

# Seattle TGA Ryan White Program Standards

## Outreach Services

*Approved by Planning Council 1/12/2026*

### **HRSA Definition:**

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.

### **Service Units:**

- Face to Face Encounters – Field
- Telephone Encounters (measured in 15-minute increments)
- Written Communication Encounters (measured in 15-minute increments)

- Collateral Contacts (measured in 15-minute increments)
- Return to Care Evaluation (measured in 15-minute increments)
- Linkage to Services Encounters (measured in 15-minute increments)

### 1.0 General Standards

	STANDARD	MEASURE
1.1	<p>The agency has the following agency/client level policies, and follows the policies:</p> <ul style="list-style-type: none"> <li>▪ Physical safety of staff and clients</li> <li>▪ Release of information (ROI)/informed consent</li> <li>▪ HIPAA Privacy and Security Policies</li> <li>▪ Appropriate Professional Behavior &amp; boundaries to include sexual harassment</li> <li>▪ To provide services regardless of an individual's ability to pay</li> <li>▪ To provide services regardless of past or present health conditions.</li> <li>▪ Agency must obtain a signed Release of Information and upload the signed form to the Provide database</li> </ul>	<p>Recipient review of documents and policies</p> <p>Signed ROI is scanned into Provide</p>

### 2.0 Outreach Activities

	STANDARD	MEASURE
2.1	<p>To identify people to engage in care, outreach activities must:</p> <ol style="list-style-type: none"> <li>1) use data to target populations and places that have a high probability of reaching PLWH who <ul style="list-style-type: none"> <li>• have been tested, diagnosed as HIV positive, but have not received their test results, or</li> <li>• have been tested, know their HIV positive status, but are not in medical care;</li> </ul> </li> <li>2) be conducted at times and in places where there is a high probability that PLWH will be identified (must contain street and field outreach components); and</li> <li>3) be delivered in coordination with local and state HIV prevention, outreach, and early intervention services programs to avoid duplication of effort.</li> </ol>	<p>Recipient review of documents and policies</p>
2.2	<p>The agency must utilize inclusive methods of contact, while being compliant with HIPAA and <a href="#">Washington Administrative Code 246.100</a>, to reach potential</p>	<p>Recipient review of documents and policies</p>

	clients. Contact methods include, but are not exclusive to, texting, phone calls, email, and field work.	
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### 3.0 Linkage to Care

	STANDARD	MEASURE
3.1	The program must prioritize engaging clients who have never been in care and re-engaging lost-to-care clients.	Review of program design documentation
3.2	<p>Upon identifying a client who has never been in care, the agency must:</p> <ul style="list-style-type: none"> <li>engage the client in conversation about why they are not in care / barriers to care</li> <li>refer the client to health care within 3 days of the client agreeing to engage in care</li> <li>refer the client to supportive services within 7 days of the client agreeing to engage in care</li> <li>offer voluntary intimate partner counseling and information regarding preventive measures for HIV-negative partner(s) such as PrEP, and referral to partner services</li> <li>verify the client's linkage to care within 30 days of referral</li> </ul>	<p>Documentation in the client record of:</p> <ul style="list-style-type: none"> <li>information provided to client regarding primary care and support services</li> <li>active referrals to services</li> <li>referrals to care and support services</li> <li>partner services offered to client, and referrals to partner services</li> </ul>
3.3	<p>Upon identifying a lost-to-care client, the agency will engage the client to identify and document the reasons why the client fell out of care.</p> <p>Additionally, the agency must:</p> <ul style="list-style-type: none"> <li>refer the client to health care within 3 days of the client agreeing to return to care</li> <li>refer the client to supportive services within 7 days of the client agreeing to return to care</li> <li>offer voluntary intimate partner counseling and information regarding preventive measures for HIV-negative partner(s) such as PrEP, and referral to partner services</li> <li>verify the client's linkage to care within 30 days of referral</li> </ul>	<p>Documentation in the client record of:</p> <ul style="list-style-type: none"> <li>information provided to client regarding primary care and support services</li> <li>active referrals to services</li> <li>referrals to care and support services</li> <li>partner services offered to client, and referrals to partner services</li> </ul>
3.4	<p>The agency must coordinate with providers and local and state HIV prevention outreach programs to:</p> <ul style="list-style-type: none"> <li>Minimize duplication of effort</li> </ul>	Documentation in Provide database

	<ul style="list-style-type: none"> <li>• Ensure efficient partnership/collaborations to engage with Out-of-Care Clients</li> <li>• Adhere to Ryan White Part A's payer of last resort requirement</li> </ul>	
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#### 4.0 Personnel

