DENVER HIV RESOURCES PLANNING COUNCIL
www.dhrpc.org

Part A
Standards of Care

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Acronyms

ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral Therapy
CAB	Community Advisory Board
CARE Act	Comprehensive AIDS Resources Emergency Act
CBC	Complete Blood Count
CD4	Cluster of differentiation 4
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CM	Case Manager
CRS	Colorado Revised Statutes
DBH	Division of Behavioral Health
DHRPC	Denver HIV Resources Planning Council
DOHR	Denver Office of HIV Resources
DORA	Department of Regulatory Agencies
EFA	Emergency Financial Assistance
EIS	Early Intervention Services
eURN	Electronic Unique Record Number
FPL	Federal Poverty Level
GMO	Grants Management Officer
HAART	Highly Active Antiretroviral Therapy
HAB	HIV/AIDS Bureau
HCHS	Home and Community-based Health Services
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
LTC	Linkage to Care
MCM	Medical Case Management
MDASC	Metro Denver AIDS Services Coalition
MH	Mental Health
OMB	Office of Management and Budget
PHS	Public Health Service
PVD	Peripheral Vascular Disease
QM	Quality Measure
RSR	Ryan White Services Report
RTD	Regional Transportation District
RW	Ryan White
RWHAP	Ryan White HIV/AIDS Program
SA	Substance Abuse
SOC	Standards of Care
STI	Sexually Transmitted Infection
TB	Tuberculosis
TGA	Transitional Grant Area
VA	Veteran’s Administration

Introduction

Purpose
This Standards of Care (SOC) document was prepared by the Denver HIV Resources Planning Council's (DHRPC) Metro Denver AIDS Services Coalition (MDASC) and the Denver Office of HIV Resources (DOHR) as a collaborative effort to guide the delivery of high quality services for people living with HIV and AIDS. This document was established to:

- Define standards of care, unit costs, and quality management indicators for Part A-funded service categories.

- Provide the DOHR with a basis to evaluate services funded through Part A.

SOC are tied to multiple process throughout the Part A system and changes reverberate throughout the entire system.

Definitions:

SOC: The minimum level or standard of care that agencies must follow in the provision of Part A funded services.

Unit Cost of Service: Define how many service units are delivered to a participant for billing and documentation purposes.

Quality Management Indicator: A measure to determine, over time, an organization's performance of a particular element of care.

Review of *the Document*
The MDASC reviews the SOC, unit costs of service, and quality management indicators on an annual basis. In 2014, MDASC identified SOC that needed revision to comply with HRSA service category definitions and changes in State of Colorado behavioral health standards, to resolve service delivery issues, or to meet patient needs resulting from the implementation of the Affordable Care Act. MDASC generated potential changes which were reviewed and voted on by the Leadership Committee. Revisions were developed by service category specific workgroups and approved by MDASC and the Leadership Committee on October 21, 2014. Final approval was obtained by the DHRPC on November 6, 2014. Committees consisted of DOHR staff, service providers and consumers of services.

Common Standards of Care

Documentation and Eligibility Screening

Standard I: Documentation and Eligibility Screening-The following information should be in all participant charts and will be checked during site visits. Agencies should not use participant self-report for any required documentation. [1]

Requirement	Indicator	Data Source
A. Providers will ensure appropriate screening and reassessment of all participants to determine eligibility.	**A. 1.** Verification of the participant's HIV status should be from a medical provider (i.e. lab work results or a letter on letterhead signed by medical staff personnel).	**Participant's file** contains confirmation of HIV status. This must be confirmed at initiation of services.
	A. 2. Participant must qualify as low income, less than or equal to 400 percent of FPL. [1]	**Participant's file** contains paycheck or stub, bank statement, or other adequate proof. If the participant is reporting no income, then the provider must document how the participant is subsisting. This must be confirmed every six months.
	A. 3. Participant must demonstrate insurance status including: • Uninsured or underinsured status. • Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare. • For underinsured, document the participant's ineligibility for service. • Veterans receiving VA health benefits are considered uninsured, thus exempting these veterans from the "payer of last resort" requirement.	**Participant's file** contains proof of insurance, underinsured, or documentation of ineligibility for third party insurance including Medicaid and Medicare. This must be confirmed every six months.

[1] 400 percent is not proscribed by HRSA. This number was chosen to match the current Part B income limit for insurance and ADAP.

Requirement	Indicator	Data Source
	• Participant can demonstrate residence within the Denver TGA.	**Participant's file** contains any of the following documents with address and participant's name: bill, copy of a current lease, or letter from Social Security. In the case of participants who are homeless, the provider needs to document how the participant is subsisting. Document must be current and must contain the participant's name. This must be confirmed every six months.
	A. 4. Document that all staff involved in eligibility determination have participated in a comprehensive training in eligibility determination requirements.	**Personnel file** of all staff involved in eligibility determination demonstrates that he/she has completed a comprehensive training in eligibility determination requirements.
	A. 5. Ensure agency client level data reporting is consistent with funding requirements, and demonstrates that eligible participants are receiving allowable services.	**Participant's file and CAREWare** data demonstrate that participants receive only allowable services.
B. Every participant's legal name will be documented and used in the creation of the eURN in CAREWare.	**B. 1.** Providers are to use the participant's legal name attained from a government issued document in all documentation and in data entry in CAREWare.	**Participant's file** contains copy of a government issued document showing legal name (e.g. driver's license, social security card). This must be confirmed at initiation of services.
C. Every participant file will have documentation of a Signed Grievance Procedures.	**C. 1.** Each participant should sign the provider's grievance procedure.	**Participant's file** contains a copy of the grievance procedure, or other documentation that the participant has received the procedures, is signed by the participant.

Access to Care

Standard II: *Access to care-Participants should be supported in having system-wide access to services and barriers to service should be eliminated.* [3]

Requirement	Indicator	Data Source
A. Providers shall eliminate barriers to service and ensure provision of services in a setting accessible to low-income individuals with HIV.	**A. 1**. Medical care, pharmaceuticals, case management and home health care shall provide a minimum of 40 hours access to services per week including after 5:00 p.m. and weekends as appropriate.	**DOHR Contract** will include the Scope of Service description, and the hours of service will be posted in a prominent place within the agency.

Requirement	Indicator	Data Source
	A. 2. Providers must have a full range of service referrals available. To establish this base of referrals, providers need to network with other AIDS service organizations and prevention programs as well as city, state, and private organizations providing similar or complimentary services in the community.	**Provider's Procedures** demonstrate that the provider effectively networks with other service providers when needed, and has established a full range of service referrals.
	A. 3. Provider will comply with Americans with Disabilities Act (ADA) requirements.	**Provider's files** will document ADA complaints and grievances, with documentation of complaint review and decision reached.
	A. 4. Appropriate accommodations shall be made to meet language or other needs such as illiteracy, visual or hearing impairment.	**Provider's Policies and Procedures** demonstrate how they provided services to those needing special accommodations.
	A. 5. Provider will ensure that the facility is accessible by public transportation or provide for transportation.	**Site visit** inspection of agency facility.
	A. .6. Providers will document efforts to inform low-income individuals of the availability of HIV-related services and how to access them. Provider will maintain file documenting agency activities for the promotion of HIV services to low- income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements.	**Provider's Files** will document agency activities for the promotion of HIV services to low- income individuals.
B. Provider shall implement structured and ongoing efforts to obtain input from participants in the design and delivery of services.	**B. 1.** Provider will maintain file of materials documenting Consumer Advisory Board (CAB) membership, meetings, and minutes.	**Provider's Files** demonstrate CAB membership and meeting minutes.
	B. 2. Provider will maintain visible suggestion box or other participant input mechanism.	**Site visit** inspection of agency facility.
	B. 3. Provider will implement participant satisfaction survey tool, focus groups, and/or public meetings, with analysis and use of results documented annually.	**Provider's Files** demonstrate implementation of satisfaction survey tool, focus groups, and/or public meetings including analysis and use of results.

