Commonwealth of Massachusetts

Ryan White Part B Service Standards

***Massachusetts Department of Public Health***

***Bureau of Infectious Disease and Laboratory Sciences***

***Office of HIV/AIDS***

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# Overview and Purpose

Standards of Service are the requirements that agencies contracted by the Massachusetts Department of Public Health **(DPH)**, Bureau of Infectious Disease and Laboratory Sciences (**BIDLS**) are expected to fulfill while providing HIV services. Agencies must develop protocols and procedures meeting these standards at a minimum, with the goal of serving residents of the Commonwealth in a consistent, timely, and informed manner. The Standards of Service are effective as of **June1, 2024.**

Universal standards apply to all funded services and include the following:

* Cultural and linguistic competence
* Intake and eligibility screening
* Service planning
* Service termination
* Client confidentiality
* Client rights, responsibilities, and grievances
* Staff and client safety
* Staff proficiency
* Data quality assurance

Service-specific standards address the following services:

* HIV medical case management
* HIV care access
* Active Retention in Care for Health (ARCH) for HIV+ individuals
* Medical Transportation
* Housing services
* Medical nutrition therapy
* HIV legal services
* HIV oral health services
* Outreach services
* HIV/AIDS Drug Assistance Program

The content for each standard includes a basic definition, goal, minimum required activities, and documentation necessary to demonstrate compliance with the standard.

# Universal Standards

## Culturally and Linguistically Competent Services

### Definition

In March 2024, DPH released the Strategic Plan to Advance Racial Equity. This new roadmap “publicly, formally, and emphatically declares that racism is an urgent public health threat that directly impacts residents across the Commonwealth of Massachusetts”. It affirms the commitment to centering health equity as the foundation of its mission to advance public health across the Commonwealth. DPH’s health equity framework leads with a racial-equity-centered intersectional approach to partnering with priority populations that experience the most deeply entrenched inequities in public health.

The following vision and mission statement guide the work of DPH in advancing public health across the Commonwealth of Massachusetts.

**DPH Vision:** The Department of Public Health envisions an equitable and just public health system that supports optimal well-being for all people in Massachusetts, centering those with systemically and culturally oppressed identities and circumstances.

**DPH Mission:** The mission of the Department of Public Health is to promote and protect health and wellness and prevent injury and illness for all people, prioritizing racial equity in health by improving equitable access to quality public health and healthcare services and partnering with communities most impacted by health inequities and structural racism.

DPH promotes the National Culturally and Linguistically Appropriate Services (**CLAS**) Standards through its funded programs to advance health equity. Culturally competent service providers acknowledge and respect cultural differences; recognize and work through the systemic and structural barriers that impact a client’s ability to engage and adhere to care; hire, train, and advance people of the communities they serve; and build a workplace culture that confronts racism, xenophobia, transphobia, homophobia, ableism, and stigmas surrounding infectious disease, substance use, and mental health. Providers rely on individualized assessments and stated client preferences rather than assumptions based on perceived or actual membership in any group or class. Linguistically competent services allow providers to communicate effectively with their clients, including clients whose preferred language is not the same as their own, who communicate through sign language, who have limited reading or writing skills, and who live with disabilities that impact communication. Cultural and linguistic competence is a continuous process of learning, growth, experience, education, and training.

Clients receive effective, 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.

### Standards

1. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
2. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
3. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
4. 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.
5. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
6. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
7. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the population in the service area.
8. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.
9. Conduct ongoing assessment of the organization’s CLAS-related activities and integrate CLAS-related metrics into measurement and continuous quality improvement activities.
10. Collect and maintain accurate and reliable demographic data to monitor and
 evaluate the impact of CLAS on health equity and outcomes to inform service delivery.
11. Conduct regular assessments of community health assets and needs and use the
 results to plan and implement services that respond to the cultural and linguistic
 diversity of populations in the service area.
12. Partner with the community to design, implement, and evaluate policies, practices,
 and services to ensure cultural and linguistic appropriateness.
13. Maintain conflict and grievance resolution processes that are culturally and
 linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
14. Communicate the organization’s progress in implementing and sustaining CLAS to all
 stakeholders, constituents, and the general public.

### Documentation

* Completed and dated CLAS Self-Assessment tool on file, and updated on an annual basis

## Intake and Eligibility Screening

### Definition

Intake is the series of steps agencies take to enroll individuals into services. During this process, staff assess clients’ immediate needs, explain available services, assess eligibility criteria (including positive HIV status, income at or below 500% Federal Poverty Level, or FPL, and Massachusetts residence), and request permission to release client information, as necessary.

**Goal**

Clients access the services they need comfortably and efficiently.

### Standards

1. Complete intake process within 30 days of client expressing interest in agency services.
2. Determine immediate service needs.
3. Provide information about available services and eligibility criteria.
4. Conduct eligibility screening.
5. Collect basic client contact information, preferred method of communication, preferred pronouns, and other information necessary to initiate client record in CAREWare.
6. Secure permission to release information if there is an immediate need to release information.
7. Describe the agency’s client confidentiality policy and provide the client with a copy.
8. Describe the agency’s client rights, responsibilities, and grievances policy, and provide the client with a copy.