	STANDARD	MEASURE
4.1	In the recruitment of personnel, the agency is encouraged to use best practices to prioritize lived experience and reflect the agency's client population to ensure the best outcomes possible for the population they serve. Some best practices include using neutral language in postings, using a variety of recruitment platforms, and creating an accessible website.	Review of job descriptions and personnel
4.2	All staff and volunteer positions have job descriptions.	Job descriptions are consistent with agency policies and exist for all staff and volunteer positions.
4.3	Program personnel have current licensure/certification/registration as required for their position.	Review of personnel credentials against those recognized by WA state as valid for their profession/position.
4.4	The agency ensures that staff who have close, direct, in-person contact with clients receive an Interferon-Gamma Release Assay (IGRA) test for tuberculosis (TB) upon hire. The agency ensures that staff who test positive for TB receive a chest x-ray and are screened for symptoms annually.	Documentation of staff TB test or referral for TB test
4.5	The agency conducts a criminal background check of staff & volunteers, as per WAC guidelines and hiring decisions should not exceed WAC requirements.	Copy of criminal background check in personnel file
4.6	When searchable databases exist, the agency screens applicants for actions taken by state/local licensing bodies (WA DOH Health Systems Quality Assurance website).	Documentation of database search in personnel file
4.7	All personnel receive an annual performance evaluation.	Performance evaluations in personnel file

#### 5.0 Staff Training

5.1	The agency provides access to continuing education needed to maintain skills/knowledge essential to job function.	Documentation of continuing education appropriate to staff position descriptions in personnel files
5.2	Agency personnel obtain the continuing education necessary to maintain licensure.	Staff licensure is current

## 6.0 CLAS Mandates

The [Culturally and Linguistically Appropriate Services \(CLAS\) standards](#) were issued by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) in 2001 to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services. OMH developed these standards to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. The CLAS standards include mandates (requirements for all recipients of federal funds), guidelines (activities recommended by OMH for adoption by Federal, State and national agencies), and recommendations (suggestions for voluntary adoption by health care organizations). The Seattle TGA HIV Planning Council has developed the following standards to help agencies meet the required four CLAS mandates (standards 4, 5, 6, and 7).

- *Standard 4: Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.*
- *Standard 5: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.*
- *Standard 6: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.*
- *Standard 7: Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.*

OMH uses the term “health care organizations” to identify the types of organizations for which CLAS standards were developed. “Health care organizations” are defined for this document as “all organizations that contract with Public Health – Seattle & King County to receive federal funding to provide care and services to people with HIV.”

*The goal of these standards is to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.*

	STANDARD	MEASURE
7.1	<p>The agency has a language access plan.</p> <p><i>A language access plan can help ensure that an organization provides high quality and appropriate language services. A language access plan can also help ensure that an organization’s staff members are aware of what to do when an individual with limited English proficiency needs assistance.</i></p>	Written plan in agency policies.
7.2	The agency provides to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.	Agencies prominently display notification informing patients of their right to receive language assistance services at no cost to them

		Client intakes include information about the client's preferred language.
7.3	<p>The agency offers and provides language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.</p> <p><i>Language services include, as a first preference, the availability of bilingual staff who can communicate directly with patients/consumers in their preferred language. When such staff members are not available, face-to-face interpretation provided by trained staff, or contract or volunteer interpreters, is the next preference. Telephone interpreter services should be used as a supplemental system when an interpreter is needed instantly, or when services are needed in an infrequently encountered language.</i></p>	<p>All requests for interpretation services are documented in client charts, including language requested, date of request, nature of the service for which the language assistance is requested and the outcome of the request.</p> <p>If agencies are unable to provide and/or locate interpretation services for patients/consumers as requested, agencies document in client charts the means undertaken to refer patients/consumers to other agencies/providers who may be able to offer the service in the language preferred by the client.</p> <p>Agencies document active attempts to recruit staff and volunteers who are bilingual in English and commonly encountered languages of the service population through job postings and outreach efforts.</p>
7.4	<p>The agency ensures the competence of individuals providing language assistance, recognizing that the use of untrained individuals as interpreters should be avoided.</p> <p><i>Under no circumstances shall minor children be used as interpreters, nor shall they be allowed to interpret for their parents when they are the patients/consumers.</i></p>	<p>Documentation that bilingual staff passed a written test, were interviewed in each language, or were otherwise evaluated to be competent to provide bilingual services.</p> <p>Documentation that interpretation was provided by certified interpreters/certified medical interpreters (for clinical visits)</p> <p>If a patient/consumer declines bilingual staff and/or outside interpretation, and instead chooses to use adult family members or friends to provide language assistance services, this declination is documented in the patient/consumers' chart and the consumer and the family/friend signed a release of information with the program staff.</p>

7.5	The agency makes available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.	Agencies post signage in their waiting rooms and/or at the reception areas in English and other languages commonly spoken by their service population to identify or label the location of specific services and amenities.  Agencies make available patient-related materials (applications, consent forms, rights and responsibilities, and other written materials routinely provided to clients) in both English and other languages commonly spoken by their service population or as requested by the client.
7.6	The agency will create a culturally inclusive environment. <ul style="list-style-type: none"> <li>Lobby / reception area (décor, posters, images, literature, brochures, etc.) welcoming to and reflective of population(s) served.</li> </ul>	Physical observation and client feedback.
7.7	The agency will educate and train governance and leadership in culturally and linguistically appropriate policies and practices on an ongoing basis.	Review of appropriate meeting minutes during site visit.

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