Requirement	Indicator	Data Source
C. Provider shall allow for the provision of services regardless of an individual's ability to pay for the service.	**C. 1.** Provider will have billing, collection, co-pay, and sliding fee policies that do not act as a barrier to providing services regardless of the participant's ability to pay.	**Provider's Policies and Procedures** document their billing, collection, co-pay and sliding fee policies and that they do not act as a barrier to providing services regardless of the participant's ability to pay.
	C. 2. Provider will maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from participants, with documentation of complaint review and decision reached.	**Provider's files** will document individuals refused services with reasons for refusal specified; include in file any complaints from participants, with documentation of complaint review and decision reached.
D. Providers will ensure provision of services regardless of the current or past health condition of the individual to be served.	**D. 1.** Eligibility Policies and Procedures state that services are provided regardless of pre-existing conditions.	**Provider's Policies and Procedures** will document that services are provided regardless of pre-existing conditions.
	D. 2. Maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from participants, with documentation of complaint review and decision reached.	**Provider's files** will document individuals refused services with reasons for refusal specified; include in file any complaints from participants, with documentation of complaint review and decision reached.

Staff and Volunteer Training and Qualification

Standard III: Staff and Volunteer Training and Qualification - The provider's staff have sufficient education, experience, and skills to competently serve the HIV/AIDS participant population.

Requirement	Indicator	Data Source
A. Staff members and volunteers will have a clear understanding of their job definition and responsibilities.	**A. 1.** Written job descriptions will be on file and signed by the staff or volunteers.	**Personnel/Volunteer file** contains signed job description**.**
B. Staff members will receive structured supervision from qualified supervisors.	**B. 1.** Every employee working directly with participants will receive supervision on both clinical and job performance issues. Providers should complete a standardized performance evaluation for each staff member at least annually.	**Personnel file** contains clinical and/or job performance evaluations for employees who have been with the provider for a year or more**.**

Requirement	Indicator	Data Source
C. Staff and supervisors are qualified to provide the necessary services to participants.	**C. 1.** Staff and Supervisors have the appropriate licensure, education and experience.	**Personnel file** has proof of licensure and/or education appropriate for the specific position**.**
D. Initial orientation and training shall be given to new direct service staff.	**D. 1.** Initial orientation and training should include at least 20 hours of training during the first six months of employment on the following: cultural competency, basic HIV/AIDS information, Ryan White Care Act Part A services and other funding sources, provider's policy and procedures, other government programs, psychological issues, and standards and requirements. Training can be internal and external to the organization.	**Personnel File** demonstrates the type, amount (minutes or hours) and date of orientation and training each staff receives both internally and externally.
E. Staff should receive the following training annually.	**E. 1.** Every staff handling confidential information will receive an annual training concerning HIPAA and confidentiality.	**Personnel file** demonstrate the type and amount of training each staff received both internally and externally.
	E. 2. Every staff receives annual training on Occupational Safety Health Administration regulations and universal precautions.	**Personnel file** demonstrates the type and amount of training each staff received both internally and externally.
	E. 3. Every direct care staff receives 20 hours of job specific professional development training annually.	**Personnel file** demonstrates the type and amount of training each staff received both internally and externally.
F. Each provider has a volunteer training program appropriate to support each volunteer position.	**F. 1.** Initial orientation and training for volunteers working directly with participants must be completed prior to working directly with participants and should include at a minimum the following: cultural competency, basic HIV/AIDS information, basic participant contact skills, HIPAA and confidentiality and provider's policy and procedures.	**Volunteer file** demonstrates the type and amount of orientation the volunteer received.
G. Staff or volunteers working with participants are to be screened in accordance with state and local laws.	**G. 1.** Background checks must be obtained as required by state and local laws.	**Personnel or Volunteer file** contains background checks.

Requirement	Indicator	Data Source
H. Staff or volunteers transporting participants will have a valid Colorado driver's license and proof of insurance.	**H. 1.** Providers will ensure that they have a current valid driver's license and current insurance information for each staff or volunteers who transports participants.	**Personnel or Volunteer File** contains a copy of a valid driver's license for those staff or volunteers who transport participants.

Quality Assurance

Standard IV: Quality Assurance: Providers are responsible for ongoing quality assurance programs to improve funded programs, as well as to offer regular feedback to staff to help promote performance improvement and quality care.

Requirement	Indicator	Data Source
A. Each provider will have written policies on Quality Management, including how data will be used to improve each funded program.	**A. 1.** Each provider will collect participant level data to support CAREWare reporting and other data reports as indicated.	**Reports from the Denver Office of HIV Resources** will be completed accurately and on time.
B. Each provider will have written policies on Quality Management, including how data will be used to improve each funded program.	**B. 1.** Each provider will adopt a quality improvement system (Chronic Care Model or other) to guide work plans and other quality management activities.	**Provider's Reports** documents the use of a quality improvement system.

Confidentiality

Standard V Confidentiality: Providers must have systems in place to protect confidentiality according to best practices and applicable regulations.

Requirement	Indicator	Data Source
A. Providers shall have written policies and procedures addressing participant confidentiality which are compliant with HIPAA.	**A. 1.** Policies and procedures should address HIV/AIDS-related confidentiality and provider procedures, including those limiting access to passwords, electronic files, medical records, faxes, and release of participant information.	**Provider's Policies and Procedures** on confidentiality.
	A. 2. Policies and Procedures are signed and dated by staff during orientation	**Personnel file** has a signed statement by each staff that the staff has read and understood the provider's policies and procedures regarding confidentiality.

Requirement	Indicator	Data Source
	A. 3. Major changes in policies and procedures are presented to all the staff they impact	**Personnel file** indicates that staff have been trained on any major changes to policies and procedures.
B. The Provider's physical set up ensures that services are provided in a private area.	**B. 1.** Areas in which participant contact occurs allow exchange of confidential information in a private manner	**Site visit** inspection of agencies facility.
C. All hard copy materials and records shall be securely maintained by the Provider.	**C. 1.** Records, hard copy materials maintained under double lock (in locked files and in locked areas) secure from public access.	**Site Visit** observation**.**
	C. 2. Each computer is password protected and staff/volunteers must change passwords every 120 days.	**Provider's Policies and Procedures** on confidentiality demonstrates compliance.
D. All participants shall be informed of their rights to confidentiality at intake.	**D. 1.** Documentation signed and dated by participant acknowledging participant was informed of his/her right to confidentiality.	**Participant's file** contains a signed statement that the participant was informed of their rights confidentiality at intake.
E. There should be no release of participant information without a signed, dated participant release.	**E. 1.** There should be a signed, dated Release of Information form specific to HIV/AIDS, TB, STI, substance abuse, mental health and any other confidential information prior to the release or exchange of any information.	**Participant's file** contains signed releases appropriate to the services provided and information needed.