### Documentation

Each client file includes the following:

* + Documentation of process to collect basic client information, preferred method of communication, preferred language of communication, demographics, insurance status, HIV care status, and other information necessary to initiate client record in CAREWare, with the date of initiation and date of completion of the process documented
	+ Documentation of eligibility:
		- Documentation of HIV diagnosis, collected once at intake and comprised of a signed and dated letter from a medical provider or HIV laboratory results.
		- Documentation of Massachusetts residency, verified and documented at least once annually – and additionally when a client’s address changes – with one or more of the following:
			* a valid Massachusetts license/Mass ID with Massachusetts address, current lease, utility bill, Social Security benefit letter, bank statements, Form 1040 from U.S. Individual Income Tax Return, MassHealth/Massachusetts Health Connector documents, Massachusetts Department of Transitional Assistance (MDTA) documentation, or case manager’s verification letter (e.g., for unhoused clients).
	+ Documentation of income, verified and documented at least once annually – and additionally when a client’s income changes – with one or more of the following: pay stubs, Form 1040 from U.S. Individual Income Tax Return with schedules, Social Security benefit letter, Form 1099, bank statement, pension documentation, unemployment letter, Massachusetts Department of Transitional Assistance (MDTA) statement for TAFDC or EAEDC, self-attestation co-signed and dated by case manager, case management letter, personal check accompanied by case manager letter.
* Documentation of insurance status.
* Documentation of status of engagement in HIV medical care.
* Signed, dated client release of information forms.

## Service Assessment and Planning

### Definition

Service assessment and planning allows providers to identify a client’s individual service needs and to communicate a timeframe for service delivery. This may include linking clients to external providers.

**Goal**

Clients receive services that meet their needs.

### Standards

1. Complete an initial service assessment within 30 days of the completion of intake.
2. Complete an initial service plan within 60 days of the completion of intake.
3. Complete updated services assessments and plans at schedules particular to specific services as necessary, e.g., Medical Case Management, and/or as client needs change.

### Documentation

Each client file includes the following:

* Documentation of service-specific assessments, including dates when the assessments were completed
* Description of services to be provided, and corresponding objectives for the intended services, along with the associated timeframe for service delivery
* Signed, dated client release of information forms

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## Service Termination

### Definition

Service termination is the official discontinuation of services. Reasons for termination include but are not limited to client choice, relocation, a change in service needs making services no longer necessary or appropriate, unresolved violation of agency policy, death, or extended loss to follow up.

### Goal

Clients are terminated from services when those services are no longer needed, desired, or appropriate to client level of need and, as applicable, clients may be transitioned to services provided by other organizations.

### Standards

1. Establish a Policy and Procedure that articulates each step of the process for clients who are terminated from services for any reason.
2. Ensure that a summary of the facts associated with a client’s case closure is in the client’s file within 30 days of termination.

### Documentation

* Each agency maintains a dated Case Closure Policy and Procedure that articulates each step of the process for clients who are terminated from services for any reason.
* Each client file for those individuals with closed cases includes a summary of the termination process, inclusive of reasons for termination and activities documenting the transition to other services, if applicable.

## Client Confidentiality

### Definition

Confidential client information regarding HIV, HCV, STI, and TB status, behavioral risk factors, and use of services is protected in compliance with state and federal law.

**Goal**

Clients are confident their information is secure and handled appropriately.

### Standards

1. Collect, store, and share data usage policies and protocols that ensure data security and client confidentiality. Protocols follow the Confidentiality Agreement that the agency signed as part of its contract with DPH.
2. Configure physical spaces and establish protocols that ensure services provided are private, whether in in-office, mobile, or virtual settings.
3. Utilize a Release of Information Form describing under what circumstances client information can be released (name of agency/individual with whom information will be shared, information to be shared, duration of the release consent, and client signature). Clients must be informed that permission for release of information can be rescinded at any time either verbally or in writing. Releases must be dated and are considered no longer binding after one year. For agencies and information covered by the Health Insurance Portability and Accountability Act (**HIPAA**), the release of information form must be a HIPAA-compliant disclosure authorization.

### Documentation

* Agency has a Confidentiality Policy on file.
* Agency has a Release of Information form that describes under what circumstances client information can be released (name of agency/individual with whom information will be shared, information to be shared, duration of the release consent, and client signature), in addition to a statement indicating that permission for release of information can be rescinded at any time either verbally or in writing.
* Each client file has signed, complete, and up-to-date releases of information for services necessitating releases of information.

## Client Rights, Responsibilities, and Grievances

### Definition

Client rights are the protections, behaviors, services, and processes to which a client is entitled as a participant in services. Client responsibilities are obligations to which a client agrees to receive services. Client grievances are expressions of dissatisfaction with service provision that is experienced by clients as program participants.

### Goal

Clients understand their rights and responsibilities and the mechanism for submitting, reviewing, and responding to grievances.

