ATTACHMENT B

Note from Mosaica: Following is an outreach protocol for a refined outreach program model that the Phoenix EMA hopes to implement. The protocol is based on an in-depth study of outreach models and the decision to have outreach workers not simply refer PLWH into care, but also provide “outreach liaison follow up” for three months, to ensure that PLWH are fully connected to care.

The protocol calls for the use of peer outreach workers – PLWH who come from backgrounds similar to the populations of PLWH they are targeting.

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1. SERVICE UNIT DEFINITION

"Programs which have as their principal purpose identifying people with HIV disease, *particularly those who know their HIV status* so that they may become aware of and may be enrolled in ongoing HIV primary care and treatment. Outreach activities must be planned and delivered in coordination with State and local HIV-prevention outreach activities to avoid duplication of effort and to address a specific service need category identified through State and local needs assessment processes. *Activities must be conducted in such a manner as to reach those known to have delayed seeking care.* **Outreach services should be continually reviewed and evaluated in order to maximize the probability of reaching** *individuals who do not know their HIV status* **or know their HIV status but are not actively in treatment.** Broad activities that market the availability of health-care services for persons living with HIV are not considered appropriate Title I outreach services)."

(for examples of these activities, please refer to the Ryan White CARE Act Title I Manual, HAB Policy Notice 02-01) – *see Appendix*

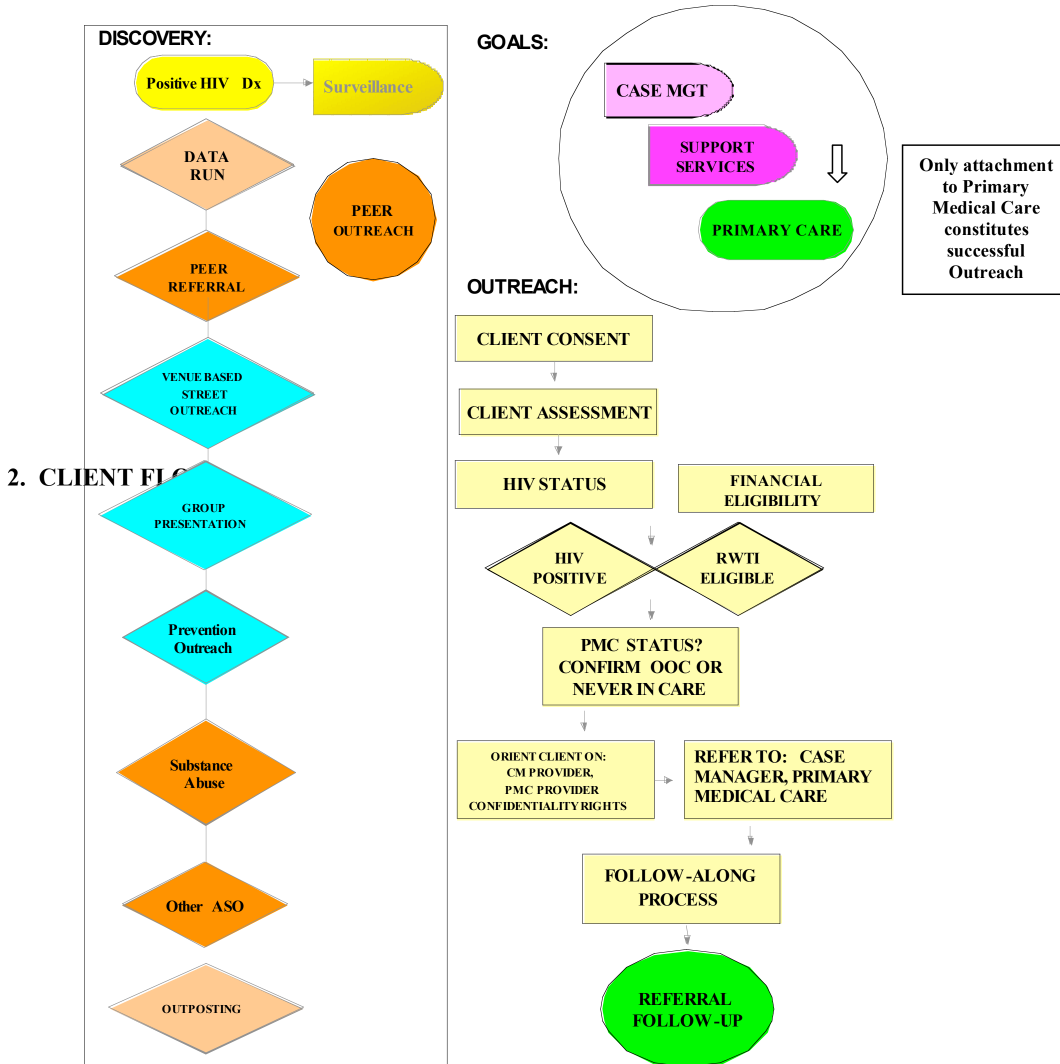
Italics: ideas to stress compared to current practices
Bold: ideas to stress