Anti-fraud, Anti-kickback

Standard VI Anti-fraud, Anti-kickback: Providers must have systems in place to avoid fraud, waste, and abuse (mismanagement.) [5]

Requirement	Indicator	Data Source
A. Providers must demonstrate structured and ongoing efforts to avoid fraud, waste and abuse (mismanagement) in any federally funded program.	**A. 1.** Medicare/Medicaid providers must have a Corporate Compliance Plan.	**Provider's Policies and Procedures** document the Corporate Compliance Plan (Medicare/Medicaid providers only).
	A. 2. Providers must have a documented Code of Ethics or Standards of Conduct.	**Provider's Policies and Procedures** document their Code of Ethics or Standards of Conduct.
	A. 3. Non-profit providers must have bylaws and board policies.	**Provider's Policies and Procedures** document board bylaws and policies.

Requirement	Indicator	Data Source
	A. 4. Providers must maintain a file documenting any complaint of violation, or actual violation, of the Code of Ethics or Standards of Conduct by an employee or board member.	**Provider's files** will document any employee or Board Member violation of the Code of Ethics or Standards of Conduct.
B. Providers will document how employees (as individuals or entities) are prohibited from soliciting or receiving remuneration for inducing referrals of items or services covered by Medicare, Medicaid, or any other federally funded program.	**B. 1.** Providers will maintain documentation of: • Service contracts that discourage agency payments for service referral. • Key employee background checks. • Recruitment practices that prohibit exorbitant signing bonuses. • Audit findings on internal controls. • Procurement policies with conflict of interest clauses. • Prohibition of higher charges for Medicare/Medicaid services. • Compliance audits or compliance checks.	**Provider's Policies and Procedures and Files** document the prohibition for receiving remuneration for inducing referrals of items or services covered by Medicare, Medicaid, or any other federally funded program.
C. Providers will document how employees (as individuals or entities) are prohibited, from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.	**C. 1.** Have adequate policies and procedures to discourage soliciting cash or in-kind payments for: • Awarding contracts. • Referring participants. • Purchasing goods or services and/or • Submitting fraudulent billings.	**Provider's Policies and Procedures** discourage soliciting cash or in-kind payments.
	C. 2. Have employee policies that include: • Background checks obtained as required by state and local laws. • Discouraging the hiring of persons with a criminal record related to Medicare or Medicaid fraud. • The hiring of persons being investigated by Medicare or Medicaid. • Large signing bonuses.	**Provider's Policies and Procedures** document hiring process.
D. Providers offering Medicaid/Medicare billable services, will document that they have a Compliance Plan/employee standard of conduct that distinguishes	**D. 1.** Provider will have in place policies and procedures that: • Delineate penalties and disclosure procedures for conduct deemed to be felonies. • Include and describe the safe	**Provider's Policies and Procedures, Compliance Plan, Employee standard of Conduct** will address consequences for non-compliance.

Requirement	Indicator	Data Source
and describes conduct that merits agency penalties from conduct that represents a possible felony.	harbors[2] laws. • Include the reporting of non-compliance with the policy.	
E. Requirement that any Compliance Plan and/or employee standard of conduct describe conduct that merits exemption from anti-kickback regulations (safe-harbors).	**E. 1.** Provider's anti-kickback policy must include the implications, appropriate uses, and application of safe harbors. Information is found in the compliance plan/employee standards of conduct that describes practices that are exempt from prosecution; included are: • Some investments in ambulatory surgical centers; • Agencies in under-served areas that: ▪ Enter into Joint Ventures; ▪ Have practitioner recruitment plans; ▪ Sell physician practices to hospitals; ▪ Give subsidies for obstetrical malpractice insurance; ▪ Have specialty referral arrangements between providers; • Cooperative agreements with 501(e) hospitals.	**Provider's Policies and Procedures** include the implications, appropriate uses, and application of safe harbors.

Limitations and Unallowable Uses of Part A Funding

Standard VII Limitations on, and Unallowable Uses of Part A Funding: Providers must have systems in place that meet the requirements outlined in the HIV/AIDS Bureau Monitoring Standards for Part A and B grantees: Part A. Fiscal Monitoring Standards (Draft July 2010) Sections A and B.[7]

Requirement	Indicator	Data Source
A. Provider will prepare project budget and track expenses with sufficient detail to allow identification of administrative expenses.	**A. 1.** Budget is prepared with sufficient detail to identify administrative expenses.	**Provider's DOHR Contract Budget** provides sufficient detail to identify administrative expenses.
	A. 2. Expenditure reports are prepared with sufficient detail to identify administrative expenses.	**Providers Monthly Invoices** to DOHR provide sufficient detail to identify administrative expenses.

2 Safe Harbor is a legal provision to reduce or eliminate liability as long as good faith is demonstrated.

Requirement	Indicator	Data Source
B. Providers will have appropriate systems in place to assure compliance with Ryan White unallowable cost policy.	**B. 1.** All budgets and expenses will be tracked in sufficient detail to document that they do not include the following unallowable costs: 1. No uses of Part A funds to purchase or improve land, or to purchase, construct, or permanently improve any building or other facility, (other than minor remodeling). 2. No cash payments to service recipients. 3. No use of Part A funds to develop materials designed to promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual. 4. No use of Part A funds for the purchase of vehicles without written Grants Management Officer approval. 5. No use of Part A funds for: • Non-targeted marketing promotions or advertising about HIV services that target the general public (poster campaigns for display on public transit, TV or radio public service announcements, etc.) • Broad-scope awareness activities about HIV services that target the general public 6. No use of Part A funds for outreach activities that have HIV prevention education as their exclusive purpose 7. No use of Part A funds to influence or attempt to influence members of Congress and other Federal personnel. 8. No use of Part A funds for foreign travel.	**Providers DOHR Contract Budget and Monthly Invoices** will be tracked in sufficient detail to document that they do not include the identified unallowable costs.

Income from Fee-for-Services

Standard VIII Income from fee for services: Providers must have systems in place that meet the requirements outlined in the HIV/AIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section C.[3]

Requirement	Indicator	Data Source
A. Providers must document the use of Part A and third party funds to maximize program income from third party sources and ensure that Ryan White is the payer of last resort. Third party funding sources include: • Medicaid • Children's Health Insurance Programs • Medicare (including the Part D prescription drug benefit) and • Private insurance	**A. 1.** Have policies and procedures documenting the requirement that Ryan White be the payer of last resort and how that requirement is met.	**Provider's Policies and Procedures** document the requirement that Ryan White be the payer of last resort and how that requirement is met.
	A. 2. Provide staff training on the requirement that Ryan White be the payer of last resort and how that requirement is met.	**Personnel file** indicates that staff have been trained on Ryan White payer of last resort policies and procedures.
	A. 3. If a participant is eligible for insurance or third party programs they are assisted applying and referred appropriately.	**Participant's file** documents they have been screened for insurance coverage and eligibility for third party programs, and helped to apply for such coverage.
	A. 4. Carry out internal reviews of files and billing system to ensure that Ryan White resources are used only when a third party payer is not available.	**Provider Files and/or Participant's file** will document an internal review process which ensures that Ryan White resources are used only when a third party payer is not available.
	A. 5. For medical providers: establish and maintain medical practice management systems for billing.	**Provider's Medical Practice Management System for billing.**
B. Providers will document billing and collection from third party payers, including Medicare and Medicaid, so that payer of last resort requirements are met.	**B. 1.** Provider will have established billing and collection policies and procedures.	**Provider's Policies and Procedures** will document the billing and collection procedures.
	B. 2. Provider will have a consistently implemented billing and collection process and/or electronic system.	**Provider's Billing and Collection System** will document a consistently implemented billing and collection process.
	B. 3. Provider will have documentation of accounts receivable.	**Provider's Billing and Collection System** will document accounts receivable.