### Standards

1. Provide clients with a Client Rights and Responsibilities document that includes, but is not limited to, the following:
	1. Commitment to ensure that services are accessible for all eligible clients.
	2. Acknowledgement of right to services that are delivered in a respectful manner.
	3. Acknowledgement of right to consent to, or refuse, any service.
	4. Description of client confidentiality policy and procedures.
	5. Description of termination and discharge policy and procedures.
	6. Description of program rules and expectations of participation.
2. Provide clients with a Client Grievance Policy that identifies the steps to follow to file a grievance and how the grievance will be handled. The policy should be offered in understandable language for the client and should outline steps that can be taken beyond the agency’s internal process, should the client require such steps be taken. The final step of the grievance policy will include information on how the client may appeal the decision if the client’s grievance is not settled to the client’s satisfaction within the provider agency.

**Documentation:**

* Agency has a Client Rights and Responsibilities document on file with the most recent date of revision.
* Agency has a Grievance Policy on file with the most recent date of revision.
* Each client file includes a Client Rights and Responsibilities document that is signed and dated by the client.
* Each client filed includes a signed and dated Grievance Policy that is signed and dated by the client.

## Staff and Client Safety

### Definition

Staff and client safety is the protection of the health and security of staff and clients while services are being provided on-site and in the field.

### Goal

Agencies minimize the risk of threats to staff and client safety and respond efficiently to threats to safety.

### Standards

1. Establish a Safety Policy and Protocol that articulates agency rules and establishes procedures for reducing risk and for responding to threats to staff and client safety.

### Documentation

* Dated Safety Policy and Protocol document that includes the following, at a minimum: emergency response, crisis intervention, protocols for fieldwork, and protocols for online safety.

## Staff Proficiency

### Definition

Staff proficiency is the skill, preparation, and experience needed to deliver the full range of activities associated with service delivery.

### Goal

Agency staff have the minimum essential knowledge and skills appropriate to their job roles and functions including, but not limited to accurate information about HIV/AIDS, viral hepatitis, sexually transmitted infection, and latent TB infection; harm reduction and risk reduction strategies and tools; agency and program policies and procedures; service standards; medical care and services available to clients in the community; and service documentation requirements.

### Standards

1. Agency has a Staff Orientation and Training Policy that describes processes for orientation and training and mechanisms for assessing staff proficiency in service delivery and documentation.
2. Agency ensures that staff understand the basic facts about HIV/AIDS, viral hepatitis, sexually transmitted infection, and latent TB infection symptoms, modes of transmission, treatment options, and associated prevention, harm reduction and risk reduction strategies and tools.
3. Agency orients staff to agency and program policies and procedures; service standards; medical care and services available to clients in the community; and service documentation requirements.
4. Agency provides a minimum of one hour per month of administrative supervision to all staff; administrative supervision consists of an in-person or virtual meeting with a supervisory professional in a group or one-on-one setting during which job responsibilities are discussed.
5. Agency provides a minimum of one hour per month of clinical supervision to all direct service staff; clinical supervision consists of an in-person or virtual meeting with an appropriately credentialed clinician (e.g., social worker, licensed mental health counselor, psychologist, etc.) during which an employee is provided the opportunity to discuss work-related experiences and the impacts of these experiences on their job performance and emotional well-being. Clinical supervision may be offered in a group setting but must also be made available in one-on-one settings.
6. Provide staff with opportunities to access training and other professional development activities that enhance knowledge and skills relevant to their job roles and functions.

### Documentation

* Staff Orientation and Training Policy is on file with the most recent date of revision.
* Staff enter complete documentation of service delivery in client files, and client files contain service-related notes that demonstrate staff proficiency.
* Client-level data that is submitted to BIDLS adheres to contract requirements.

## Data Quality Assurance

### Definition

Data quality assurance is a consistent and ongoing process to ensure that data collected, reviewed, and submitted is complete and accurate.

### Standards

1. Agency has a Data Quality Assurance Protocol that specifies each step associated with collecting, reviewing, and submitting required data.

### Documentation

* Agency Data Quality Assurance Protocol is on file with the most recent date of revision.

# Service-Specific Standards

## HIV Medical Case Management

### Definition

HIV Medical Case Management (**MCM**) is the provision of a range of client-centered services designed to improve health outcomes related to linkage to HIV medical care, retention in care, and HIV viral suppression.

### Service Description

MCM facilitates client access to medical, behavioral health, infectious disease prevention, and other services and supports client progress towards HIV disease self-management. MCM includes the following service components:

* Medical care coordination
* Benefits advocacy
* Medical adherence support
* Sexual and reproductive health promotion and risk reduction services
* Risk reduction/harm reduction services for substance use disorder
* Latent TB infection risk assessment, evaluation, and treatment services

MCM providers assess client needs by completing the OHA Acuity Assessment Tool in its entirety; MCM providers plan client services by completing an Individual Service Plan (**ISP**). OHA has an ISP template that providers may utilize; at minimum, the ISP must be client-driven and include SMART[[1]](#footnote-2) goals.

In addition to baseline eligibility criteria that include verification of HIV+ status, residency in Massachusetts, and income at or below 500% of the Federal Poverty Level (**FPL**), additional requirements to qualify for MCM include a documented overall acuity score of nine (9) or more, and scores higher than one (1) in any area of function.

### Goal

Clients maintain engagement and retention in care (medical, behavioral health, and psychosocial services) to optimize positive health outcomes (including but not limited to viral suppression) and to reduce potential for HIV transmission.

