have documentation of access to primary medical care within 3 months of initial Outreach intake and assessment</li> </ul>