[3] HIV/AIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section C; Part A Program Guidance RW Part A 2604(g) 1-2; RW Part A 2604 h 3; 45 CFR Part 74.14; 45 CFR Part C 92.25; 2 CFR Part C 215.24; 45 CFR 74.24 and 92.25; 2 CFR Part C 215.24

Requirement	Indicator	Data Source
C. Providers who receive funding in Medicaid eligible service categories will document participation in Medicaid and certification to receive Medicaid payments, unless waived by the Secretary of Health and Human Services.	**C. 1.** Document and maintain file information on Medicaid status: • Maintain file of contracts with Medicaid insurance companies; • If no Medicaid certification, document current efforts to obtain such certification; If certification is not feasible, request a waiver where appropriate.	**Provider Files** will document and maintain file information on Medicaid status
D. Provider must document retention of program income derived from Ryan White-funded services and use of such funds in one or more of the following ways: • Funds added to resources committed to the project or program, and used to further eligible project or program objectives; • Funds used to cover program costs. *Note:* Program income funds are not subject to the federal limitations on administration (10%), quality management (5%), or core services (75% minimum). For example, all program income can be spent on administration of the Part A program.	**D. 1.** Provider will document billing and collection of program income, and will report program income documented by charges, collections, and adjustment reports or by the application of a revenue allocation formula.	**Provider's Accounting Systems and DOHR mid-year and year-end reports** will document program income by charges, collections, and adjustment reports or by the application of a revenue allocation formula.

Imposition of Participant Charges

Standard IX Imposition of Participant Charges: Providers must have systems in place that meet the requirements outlined in the HIV/AIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section D.[4]

Requirement	Indicator	Data Source
A. Providers must document policies and procedures that specify charges to participants for services.	**A. 1.** Policies and procedures must document sliding fee discount policy.	**Provider's Policies and Procedures** document a sliding fee discount policy.
	A. 2. Policies and procedures must document current fee schedule.	**Provider's Policies and Procedures** document a current fee schedule.
	A. 3. Participant's files/records must document sliding fee eligibility applications.	**Participant's File** includes sliding fee eligibility applications.
	A. 4. Participant's files/records must document fees charged to and paid by participants.	**Participant's File** documents fees charged to and paid by participants.
	A. 5. Policies and procedures must document process for charging, obtaining, and documenting participant charges through a medical practice information system, manual or electronic.	**Provider's Policies and Procedures** documents process for charging, obtaining, and documenting participant charges through a medical practice information system, manual or electronic.
B. Provider's policies and procedures must document that no charges are imposed on participants with incomes below 100 percent of FPL.	**B. 1.** Provider's policy and procedures document that the sliding fee discount policy and schedule do not allow participants below 100 percent of FPL to be charged for services	**Provider's Policies and Procedures** document that the sliding fee discount policy and schedule do not allow participants below 100 percent of FPL to be charged for services.
	B. 2. Participant files demonstrate that the policy is being consistently followed.	**Participant's Files** demonstrates that the charges are not assessed on participants with incomes below 100 percent of FPL.
C. Provider's policies and procedures must document that charges to participants with incomes greater than 100 percent of poverty are based on a discounted fee schedule and a sliding fee scale. The policies must cap total annual charges for Ryan White services based on percent	**C. 1.** Providers must have in place a fee discount policy that caps total annual charges for Ryan White services based on percent of patient's annual income, as follows: • Five percent for patients with incomes between 100 percent and 200 percent of FPL.	**Provider's Policies and Procedures** document a fee discount policy that caps total annual charges for Ryan White services based on percent of patient's annual income, as follows: • Five percent for patients with incomes between 100 percent

[4] HIV/AIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section D; Part A 2605 2 A-B; RW part A 2605 (e) 1 A-B; RW part A 2605 (e) 1 C-E

Requirement	Indicator	Data Source
of patient's annual income.	• Seven percent for patients with incomes between 200 percent and 300 percent of FPL. • 10 percent for patients with incomes greater than 300 percent of FPL.	and 200 percent of FPL. • Seven percent for patients with incomes between 200 percent and 300 percent of FPL. • 10 percent for patients with incomes greater than 300 percent of FPL.
	C. 2. Identify who has responsibility for annually evaluating participants to establish individual fees and caps.	**Provider's Policies and Procedures** identify who has responsibility for annually evaluating participants to establish individual fees and caps.
	C. 3. Track Part A charges or medical expenses inclusive of enrollment fees, deductible, co-payments, etc.	**Provider's tracking system,** documents all Part A charges or medical expenses inclusive of enrollment fees, deductible, co-payments, etc.
	C. 4. A process for alerting the billing system that the participant has reached the cap and should not be further charged for the remainder of the year.	**Provider's Policies and Procedures** identify a process for alerting the billing system that the participant has reached the cap and should not be further charged for the remainder of the year.
	C. 5. Participant files demonstrate that the policy is being consistently followed.	**Participant's File** demonstrates the policy is being followed and caps total annual charges for Ryan White services based on percent of patient's annual income.

Fiscal Management

Standard X Fiscal Management: Providers must have systems in place that meet the requirements outlined in the HIV/AIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Sections E and F.[5]

Requirement	Indicator	Data Source
A. Provider must comply with all the established standards in the CFR for nonprofit organizations, hospitals, institutions of higher education, and state and local governments.	**A. 1.** Provider must comply with all the established standards in the CFR for nonprofit organizations, hospitals, institutions of higher education, and state and local governments. Included are expectations for: • Payments for services • Program income • Revision of budget and program plans • Non-federal audits • Purpose of property standards, including the purpose of insurance coverage, equipment, supplies, and other expendable property • Purpose of procurement standards, including recipient responsibilities, codes of conduct, competition, procurement procedures, cost and price analysis, and procurement records. • Purpose of reports and records, including monitoring and reporting, program performance, financial reports, and retention and access requirements. • Purpose of termination and enforcement and purpose of closeout procedures.	**Provider's Policies and Procedures and Accounting Systems.** Provider must give grantee representative access to: • Accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports of the provider • All financial policies and procedures, including billing and collection policies and purchasing and procurement policies • Accounts payable systems and policies.
B. Provider will maintain comprehensive budgets and reports.	**B. 1.** Provider will maintain comprehensive budgets and reports with sufficient detail to account for Ryan White funds by	**Provider's Policies and Procedures, Reports, and Accounting System.** The following will be reviewed:

[5] HIV/AIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Sections E and F; 45 CFR 77; 45 CFR 74; 45 CFR 78; 45 CFR 94; 45 CFR 79; 45 CFR 80; 45 CFR 82; 45 CFR 74.34; 2 CFR 215.34; 45 CFR 92.32 9(a)

Requirement	Indicator	Data Source
	service category, administrative costs and 75/25 rule, and to delineate between multiple funding sources and show program income.	• Accounting policies and procedures • Ryan White provider budgets • Accounting system used to record expenditures using the specified allocation methodology • Reports generated from the accounting system to determine if detail and timeliness are sufficient to manage Ryan White program.
C. Providers must develop and maintain a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source.	**C. 1.** Provider must track and report on tangible nonexpendable personal property, including exempt property, purchased directly with Ryan White Part A funds and having: • A useful life of more than one year, and • An acquisition cost of $5,000 or more per unit (Lower limits may be established, consistent with recipient policies).	**Provider Reports** will document a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source.