### Standards

1. Clients are screened for eligibility at intake and once annually thereafter.
2. Initial acuity assessments are completed within 30 days of intake.
3. Acuity reassessments are completed every six months, at minimum.
4. Individual Service Plans (**ISPs**) are completed within 60 days of intake.
5. ISPs are updated within 30 days after each reassessment (every six months, at a minimum).
6. Clients are provided with and/or linked to services that are consistent with action steps identified in their ISPs.
7. Client engagement in care is assessed via routine monitoring of HIV medical visit attendance and HIV laboratory data.

1. Clients receive accurate information about HIV, viral hepatitis, STIs, and TB infection, symptoms, modes of transmission, and basic risk reduction strategies.
2. Clients are offered viral hepatitis, chlamydia, gonorrhea, syphilis, and TB testing and partner services at least once every year.
3. Clients whose acuity reassessment indicate overall acuity scores of eight (8) or less and scores no higher than one (1) in any area of function are transitioned to Care Access or self-management within 60 days of completion of the reassessment.
4. Supervisory review of client records is completed once annually

### Documentation

* Client records include the following documentation of eligibility:
	+ Verification of HIV status; collected once at intake and stored in client file.
	+ Income verification at intake and once annually thereafter
	+ Verification of Massachusetts residency at intake and once annually thereafter
* Client records include the following documentation of service provision:
	+ Complete, dated, initial acuity assessment and acuity tool
	+ Complete, dated, acuity reassessment and acuity tool
	+ Complete, dated, initial Individual Service Plan (ISP)
	+ Complete, dated, updated ISPs
	+ Evidence of implementation of action steps identified in ISPs, inclusive of direct service provision and confirmed referrals.
	+ Contact information for HIV medical care provider, dates of HIV medical appointments, and dates and results of HIV laboratory tests.
	+ Accurate information about HIV, viral hepatitis, STIs, and TB infection, symptoms, modes of transmission, and/or basic risk reduction strategies has been provided as documented by progress notes and referrals
	+ Documentation of HCV, chlamydia, gonorrhea, syphilis, and TB test results and partner services referral or, at a minimum, documentation of offer
	+ Documentation of supervisory review at least once annually (e.g., as evidenced by supervisor signature/initials on a log maintained in the client file)
* CAREWare data reflects service provision that is compliant with standards, and consistent with information documented in client records.

## Care Access

### Definition

HIV Care Access is a care coordination service for clients with low acuity who benefit from a connection to case management for support with intermittent needs that impact retention in HIV medical care and adherence to HIV medication.

### Service Description

Care Access services involve the same types of services as MCM but on a less frequent basis, and with less intensive staff involvement. Care Access is not available to clients newly enrolled at an agency and/or new to medical case management. In addition to the eligibility criteria that include HIV+ status, Massachusetts state residency, and income at or below 500% of the Federal Poverty Level (**FPL)**, clients must meet the following criteria:

* Receive an overall score of eight (8) or less on the OHA acuity tool; and
* Do not receive a score higher than one (1) in any area of function; and
* Have no expressed needs for services beyond minimal engagements with the MCM.

Due to lower levels of both client need and frequency of service encounters than those associated with MCM, caseloads per staff FTE are expected to be significantly higher.

### Goal

Clients maximize positive health outcomes (including but not limited to viral suppression) to optimize health and reduce the potential for HIV transmission.

### Standards

1. Clients are screened for eligibility
2. Acuity reassessments are completed every six months, at minimum.
3. Clients participate in a minimum of two encounters in a 12-month period.
4. Client engagement in care is assessed via routine monitoring of HIV medical visit attendance and HIV laboratory data.
5. Clients receive accurate information about HIV, viral hepatitis, STIs, and TB infection, symptoms, modes of transmission, and basic risk reduction strategies.
6. Clients are offered HCV, chlamydia, gonorrhea, syphilis, and TB testing and partner services at least once every year.
7. Clients whose acuity reassessment indicate overall acuity scores of nine (9) or more or scores higher than one (1) in any area of function are transitioned to MCM or ARCH within 60 days of completion of the reassessment.
8. Documentation of supervisory review at least once annually (e.g., as evidenced by supervisor signature/initials on a log maintained in the client file)

### Documentation

* Client records include the following documentation of eligibility:
	+ Verification of HIV status (collected at intake and stored in the client file)
	+ Income verification collected at intake and once annually thereafter
	+ Verification of Massachusetts residency collected at intake and once annually thereafter
* Client records include the following documentation of service provision:
	+ Complete, dated, initial acuity assessment and acuity tool
	+ Evidence of at least 2 client encounters within a 12-month period
	+ Contact information for HIV medical care provider, dates of HIV medical appointments, and/or dates and results of HIV laboratory tests
	+ Documentation that accurate information about HIV, viral hepatitis, STIs, and TB infection, symptoms, modes of transmission, and/or basic risk reduction strategies has been provided. Documentation of the discussion found in progress notes.
	+ Documentation of HCV, chlamydia, gonorrhea, syphilis, and TB test results, partner services referral or, at a minimum, documentation of the offer in progress notes.
	+ Documentation of supervisory review at least once annually (e.g., as evidenced by supervisor signature/initials on a log maintained in the client file)
* CAREWare data reflects service provision that is compliant with standards.

