HIV Services Program

Outreach Services Service Standard

November 2025

Health Resources and Services Administration (HRSA) service definition:

The outreach services (OS) 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 people living with HIV P(LWH) who know their status into HRSA Ryan White HIV/AIDS Program (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.

HIV Services Program service standards:

Key service components and activities are noted in the service standards below.

Standard	Documentation
Personnel Qualifications	
1. Persons delivering outreach services as a lost-to-care disease intervention specialists (DIS) must be trained as a DIS by completing the Passport to Partner Service or equivalent training. 2. People who deliver outreach services in a non-DIS capacity must be trained according to the personnel policy or procedures set by sub-recipient, which must minimally require: a. Individuals possess a comprehensive knowledge of or professional experience in community health, direct patient health care, public health, or social work	1. Documentation of applicable experience and qualifications are in personnel files and must be made available for review by the Indiana Department of Health (IDOH) upon request.
Eligibility Criteria	
1. At first encounter, presumptive Ryan White eligibility is determined. a. Eligibility is determined within 30 days of first encounter. 2. For Lost-to-Care Program DIS Program: a. DIS will determine eligibility through RWISE at first encounter according to Lost-to-Care DIS Program Policies. i. When eligibility cannot be determined at first encounter, DIS will refer the client to a non-medical case management (NMCM) care site for services and eligibility determination.	1. Non-medical case managers/appropriate agency staff must maintain up to date eligibility records for clients according to agency protocol and in any data system required by IDOH. 2. Documentation must be made available for review by IDOH upon request.

Assessment	
1. Service provider will assess consumers for the following service needs: a. Partner services (applies to DIS only) b. Medical needs c. Disease comprehension and prevention d. Medical history e. Medical insurance status f. Mental health and psychosocial needs	1. Documentation of assessment in the client record.
Service Delivery/Treatment	
1. Service provider will facilitate referrals for the client to access services that were identified as needs in the assessment process.	1. Documentation of referrals in the client record. 2. Services units provided must be recorded in CAREWare service tracking system no later than 20 days after the end of each month in which services were provided. Case notes entry is required, but the deadline for entry is determined by the funded agency.
Discharge	
1. Client discharge will include a verbal plan between service provider and client for the continuation of medically necessary services, except for instances when clients refuse to continue medical services or are lost-to-care.	1. Documentation of verbal plan creation with client in: a. The absence of discharge plan, documentation is acceptable only when clients refuse to continue medical services or are lost-to-care

Subservices:

- OS – Outreach

Service unit definition:

- Unit = One contact