Cost Principles

Standard XI Cost Principles: Providers must have systems in place that meet the requirements outlined in the HIV/AIDS Bureau Monitoring Standards for Part A and B grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section G.[6]

Requirement	Indicator	Data Source
A. Providers must develop and maintain documentation that services are cost based.	**A. 1.** Ensure that budgets and expenses conform to federal cost principles.	**Provider Policies and Procedures and Budgets** will conform to federal cost principles.
B. Provider must have written procedures for determining the reasonableness of costs, the process for allocations, and policies for allowable costs in accordance with provisions of applicable	**B. 1.** Providers must have in place policies and procedures to determine allowable and reasonable costs.	**Provider's Policy and Procedure** will document procedures to determine allowable and reasonable costs.
	B. 2. Providers must have reasonable methodologies for allocating costs among different funding sources and Ryan White categories.	**Provider's Policy and Procedure** will document methodologies for allocating costs among different funding sources and Ryan White

[6] HIV/AIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section G: 2 CFR 230 or OMB A-122; 2 CFR Appending A 225 D 1 (51912) or OMB-87; 2 CFR 230: OMB 122 Appendix A to Part 230; 2 CFR A II 225 Appendix A C (2); 2 CFR 220 Appendix A (C) 3 or OMB A-21; 2 CFR 230; OMB 122; *Determining the Unit Cost of Services* (HRSA publication);

Requirement	Indicator	Data Source
Federal cost principles and the terms and conditions of the award. Costs considered to be reasonable when they do not exceed what would be incurred by a prudent person under circumstances prevailing at the time the decision was made to incur the costs.		categories. Make available to the grantee very detailed information on the allocation and costing out of expenses for services provided.
C. Requirements to be met in determining the unit cost of a service: • Unit cost not to exceed the actual cost of providing the service. • Unit cost to include only expenses that are allowable under Ryan White requirements. • Calculation of unit cost to use a formula of allowable administrative costs plus allowable program costs divided by number of units to be provided.	**C. 1.** Providers must have in place systems that can provide expenses and participant utilization data in sufficient detail to do the following: • Calculate unit costs based on historical data • Reconcile projected unit costs with actual unit costs on a yearly or quarterly basis.	**Provider's Policy and Procedure** will document systems that can provide expenses and participant utilization data in sufficient detail to calculate unit cost. Providers must have unit cost calculations available for grantee review

Auditing Requirements

Standard XII Auditing Requirements. Providers must have systems in place that meet the requirements outlined in the HIV/AIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section H.[7]

Requirement	Indicator	Data Source
A. Recipients and sub-recipients of Ryan White funds that are institutions of higher education or other non-profit organizations (including hospitals) are subject to audit requirements contained in the Single Audit Act Amendments of 1996 (31 USC 7501–7507) and revised OMB Circular A-133, with A-133 audits required for all grantees and sub-grantees receiving more than $500,000 per year in federal grants.	**A. 1.** Provider will: • Conduct a timely annual audit (an agency audit or an A-133 audit, depending on amount of federal funds). • Request a management letter from the auditor. • Submit the audit and management letter to the grantee. • Prepare and provide auditor with income and expense reports that include payer of last resort verification.	**Provider Documentation** Provider will submit the audit and management letter to the grantee. Any reportable conditions will be addressed in DOHR monitoring recommendations for the Provider through the Recommended Improvement Plan and/or Compliance Plan.
B. Selection of auditor is based on policies and procedures established by the Board of Directors (if nonprofit).	**B. 1.** Provider will have financial policies and procedures that guide selection of an auditor.	**Provider's Policies and Procedures** will document the process for selection of an auditor.

Matching or Cost Sharing Funds

Standard XIII Matching or Cost Sharing Funds: Providers must have systems in place that meet the requirements outlined in the HIV/AIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section I.[8]

Requirement	Indicator	Data Source
A. Providers who provide matching or cost sharing funds must report these funds to DOHR and meet the verification process.	**A. 1.** Providers who provide matching or cost sharing funds meet the following verification process to ensure that non-federal contributions: • Are verifiable in provider records? • Are not used as matching for another federal program? • Are necessary for program objectives and outcomes? • Are allowable?	**Provider's Financial Documentation** will include and make available for review: • Annual comprehensive budget. • Documentation of all in-kind and other contributions to Ryan White program. • Documentation of other contributed services or expenses.

[7] HIV/AIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section H; CFR 74.26; 2 CFR 215/26 A-133 Audit Guidelines; Circular A-133 or Audits for Non-profits

[8] HIV/AIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section I; CFR 45 part 74.2 Definitions 45; CFR Part C 92.24 2; CFR 215.27; CFR 74.23

Requirement	Indicator	Data Source
	• Are not part of another federal award contribution (unless authorized)? • Are part of the approved budget? • Are part of unrecovered indirect cost (if applicable)? • Are apportioned in accordance with appropriate federal cost principles? • Include volunteer services, if used, are an integral and necessary part of the program, with volunteer time allocated value similar to amounts paid for similar work in the provider organization. • Value services of contractors at the employees' regular rate of pay plus reasonable, allowable and allocable fringe benefits. • Assign value to donated supplies that are reasonable and do not exceed the fair market value. • Value donated equipment, buildings, and land differently according to the purpose of the award. • Value donated property in accordance with the usual accounting policies of the recipient (not to exceed fair market value).	

Fiscal Procedures

Standard XIV Fiscal Procedures: Providers must have systems in place that meet the requirements outlined in the HIV/AIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section K.[9]

Requirement	Indicator	Data Source
A. Provider has policies and procedures for handling revenues from the Ryan White grant, including program income.	**A. 1.** Establish policies and procedures for handling Ryan White revenues including program income.	**Provider's Policies and Procedures**, detailed chart of accounts and general ledger will be made available for grantee review upon request.
	A. 2. Prepare a detailed chart of accounts and general ledger that provide for the tracking of Part A revenue.	**Provider will provide a** detailed chart of accounts and general ledger. These will be made available for grantee review upon request.

[9] HIV/AIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section K; A-133 Accounting Standards; 45 CFR 74.61 (b)4 (e)
45 CFR 92.4; Fair Labor Standards A (29 CFR Part 516);A-122 8 a-m; A-122; 2010 Part A Guidance

Requirement	Indicator	Data Source
B. Providers will grant access to payroll records, tax records, and invoices with supporting documentation to show that expenses were actually paid appropriately with Ryan White funds.	**B. 1.** Maintain file documentation of payroll records and accounts payable, and hard-copy expenditures data.	**Provider's files and documentation** will be made available to grantee upon request.
C. Providers will document employee time and effort, with charges for the salaries and wages of hourly employees.	**C. 1.** Maintain payroll records for specified employees. Establish and consistently use allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources. This must: • Be supported by documented payrolls approved by the responsible official. • Reflect the distribution of activity of each employee. • Be supported by records indicating the total number of hours worked each day.	**Provider's Payroll records and allocation methodology** will be made available to grantee upon request.
D. Provider's fiscal staff have responsibility to: • Ensure adequate reporting, reconciliation, and tracking of program expenditures • Coordinate fiscal activities with program activities (For example, the program and fiscal staff's meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures, formula and supplemental unobligated balances, and program income). • Have an organizational and communications chart for the fiscal department	**D. 1.** Providers will maintain: • Program and fiscal staff resumes and job descriptions. • Staffing Plan and grantee budget and budget justification. • Provider's organizational chart.	**Provider's documents and files demonstrate:** • Program and fiscal staff resumes and job descriptions. • Staffing Plan and grantee budget and budget justification. • Provider's organizational chart.