## Active Retention in Care for Health (ARCH)

### Definition

ARCH is a short-term, intensive intervention for HIV+ individuals with high levels of acuity that promotes successful linkage to and retention in HIV medical care following diagnosis, re-entry into care following an interruption in care engagement, and treatment adherence following a period of viral non-suppression.

### Service Description

ARCH facilitates client access to medical, behavioral health, infectious disease prevention, and other services and supports client progress towards lower levels of acuity and service need. ARCH includes following service components:

* Medical care coordination
* Benefits advocacy
* Medication adherence support
* Social services and housing coordination
* Sexual and reproductive health promotion and risk reduction services
* Substance use health promotion and risk/harm reduction services
* Latent TB infection risk assessment and risk/harm reduction services

ARCH providers assess client needs using all components of the OHA acuity tool, and plan services using all components of the OHA Individual Service Plan.

The ARCH model integrates regular (e.g., monthly) communication with DPH epidemiologists to exchange disease surveillance and clinical data to identify patients who are out-of-care and to facilitate re-engagement. ARCH providers engage in routine review of data received by DPH and of internal Electronic Health Record (**EHR**) and other data, communication of relevant data with the care team, and use of data for client follow-up.

In addition to positive HIV status, Massachusetts residence, and income at or below 500% of the Federal Poverty Level (**FPL**), eligibility includes any one of the following:

* Newly diagnosed with HIV within the last 12 months
* Diagnosed during the acute stage of HIV infection
* Disengaged from medical care as indicated by a gap of six months or more in health care engagement
* Frequent missed appointments
* Sustained detectable HIV viral load indicative of lapses in care, suboptimal adherence to treatment, and/or need for reassessment of treatment regimen(s)
* Co-infection with HBV, HCV, STIs, and or TB, or presence of other significant medical need that necessitates immediate medical attention and service support

Due to the high intensity of need presented by clients, the ARCH model incorporates frequent engagement with clients, high volumes of care/service coordination on clients’ behalf, and service delivery to clients in both agency and field-based (community, home) settings. To accommodate the nature of this work, ARCH caseloads include approximately 20 clients per staff team. Services are provided by a team that includes – at a minimum – one member with clinical expertise (e.g., nurse, social worker, mental health clinician, etc.) and one health navigator (e.g., community health worker, HIV+ peer, etc.). The team may include a staff member who completes discrete, routine Care Access or MCM functions, however the team of clinical and health navigator staff implement most service encounters. ARCH staff have access to medical records (including the Electronic Health Record), have a direct connection to client medical care providers, and function as members of an interdisciplinary care team. Services are provided for a minimum of 3 months and a maximum of 12 months.

### Goal

Clients maximize positive health outcomes (including but not limited to viral suppression) to optimize health and reduce the potential for HIV transmission.

### Standards

1. Clients are screened for eligibility at intake and annually thereafter.
2. Initial acuity assessment is completed at intake if acuity has not been assessed within the past 30 days.
3. Clients are assessed for acuity using the OHA Acuity Tool at intake and at discharge.
4. Individual Service Plans (**ISPs**) are completed within 60 days of intake and address needs identified in the acuity reassessment.
5. Clients are provided with and/or linked to services that are consistent with action steps identified in their ISPs.
6. Client engagement in care is assessed by means of routine communication with DPH to share disease surveillance and clinical data, and by means of monitoring of HIV medical visit attendance and data in the client’s medical record.
7. Clients receive accurate information about HIV, viral hepatitis, STIs, and TB infection, symptoms, modes of transmission, and basic risk reduction strategies, as documented in progress notes and evidenced by client referrals.
8. Clients are offered HCV, chlamydia, gonorrhea, syphilis, and TB testing and partner services at least once every year
9. Clients are transitioned from ARCH into Care Access, MCM, or self management within 12 months of service initiation.
10. Documentation of supervisory review at least once annually (e.g., as evidenced by supervisor signature/initials on a log maintained in the client file)

### Documentation

* Client records include the following documentation of eligibility:
	+ Documentation of HIV status
	+ Income verification at intake and once annually thereafter
	+ Verification of Massachusetts residency at intake and once annually thereafter
* Client records include the following documentation of service provision:
	+ Complete, dated acuity assessment using the OHA Acuity Tool at intake
	+ Complete, dated acuity reassessment using the OHA Acuity Tool at discharge
	+ Complete, dated initial Individual Service Plan (ISP) once at intake and then every six months, if the client is engaged in ARCH services for longer than six months
	+ Evidence of implementation of action steps identified in ISPs, inclusive of direct service provision and confirmed referrals
	+ Dates of HIV medical appointments and dates and results of HIV laboratory tests
	+ Evidence of monthly – at a minimum – monitoring of, and follow-up related to, retention in HIV care and adherence to HIV treatment
	+ Accurate information about HIV, viral hepatitis, STIs, and TB infection, symptoms, modes of transmission, and/or basic risk reduction strategies has been provided as documented by progress notes and referrals
	+ Documentation of HCV, chlamydia, gonorrhea, syphilis, and TB test results and partner services referral or, at a minimum, documentation of offer
	+ Documentation of supervisory review at least once annually (e.g., as evidenced by supervisor signature/initials on a log maintained in the client file)
* CAREWare data reflects service provision that is compliant with standards
* DPH data systems reflects monthly exchange of disease surveillance and clinical data that is compliant with standards

## Medical Transportation

### Definition

Medical transportation is the provision of nonemergency transportation services that enable an eligible client to access or stay retained in medical care and support services.