Service	$ Value	Units utilized to Date	$ utilized to date
Venue based Street Outreach	$10.00	2,579	$25,790.00
Group Presentation	$90.50	13	$1,176.50
Outreach Contact	$15.00	2,882	$43,230.00
Agency Visit	$40.00	16	$640.00
Case Finding	$1,400	28	$39,200.00
Gatekeeper	$45.25	36	$1,629.00
Follow-up	$40.00	50	$2,000.00
		5,604	$113,665.50

Tracy Kulik 4/2/06 9:45 PM
Comment: KEVIN: 2 questions: 1. Is this follow-up to Outreach Contact? Or to Case Finding/Referred Outreach Client? If b) shouldn't there be equal or less follow-up than case findings. 2) Were current agencies contracted since Sept 2005 or for full FY (4 vs. 10 months as of 12/31/05)

TARGETED OUTREACH - Client Flow

2. CLIENT FL



3. PROTOCOL

The Outreach protocol identifies the steps involved in delivering Outreach services, as determined in revision of processes related to this service. Steps are categorized by determination of clients needing Outreach services ('Outreach Focus) and Delivery of Outreach Services ('Outreach Service Delivery').

Outreach Focus

Referral for Outreach

Referral to Outreach services can occur through a variety of sources, including peers, AIDS Service Organizations, the HIV Surveillance division of the Maricopa Department of Public Health and/or Substance Abuse/Mental Health providers.

Outreach Service Delivery

Client Consent

Outreach individuals identified through either HIV Surveillance, Out of Care studies or outposting, shall consent to being assessed for potential referral to primary care and/or case management services.

Client Assessment

Outreach workers, upon receiving client consent, should assess willingness and capability to enter primary medical care. Client willingness and ability to comply with medical appointments, scheduled laboratory visits and documentation of possible barriers should be identified. Willingness to enter case management to link to a constellation of services and reduce barriers to entering and maintaining primary care should also occur.

For clients who have never been in primary care, detailed barriers should be listed using the Outreach Assessment Tool The benefits of primary medical care should be summarized with review of available medical providers, hours of operation and options for attachment. In addition, listing of key support services required to maintain access to primary care and case management should occur.

Certification/Referral forms should be completed at this time.

Verification (HIV status, Financial Eligibility)

Outreach staff shall target HIV-positive individuals in under-served populations for outreach activities. To verify that outreach clients are eligible for Ryan White Title I services, both HIV status (HIV-positive) and financial eligibility (not eligible for other insurance provision and meeting income qualifications) shall occur.

Client Referral

Referral to case management and/or primary care will occur at this point. The Outreach Liaison will determine if referral will take place to a case manager, case manager and primary care provider or both. Determination of the need to accompany the client will also take place and be documented.

Client Orientation

Orientation to primary care, medication, laboratory testing, case management and other support services will occur at this time, with scheduling of the initial primary care and/or case management appointment. Final summary of the care processes associated with case management to reduce barriers to primary care entry and primary medical care services is provided, with repeat of individual (client vs. outreach liaison responsibilities).

Follow-up

Outreach staff will record all case management referrals on the Outreach Referral Tracking Form. Follow-up shall occur two (2) weeks from the date the referral was given to the client.

'Follow-along' process (transition to Case Management)

Outreach staff will 'follow-along' the outreach client as they interface with case management, primary care and other referred services. This 'follow-along' will occur for a period of three (3) months, with understanding that issues after that date are the responsibility of the case manager.