Service Category Standards of Care

AIDS Pharmaceutical Assistance

HRSA Service Category Definition: AIDS pharmaceutical assistance-local (APA) includes local pharmacy assistance programs implemented by Part A or B grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds or Part B base award funds. These organizations may or may not provide other services (e.g., outpatient/ambulatory medical care or case management) to the clients they serve through a Ryan White HIV/AIDS Program contract with their grantee.

Programs are considered APAs if they provide HIV/AIDS medications to clients and meet all of the following criteria:

- Have a client enrollment process;
- Have uniform benefits for all enrolled clients;
- Have a record system for distributed medications; and
- Have a drug distribution system.

Programs are not APAs if they dispense medications in one of the following situations:

- As a result or component of a primary medical visit;
- On an emergency basis (defines as a single occurrence of short duration); or
- By giving vouchers to a client to procure medications.

Local APAs are similar to AIDS Drug Assistance Program's (ADAPs) in that they provide medications for the treatment of HIV disease. However, local APAs are not paid for with Part B funds "earmarked" for ADAP. **Source:** 2012 Annual Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual

Unit of Service: 1 unit = 1 filled prescription

Requirement	Indicator	Data Source
A. Provider must ensure that participant falls under the income requirement.	**A. 1.** Income must be at or below 400 percent of FPL (agencies can implement stricter requirements).	**Participant's file** demonstrates that participant's income level qualifies them for services.
B. Every participant served by an infectious disease pharmacy and/or a drug reimbursement program should expect these programs to provide the following:	**B. 1.** Each prescription is filled correctly.	**Participant's file** does not state any incorrectly filled prescriptions.
	B. 2. Each prescription includes proper indications and dosing.	**Participant's file** does not state any incorrectly filled prescriptions.

Requirement	Indicator	Data Source
	B. 3. Provide education and counseling for HIV-infected patients that includes a review of drug interactions specific to antiretroviral therapy and the HIV disease state.	**Provider's policies and procedures** outline the procedures for reviewing drug interactions.
	B. 4. Counsel each participant on how his/her medication should be taken and any possible side effects with a mandatory five minute initial consultation when dispensing to a patient that is new to antiretroviral therapy.	**Provider's policies and procedures** describe the guidelines for counseling participants on medications and possible side effects. Providers can demonstrate how counseling is given.
	B. 5. New prescriptions and refills are available to participants in a reasonable amount of time.	**Participant's file** shows that there are no unnecessary delays in availability of medications.
	B. 6. Provide prescription label directions and participant medication information in Spanish whenever appropriate.	**Provider's policies and procedures** demonstrate how the provider overcomes language barriers.
	B. 7. Utilize an equitable screening process to establish a participant's eligibility into the program.	**Provider's policies and procedures**
	B. 8. Ensure and maintain participant confidentiality.	**Provider's policies and procedures** are in compliance with HIPAA Regulations.
	B. 9. Offer a one-on-one program information source with a 1-800 number that can be called from anywhere in Colorado.	**Provider's policies and procedures**
C. Provider works to establish relationships with other health professionals and drug companies to ensure best services are given to the participant.	**C. 1.** Supply participant refill history directly to participant's health provider whenever possible or requested.	**Provider's policies and procedures** demonstrates how this is done in compliance with HIPAA Regulations.

Requirement	Indicator	Data Source
	C. 2. Provide pharmaceutical care and assist the medical team with adherence and monitoring of the patient while on antiretroviral therapy.	**Participant's file** demonstrates communication with medical team concerning adherence and monitoring when necessary.
	C. 3. Inform other service providers about the Drug Reimbursement Program so they can refer participants whenever appropriate.	**Provider** can demonstrate how they market their program to other service providers.
	C. 4. Access drug company sponsored patient assistance programs for medications and participants not covered by the drug reimbursement program whenever possible.	**Provider** can demonstrate how they utilize drug company sponsored assistances

AIDS Pharmaceutical Assistance-Local Quality Measures		
Quality Measures	**Indicator**	**Data Source**
Drug Reimbursement Quality Measures	**APA QM 1.** 100 percent of patients will have a drug profile in the pharmacy.	**Participant's file** review.
	APA QM 2. All of prescriptions are filled properly.	**Participant's file** and **Provider Report** on properly filled prescriptions.

Case Management

HRSA Service Category Definition: Case management (CM) services include advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. CM does not involve coordination and follow-up of medical treatments.
Source: 2012 Annual RSR Instruction Manual

Unit of Service: 1 Unit = 30 Minutes or less

Requirement	Indicator	Data Source
A. Scheduling and access to services.	**A. 1.** Participant will begin the eligibility screening and admissions process within one week of the initial contact or be placed on a waiting list and filtered into a caseload as soon as a space becomes available.	**Provider's Policies and Procedures** demonstrate their intake process per the regulations and how waiting lists are managed.
	A. 2. No participant shall be placed on a waiting list for over two weeks from the initial contact without being given a list of other case manager providers.	**Provider's Policies and Procedures** demonstrate how waiting lists and referrals are managed.
B. Every participant shall have an intake interview and needs assessment to collect data important for care.	**B. 1.** Participants shall schedule an intake interview within two weeks of assignment to a case manager.	**Participant's file** will demonstrate an intake interview was conducted within two weeks of assignment.
	B. 2. Initial assessment of a participant's functional and cognitive capacity, health, strengths, abilities, mental health, substance abuse, resources, and needs will be completed within one month of intake interview.	**Participant's file** has initial assessment with all necessary information completed within the one month time period.
C. An Acuity Assessment shall be completed for each participant to determine "Level of CM".	**C. 1.** Every participant should be assessed at intake or within 30 days of initiating CM services, utilizing the TGA CM Acuity Assessment Tool.	**Participant's file** documents compliance.

Requirement	Indicator	Data Source
	C. 2. Every participant should be re-assessed for acuity, as life changes indicate, or at a minimum based on the acuity level: • Intensive Level: Every six months; • Moderate Level: Every six months; • Monitoring Level: Annually.	**Participant's file** documents compliance.
D. High medical acuity referral	**D. 1.** In order to improve medical coordination, any participant who scores a high level of need (three) in any high impact medical category, or if they score a medium level of need (two) on multiple medical categories, should be offered a referral to Medical Case Management (MCM. High impact medical categories from the Acuity Assessment tool include: • Assessment and retention in medical care; • HIV Disease progression; • Medication adherence; • Access: health insurance, medical, medications; • Medical Self-management; • Mental Health; • Substance Abuse; • Housing.	**Participant's file** documents referrals made. If the participant refuses the referral, this should be documented.
E. Annual adherence assessment.	**E. 1.** Every participant should be assessed for adherence to their HIV medication at least annually, utilizing an approved tool. If adherence barriers are identified, CM should make a referral to medical provider, medical social worker, and/or medical case manager for adherence counseling and to align adherence messaging.	**Participant's file** will contain an annual assessment of adherence to their HIV medication.