### Service description

Medical transportation may be provided through contracts with transportation companies, round trip bus/subway passes, non-cash mileage reimbursement that does not exceed federal per-mile reimbursement rates[[2]](#footnote-3), and lease or organizational vehicles for client transportation programs. Unallowable costs include direct cash payments or cash reimbursements to clients, and costs associated with a privately-owned vehicle – inclusive of volunteer transportation.

### Goal

HIV+ clients are engaged and retained in health care services, maintain suppressed HIV viral loads to maximize positive health outcomes, and reduce potential for transmission of HIV. Clients diagnosed with HCV, STIs, and/or LTBI successfully complete treatment.

### Standards

1. Clients are screened for eligibility at intake and once annually thereafter.
2. Client's need for medical transportation is assessed at least every six months or when residential, health status, income, or other health or social circumstances may change. This can be done using the OHA Acuity Tool.
3. Supervisory review of client records is completed once annually.
4. Resources are used only after other transportation resources (e.g., MassHealth PT1) are exhausted.
5. Services enable an eligible individual to access HIV-related health and support services.
6. Services may be provided through contracts with transportation companies, purchase of round-trip bus/subway passes, non-cash mileage reimbursement that does not exceed federal per-mile reimbursement rates, and/or leased or purchased organizational vehicles approved for client transportation programs.

### Documentation

* The agency maintains a written implementation protocol that includes, at a minimum, approved transportation methods, and a process for assessing transportation needs.
* Client records include the following documentation of eligibility for HIV+ clients:
	+ Documentation of HIV status
	+ Income verification at intake and once annually thereafter
	+ Verification of Massachusetts residency at intake and once annually thereafter
* Client records include the following documentation of service provision:
	+ Dates of medical appointment(s), type of service received, and the purpose of the medical or support service for which transportation assistance is necessary.
	+ Transportation method utilized, trip origin and destination, cost, and purpose of each trip
	+ Name of staff authorizing service
* CAREWare data reflects service provision that is compliant with standards.

## Housing

## Housing Access and Stabilization: Housing Search and Advocacy

### Definition

Housing search and advocacy services help clients obtain and remain in housing that is stable, affordable, and suitable to support their health and quality of life.

### Service Description

Housing search and advocacy services include assessment, search, placement, stabilization, and eviction prevention support. Programs assess client needs, review housing options, assist completion and submission of housing applications, navigate barriers related to CORI[[3]](#footnote-4) and other challenges, and connect clients to legal services when necessary.

### Goal

HIV+ individuals stay retained in care and maintain adherence to HIV medication regimens. Clients at high risk for HIV remain HIVnegative. Clients prescribed HCV treatment accomplish HCV cure and engage in risk reduction behaviors to prevent reinfection. Clients prescribed treatment for TB infection successfully complete the prescribed course of treatment to prevent progression to TB disease.

### Standards

All clients:

1. Clients are assessed for service needs within 30 days of intake
2. Clients have a housing-related service plan completed within 60 days of intake

For clients living with HIV:

1. Clients are screened for HIV-specific eligibility criteria at intake and annually thereafter

### Documentation

All Clients:

* Client files include the following documentation:
	+ Service assessment
	+ Housing-related service plan designed to help client obtain and maintain stable, long-term housing
	+ Evidence of implementation of action steps identified in service plan, inclusive of direct service provision and confirmed referrals
	+ Temporary, transitional, and permanent housing placements
	+ Documentation of supervisory review at least once annually (e.g., as evidenced by supervisor signature/initials on a log maintained in the client file)
* CAREWare data reflect service provision that is compliant with standards

For clients living with HIV:

* Documentation of HIV status
* Income verification at intake and once annually thereafter
* Verification of Massachusetts residency at intake and once annually thereafter

## Housing Access and Stabilization: Rental Assistance

### Definition

Rental assistance is a short-term and/or emergency direct payment to property owners/managers or utility companies to help clients prevent homelessness and/or utility shut-off, and to secure or maintain housing necessary to promote positive health outcomes.

### Service Description

Rental assistance includes rental start-up payments (first and last month’s rent and one additional month of rent), homelessness prevention payment (current month’s rent, up to two months of future rent, and back rent subject to conditions described below), and housing utility assistance payments (electricity, gas, oil, local telephone service, water). Programs ensure that clients access other rental assistance resources for which they are eligible prior to accessing this resource.

### Goal

HIV+ individuals stay retained in care and maintain adherence to HIV medication regimens. Clients at high risk for HIV remain HIV negative. Clients prescribed HCV treatment accomplish HCV cure and engage in risk reduction behaviors to prevent reinfection. Clients prescribed treatment for TB infection successfully complete the prescribed course of treatment to prevent progression to TB disease.