4. FORMS

a) **Outreach Assessment Tool**
b) **Client certification**
c) **Outreach Follow-Up**

a) Outreach Assessment Tool

OUTREACH ASSESSMENT & REFERRAL TOOL

DATE: ____________________________ **CLIENT NAME:** ___________________________
LOCATION: __________________________ **CLIENT ADDRESS:** ___________________________
OUTREACH LIAISON: ___________________ **CLIENT TELEPHONE:** ___________________________

White not Hispanic	**Native American**		**MSM**
Black not Hispanic	**Asian/Pacific Islander**		**IDU**
Hispanic	**Undocumented citizen**		**Heterosexual transmission**

Y N IS CLIENT HIV POSITIVE? (SELF DISCLOSED VALIDATED)

Y N IS CLIENT PARTICIPATING IN HIV PRIMARY MEDICAL CARE?

- **IF YES, conclude interaction**
- **IF NO, follow protocol and refer to case manager, with consent or primary care (if not wanting case management)**

DOCUMENT Barriers: (check)

BARRIER		**INSURANCE**
NO INTEREST	Cost of Medications	No health insurance
Transportation	Substance use	No Medicaid
Child Care	Fear/stigma	No SS
Undocumented	Homeless	No SSI

Linkage request: (check)

Case management	Housing	Food
Primary Care	Dental	Child Care
Substance Abuse	Transportation	Other (list):
Mental Health	Emergency Financial Assistance	

CHECK COMPLETION	**YES**	**NO**
Release of information on certification on file:		
Client eligibility on file		
Confidentiality on file		
Consent below		

Current Medications:		
Last CD4 Count:		
Last Viral Load:		

White not Hispanic	**Native American**		**MSM**
Black not Hispanic	**Asian/Pacific Islander**		**IDU**
Hispanic	**Undocumented citizen**		**Heterosexual transmission**

___________________________ _____ ___________________ ___________________
Client signature **Date** **Outreach Liaison** **Referring Agency**

CLIENT REFERRED TO CASE MANAGER PER PROTOCOL WITH THEIR CONSENT
CLIENT REFERRED DIRECTLY TO PRIMARY MEDICAL CARE
CLIENT DOES NOT WISH TO SEEK PRIMARY MEDICAL CARE, GIVEN INFORMATION

b) Client certification (completed by Case Manager or Primary Medical Care)

SECTION I – Client Information

Date of Certification:
Eligibility ___________ Referral __________ Re-certification of eligibility ___________

Client name:
Address:
City:
Phone #:
DOB:
SS #:

Race/ethnic background and exposure:

White not Hispanic	Native American		MSM
Black not Hispanic	Asian/Pacific Islander		IDU
Hispanic	Undocumented citizen		Heterosexual transmission

Medicaid #:
Medicare #:

SECTION II – TYPE OF ASSISTANCE REQUESTED

Client referral to: ____

Name and location of agency ***Agency contact***

Additional instructions:

Case management	Mental health
Child care	Nutritional counseling
Complementary therapies	Primary Medical care
Emergency financial assistance	Substance Abuse
Food bank	Support Groups
Medications	Transportation

SECTION III - CERTIFICATION

I certify: (initial all that apply):

The individual identified above meets all Federal, State and local eligibility requirements for referred services funded under Title I
Our agency has on file proof of the client's medical eligibility
Our agency has on file proof of the client's financial eligibility
Our agency has on file proof of the client's Maricopa or Pinal county residency
Our agency has on file Consent form
Client has been screened for Medicaid, Medicare or other public funding sources

I further certify that all information provided on this form is accurate and available for inspection in accordance with Federal and State confidentiality laws, and that the client has submitted a signed authorization and release of information to obtain requested services.

_________________________________ _____________

Case Manager or Primary Medical Care signature *Date*

c) Outreach Follow-Up

REFERRAL STATUS	Date	Date	Date	Date
1) Client currently in primary medical care **a) per case manager** **b) per primary care provider**				
2) Client has not contacted case manager				
3) Resolution of barriers to care in progress per case manager				
4) Client chose not to receive primary medical care				
Reasons:				
5) Client lost to contact				