Requirement	Indicator	Data Source
F. Every participant shall have an Individual Service Plan which guides their care.	**F. 1.** The Individual Service Plan will demonstrate how the participant will get medical care at least once every six months, or as medically indicated.	**Participant's file** contains Individual Service Plan which demonstrates connections to medical care.
	F. 2. Development of an Individual Service Plan is based on the initial and ongoing assessment and meets the participant's needs and preferences. The plan will be completed within two weeks of assessment.	**Participant's file** contains Individual Service Plan that is completed within the required timeframe.
	F. 3. The Individual Service Plan demonstrates the participant is linked to all appropriate services needed.	**Participant's file** documents all referrals.
	F. 4. The Individual Service Plan contains goals which define what the participant needs to achieve in the case management relationship.	**Participant's file** contains Individual Service Plan with appropriate goals.
	F. 5. Individual Service Plans contains objectives for each goal, stating how the participant will reach the goals. Objectives are measurable and achievable.	**Participant's file** contains Individual Service Plan with measurable and updated objectives.
	F. 6. Individual Service Plans must include a prevention component addressing any high risk sexual and drug use behavior.	**Participant's file** demonstrates a secondary prevention component in service plan or states that no need exists.
	F. 7. Each participant's needs are reassessed as life changes indicate, or at a minimum based on the CM Level determined by the CM Acuity Assessment: • Intensive Level: Every six months; • Moderate Level: Every six months; • Monitoring Level: Annually.	**Participant's file** documents that the Individual Service Plan is updated annually or as indicated by life events.

Requirement	Indicator	Data Source
	This reassessment is documented in updates to the Individual Service Plan.	
G. Progress notes shall be completed after every significant contact with participant. Significant contact is defined as contact over 15 minutes or that is significant to care.	**G. 1.** Progress notes demonstrate that the Individual Service Plan is being implemented and followed or revised to meet the participant's changing needs.	**Participant's file** contains progress notes related to the Individual Service Plan.
H. CM collaboration and coordination with medical providers.	**H. 1.** CM will coordinate and collaborate with the medical providers based on the CM Level determined by the CM Acuity Assessment at a minimum: • Intensive Level: Coordination and collaboration required, including one case conference at least annually; • Moderate Level: Coordination and collaboration recommended; • Monitoring Level: Coordination and collaboration recommended on an “as needed basis.” Coordination may take the form of shared service planning, acuity assessment, phone and secure email communication, and case conferences.	**Participant's file** documents compliance.
I. Discharge shall be documented and proper referrals made, if applicable.	**I. 1.** Discharge from CM will be completed at the request of participant, a provider, or at death, using pre-established provider guidelines and criteria. Participants should be referred to appropriate providers upon discharge when appropriate.	**Participant's file** states the reason for discharge and that proper referrals are made.

Requirement	Indicator	Data Source
J. Caseload	**J. 1.** Caseload size will be determined by individual providers. Caseload sizes shall be routinely assessed by supervisor.	**Provider's policies and procedures** and **Report from provider on caseloads.**

CM Quality Measures		
Quality Measures	**Indicator**	**Data Source**
CM QM 1. Care Plan (Individual Service Plan)	**CM QM 1.** Percentage of case management patients, regardless of age, with a diagnosis of HIV who had a case management care plan developed and/or updated two or more times in the measurement year Goal: 75 percent	***Data Source:*** **Participant's file**, practice management system **Monitoring:** Use HAB Performance Measures. MCM Measures **Numerator:** Number of case management patients who had a case management care plan developed and/or updated two or more times that are at least three months apart in the measurement year **Denominator:** Number of case management patients, regardless of age, with a diagnosis of HIV who had at least one case management encounter in the measurement year **Exclusions:** 1) Case management patients who initiated case management services in the last six months of the measurement year. 2) Case management patients who were discharged from case management services prior to six months of service in the measurement year. 3) Case management patients who are assessed as a "monitoring" CM Level. **Frequency of collection:** Yearly at annual site visit.
CM QM 2. Gap in HIV medical visits	**CM QM 2.** Percentage of CM patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last six months of the measurement year (that is documented in the case management record) Goal: <15 percent	***Data Source:*** **Participant's file**, practice management system or CAREWare **Monitoring:** Use HAB Performance Measures. MCM Measures **Numerator:** Number of case management patients in the denominator who did not have a medical visit in the last six months of the measurement year (that is documented in the case management record) **Denominator:** Number of case management patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first 6 months of the measurement year **Exclusions:** Case management patients who died at any time during the measurement year

		Frequency of collection: Yearly at annual site visit.
CM QM 3. Medical Self-Management	**CM QM 3.** Percentage of CM patients, regardless of age, with a diagnosis of HIV who were assessed for Medical Self-Management. Goal: 85 percent	***Data Source:*** **Participant's file**, practice management system **Monitoring:** Local process measure. **Numerator:** Number of Case Management patients in the denominator who were assessed for Medical Self-Management in the 12-month measurement period. **Denominator:** Number of Case Management patients, regardless of age, with a diagnosis of HIV with a Case Management visit in the 12-month measurement period. **Exclusions:** Case Management patients who died at any time during the 12-month measurement period. Case Management patients who were new to services during the 12-month measurement period. **Frequency of collection:** Yearly at annual site visit.

Early Intervention Services

HRSA Service Category Definition: Early intervention services (EIS) for Parts A and B include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, to diagnose the extent of immune deficiency, and to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic measures. **Source:** 2012 Annual RSR Instruction Manual

Denver Part A Clarification: HIV testing and laboratory tests (not covered by Medicaid or health insurance) will be done in collaboration with existing testing and care programs and will not be funded by Part A EIS. EIS consists of two different programs within the category: Linkage to Care (LTC) and Reengagement. Each program has its own set of standards.

Unit of Service: 1 Unit = 30 Minutes or less

EIS Linkage to Care Program

Requirement	Indicator	Data Source
A. EIS Linkage will be coordinated with existing services.	**A. 1.** Establish linkage agreements with testing sites and key points of entry. Key points of entry include: • Emergency Departments, • Substance abuse and mental health treatment programs, • Detoxification centers, • Detention facilities, • Sexually transmitted infection clinics, • Homeless shelters, • HIV counseling and testing sites, • Public health departments, • Health care points of entry specified by eligible areas, • Federally Qualified Health Centers, • Ryan White Part C and D grantees, • Syringe Exchange Programs.	**Provider's records** will document linkage agreements.

Requirement	Indicator	Data Source
B. EIS Linkage is utilized to connect individuals newly diagnosed with HIV to care and other services they need to manage their HIV.	**B. 1.** Participants eligible for EIS LTC are those who meet one or more of the following: • Individuals newly diagnosed with HIV; • Individuals with HIV who have never engaged in care; • Individuals with HIV who are new to the TGA.	**Participant's file** will demonstrate that the participant is eligible for EIS.
	B. 2. Participants eligible for EIS LTC should not be currently engaged in any other Part A funded service or with another medical care provider.	**Participant's file** demonstrates that the participant is not engaged in Part A services or medical care. Exceptions to this restriction must be documented and justified in the file.
	B. 3. EIS should not last longer than three months unless a barrier is identified.	**Participant's file** documents that services last no longer than three months, unless barriers are clearly identified to justify need to continue EIS.
	B. 4. Participant will be linked and successfully attend a medical appointment within 30 days but not to exceed 90 days of entry into EIS. A release of information will be established between the EIS LTC provider and medical provider.	**Participant's file** will document the date of the medical appointment attended by the participant who is within 90 days of entering EIS and contain a release of information with the medical care provider, signed by the participant. If a release of information is unnecessary or refused by participant, the reason is documented.
	B. 5. If appropriate, a referral to a CM provider will occur within 30 days of entering EIS. A release of information will be established between the EIS provider and CM provider.	**Participant's file** will document linkage referral to CM within 30 days and contain a release of information signed by the participant. If not appropriate for referral or if release of information is refused by participant, the reason is documented.