### Standards

All clients:

1. Clients are assessed for service need within 30 days of intake.
2. Clients have a housing-related service plan completed within 60 days of intake.
3. Services are limited to the following:
	1. Rental start-up: first and last month’s rent and one additional month
	2. Homelessness prevention: current month’s rent and up to two months of future rent. May also include up to two months of back rent for market-rate housing and up to three months of back rent for subsidized housing if the client has been a tenant for at least three (3) months and has paid at least three (3) months rent over their course of the occupancy.
	3. Utilities assistance: electricity, gas, oil, local telephone service, water
4. Services are short-term, with access negotiated between the vendor and DPH.
5. Payments are made directly to the landlord/property owner and/or utility company (RWHAP Part B funds may not be applied to security deposits).
6. Service data are accurate, complete, and submitted in a timely manner.

For clients living with HIV:

1. Clients are screened for HIV-specific eligibility at intake and once annually thereafter.

### Documentation

All clients:

* Written policies and protocols
* Client records include the following:
	+ Evidence of tenancy/residency
	+ Service assessment/documentation of service need
	+ For each service type: description of service provided, service date, and service expense
	+ Plan to assist client access or sustain long-term housing affordability
	+ Documentation of supervisory review at least once annually (e.g., as evidenced by supervisor's signature/initials on a log maintained in the client file)
* CAREWare data reflects service provision that is compliant with standards

For clients living with HIV:

* Documentation of HIV status
* Income verification
* MA residency

## Medical Nutrition Therapy

### Definition

Medical nutrition therapy is a dietary intervention conducted outside of a primary care visit that helps prevent or treat symptoms associated with HIV, HCV, or TB disease and/or side effects associated with treatment for these infections.

### Service Description

Medical nutrition therapy includes nutrition assessment, food, and nutrition education and/or counseling. Services are pursuant to a medical provider’s recommendation and are based on a nutritional plan developed by a licensed, registered dietician.

### Goal

People living with HIV, and/or people in the process of completing HCV or TB treatment access nutritionally appropriate, prepared food, that help them to maximize health outcomes.

### Standards

All clients:

1. Clients’ nutritional needs are assessed by licensed, registered dieticians at enrollment and at six-month intervals.
2. Nutrition assessments inform client meal plans developed by registered dieticians in consultation with clients.

For clients living with HIV:

1. Clients are screened for eligibility at intake and once annually thereafter.

### Documentation

* For HIV+ clients, client records include the following documentation of eligibility:
	+ Documentation of HIV status
	+ Income verification at intake and once annually thereafter
	+ Verification of Massachusetts residency at intake and once annually thereafter
* Copies of professional licensure of registered dieticians who complete assessments and develop meal plans
* Client records include the following documentation of service provision:
	+ Physicians’ recommendation
	+ Initial nutritional assessment
	+ Nutritional re-assessments dated at six-month intervals
	+ Nutritional plan, signed, and dated by a registered dietician, including quantity, type, frequency, and duration of service delivery
	+ Documentation of supervisory review at least once annually (e.g., as evidenced by supervisor signature/initials on a log maintained in the client file)
* CAREWare data reflects service provision that is compliant with standards

## HIV Legal Services

### Definition

HIV legal services ensure protection of client civil rights and entitlements and optimize access to resources directly connected to successful management of HIV disease and health.

### Service Description

Legal services are provided by attorneys, paralegals, and paraprofessionals under the direct supervision of attorneys or paralegals and involve legal matters that are directly related to clients’ HIV disease. Services include interventions related to eviction prevention, access to eligible benefits, Social Security Disability Determination, immigration, health insurance coverage, discrimination, breach of confidentiality, and preparation of powers of attorney and wills, including preparation of custody options for legal dependents. Legal services exclude criminal defense, divorce, bankruptcy, and class action lawsuits.

### Goal

People living with HIV have equitable access to legal services that promote positive health outcomes, financial security, and/or family stability.

### Standards

All clients:

1. Services are provided by attorneys, paralegals, and/or paraprofessionals under the direct supervision of attorneys or paralegals.
2. Clients’ legal needs are assessed at enrollment and at six-month intervals.
3. Legal services assessments inform legal assistance plans.
4. Services do not involve criminal defense, divorce, bankruptcy, and class action suits.
5. Clients are screened for eligibility at intake and once annually thereafter.

For clients living with HIV:

1. Clients are screened for eligibility at intake and once annually thereafter

### Documentation

* For HIV+ clients, client records include the following documentation of eligibility:
	+ Documentation of HIV status
	+ Income verification at intake and once annually thereafter
	+ Verification of Massachusetts residency at intake and once annually thereafter
* Copies of professional licensure of legal services providers are maintained on file.
* Client records include the following documentation of service provision:
	+ Legal services assessment
	+ Documentation of how professional services are necessitated by the individual’s HIV status.
	+ Documentation of supervisory review at least once annually (e.g., as evidenced by supervisor signature/initials on a log maintained in the client file)
* CAREWare data reflects service provision that is compliant with standards.

## HIV Oral Health Services

### Definition

Oral health services are diagnostic, preventive, and therapeutic services provided by dental health care professionals.

### Service Description

Oral health services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

**Goal:**

HIV+ individuals will have the resources to prevent and manage oral health challenges commonly related to HIV infection, and to detect oral manifestations of HIV disease in a timely manner to prevent disease progression.

### Standards

1. Individuals providing oral health services have required licensure based on State and local laws.
2. Clients are screened for eligibility at intake and once annually thereafter.
3. Clients have dated oral health treatment plans on file that are signed by oral health professional providing the services.
4. Services meet criteria related to allowable oral health procedures, costs, and caps on providing oral health services.

### Documentation

* Client records include the following documentation of eligibility:
	+ Documentation of HIV status
	+ Income verification at intake and once annually thereafter
	+ Verification of Massachusetts residency at intake and once annually thereafter
* Copies of professional licensure and certification of oral health providers
* Client records include the following documentation of service provision:
	+ Signed and dated oral health treatment plans
	+ Services provided
	+ Service expenses
	+ Documentation of supervisory review at least once annually (e.g., as evidenced by supervisor signature/initials on a log maintained in the client file)
* CAREWare data reflects service provision that is compliant with standards

## Outreach Services

### Definition

DPH employs a team of Field Epidemiologists dedicated to respond to all new diagnoses of HIV and provide specialized follow-up on acute HIV infections and HIV+ persons identified as out of care. Field Epidemiologist follow up is deployed in response to all newly identified HIV diagnoses. Field Epidemiologists ensure that confirmed cases and their sexual and/or drug injection partners are promptly linked to care and treatment services, including substance use disorder programs, to reduce the likelihood of continued substance use and potential for onward transmission of infectious disease through sharing of injection equipment.

**Goal:**

All newly diagnosed or out of care HIV+ individuals are promptly linked to medical care, referred to appropriate services, and offered partner services to notify exposed contacts.

### Eligibility

Individuals newly diagnosed with HIV and/or those individuals identified as either out of care or engaged in suboptimal medical care.

### Standards

Field Epidemiologists follow processes outlined in field investigation protocols for investigating HIV cases. The following are field investigation requirements:

1. Individuals newly diagnosed with HIV infection are contacted by a DPH Field Epidemiologist by phone, text, mail, field visits, and/or geosocial networking platforms.
2. Field Epidemiologists coordinate with providers and gather pertinent clinical and locating information to offer tailored interventions to confirmed cases.
3. Upon establishing contact, HIV+ individuals are linked to medical care and treatment services.
4. Partners elicited through contact tracing are provided referrals for testing, treatment and other prevention services including nPEP and PrEP.
5. All information obtained during HIV follow-up is documented in the Massachusetts Virtual Epidemiologic Network (**MAVEN**), automated extracts are performed at routine intervals and uploaded to Enhanced HIV/AIDS Reporting System (**eHARS**).

**Documentation:**

Client files include the following documentation:

□ Year of birth, race/ethnicity, sex at birth, current gender identity, and other
 geographic information.

□ Documentation of HIV laboratory results and associated information

□ Documentation of client contact, including dates, and summary of services provided (e.g., linkage to medical care, partner services)

## HIV Drug Assistance Program

### Definition

The HIV Drug Assistance Program (HDAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA) - approved medications to low-income clients living with HIV who have no coverage or limited health care coverage.

### Service Description

HDAP provides access to treatment for HIV and HIV-related conditions by covering the cost of medications for uninsured eligible individuals and health insurance premiums and prescription copays for eligible insured individuals. According to HRSA requirements, the program must include at least one FDA-approved medication in each drug class of core HIV antiretroviral medicines from the U.S. Department of Health and Human Services’ *Clinical Guidelines for Treatment of HIV*. The program is also required to compare the aggregate cost of paying for health coverage for clients versus paying for the full cost of medications to ensure the purchase of health care coverage is cost effective in the aggregate.

### Goal

Ensure eligible uninsured and underinsured HIV+ residents of Massachusetts have access to treatment for HIV and HIV-related conditions.

### Standards

1. Complete applications for new clients are screened within two weeks of receipt and 6-month recertifications are screened within 30 days of receipt.
2. RWHAP Part B program funding is utilized as the payer of last resort.
3. An “open formulary” is maintained, with a limited list of exclusions, by ensuring coverage of all new FDA approved treatments for HIV and HIV related conditions once pricing negotiations are complete.
4. Health insurance Summary of Benefits & Coverage **(SBCs)** or terms of coverage are reviewed to ensure premium assistance applies only to those healthcare insurance policies that include a formulary of covered medications comparable to the HDAP open formulary.

### Documentation

Client records include the following documentation of eligibility:

* Verification of HIV status at initial application
* Income verification at intake and every six months thereafter (client may submit self-attestation form every other six months)
* Verification of Massachusetts residency at intake and every six months thereafter (client may submit self-attestation form every other six months)
* Verification of payer of last resort at intake and annually thereafter
* Verification of premium amounts for clients receiving premium assistance
1. SMART stands for Specific, Measurable, Attainable, Realistic, and Time-Framed [↑](#footnote-ref-2)
2. [Standard mileage rates | Internal Revenue Service (irs.gov)](https://www.irs.gov/tax-professionals/standard-mileage-rates) [↑](#footnote-ref-3)
3. Criminal Offender Record Information: https://www.mass.gov/massachusetts-criminal-offender-record-information-cori [↑](#footnote-ref-4)