Requirement	Indicator	Data Source
C. Initial screening: Every participant shall be screened, utilizing an approved tool, to identify client needs and develop a referral plan.	**C. 1.** Provider shall schedule an EIS screening interview within two business days of a positive diagnosis or within one week of an identified need.	**Participant's file** will document that a screening interview was scheduled within two days of a positive diagnosis or within one week of an identified need.
	C. 2. Initial screening interview will document the client's needs and the referral plan.	**Participant's file** will document referral source or point of entry to the EIS program.
	C. 3. Initial referral screening will include participant's health (including oral health), mental health, substance abuse, health and system literacy, resources, and insurance eligibility.	**Participant's file** has initial screening interview with all necessary information completed within the first two meetings.
D. Every participant shall have a Referral Plan* that guides their LTC.	**D. 1.** The Referral Plan will document a plan for needs identified in the initial screening. The plan will contain action steps, referral logs and outcomes.	**Participant's file** contains Referral Plan which demonstrates connections to proper services.
	D. 2. The plan will be completed within one week of the initial screening.	**Participant's file** contains Referral Plan that is completed within the required timeframe.
	D. 3. If at the end of three months, EIS services are continued, a new Referral Plan should be established for current needs.	**Participant's file** contains a revised Referral Plan with documented progress and new referrals if necessary.
E. Progress notes shall be completed after every significant contact with participant. Significant contact is defined as contact over 15 minutes or that is significant to care.	**E. 1.** Progress notes demonstrate that the Referral Plan is being implemented and followed or revised to meet the participant's changing needs.	**Participant's file** contains progress notes related to the Referral Plan.
F. EIS will ensure that participant has engaged with medical care six months after close date from EIS.	**F. 1.** EIS staff will follow-up with medical provider six months after closing out EIS to ensure participant has engaged in medical care.	**Participant's file** demonstrates participant is engaged in medical care six months after EIS close date.
	F. 2. If participant has not engaged in medical care, EIS staff will work to reengage	**Participant's file** documents outreach coordination efforts and demonstrate who will work

Requirement	Indicator	Data Source
	participant in EIS.	to engage participant. If needed, file will demonstrate that participant is re-engaged in EIS if they have fallen out of medical care. If participant refuses to reengage the file documents the participant's reason.

EIS Linkage Quality Measure		
Quality Measures	**Indicator**	**Data Source**
EIS Linkage Quality Measures	**EIS Linkage QM 1.** 85 percent of participants determined eligible for EIS will have attended a medical appointment within 90 days of becoming a participant of an EIS program.	**Participant's file** documents that a medical appointment for those within 90 days.
	EIS Linkage QM 2. 85 percent of participants determined eligible for EIS will be assigned a CM within 90 days of becoming a participant of an EIS program, if appropriate.	**Participant's file** documents an assignment of a MCM within 90 days or a reason that a MCM is not needed.
	EIS Linkage QM 3. 75 percent of EIS participants will still be engaged in medical care six months after their close date.	**Participant's file** will document engagement in medical care six months after close date.

Early Intervention Services Reengagement Program

Requirement	Indicator	Data Source
A. EIS Reengagement is utilized to identify and reengage participant who have fallen out of medical care.	**A. 1.** Participants eligible for EIS are those who meet one or more of the following: • Not had a medical care appointment for over eight months. • Have a high degree of medical concerns or have not been seen within the prescribed timeframe set by their physician. • Have been identified by another professional to have intense issues that	**Participant's file** will demonstrate that the participant is eligible for EIS.

Requirement	Indicator	Data Source
	would likely prevent them from continuing to engage in healthcare.	
B. EIS Reengagement providers should have strategies and protocols in place to search for participants who have disengaged from care.	**B. 1.** Providers have a documented set of procedures they utilize to find and reengage EIS Reengagement participants.	**Provider's procedures** demonstrate their protocol for reengaging participants. **Participant's file** will demonstrate reengagement efforts in progress notes.
C. Length of EIS Reengagement	**C. 1.** EIS are reengaging participants with medical care and other needed services and follow up to ensure these services are implemented. EIS should not last longer than three months after the participant is found. If a barrier is identified that requires more than three months of EIS services this should be documented.	**Participant's file** documents that services last no longer than three months unless barriers are clearly identified to justify need to continue EIS.
D. Initial screening: When a re-engagement participant is found, they shall be screened, utilizing an approved tool, to identify client needs and develop a referral plan.	**D. 1.** Provider will conduct a screening interview to assess the reasons why the participant disengaged from care and identify barriers that might cause disengagement in the future.	**Participant's file** complete in initial screening interview identifying reason for current and possible future disengagement.
	D. 2. Initial referral screening will include participant's health, including oral health, mental health, substance abuse, health and system literacy, resources, and insurance eligibility.	**Participant's file** has initial interview screening with all necessary information completed within the first two meetings.
E. When a participant is found the EIS provider will create a Reengagement Plan* with the participant on how they will stay engaged in care.	**E. 1.** The Reengagement Plan will document a plan for needs identified in the initial screening. The plan will contain action steps, referral logs and outcomes.	**Participant's file** contains Reengagement Plan which demonstrates connections to proper services.
	E. 2. The plan will be completed within one week of the screening.	**Participant's file** contains a Reengagement Plan completed within required timeframe.

Requirement	Indicator	Data Source
	E. 3. If at the end of three months, EIS Reengagement services are continued, a new plan should be established for current needs.	**Participant's file** contains a revised Reengagement Plan with documented progress and new referrals if necessary.
F. Progress notes shall be completed after every significant contact with participant. Significant contact is defined as contact over 15 minutes or that is significant to care.	**F. 1.** Progress notes demonstrate that the Reengagement Plan is being implemented and followed or revised to meet the participant's changing needs.	**Participant's file** contains progress notes related to the Reengagement Plan.
G. If the participant is located, EIS will ensure that participant has engaged in services with medical care six months after the close date from EIS.	**G. 1.** EIS staff will follow-up with medical provider six months after the EIS close date to ensure participant has engaged in medical care.	**Participant's file** demonstrates participant is engaged in medical care six months after EIS close date.
	G. 2. If participant has not engaged in medical care, EIS staff will work to reengage participant in EIS.	**Participant's file** documents outreach coordination efforts and demonstrate who will work to engage participant. If needed, file will demonstrate that participant is reengaged in EIS if they have fallen out of medical care. If participant refuses to reengage the file documents the participant's reason.

EIS Reengagement Quality Measures		
Quality Measures	**Indicator**	**Data Source**
EIS Reengagement Quality Measures	**EIS Reengagement QM 1.** 65 percent of participants determined eligible for EIS will be found.	**Participant's file** shows that the participant was contacted successfully by the provider.
	EIS Reengagement QM 2. 75 percent of participants found will have attended a medical visit within 90 days of being found.	**Participant's file** documents a medical visit.
	EIS Reengagement QM 3. 75 percent of EIS participants will still be engaged in medical care six months after their close date.	**Participant's file** will document engagement in medical care six months after close date.

*Tools available to assist with meeting above requirements are: the Initial Screening and Referral Form and Substance Abuse and Mental Illness Symptom Screener.

Emergency Financial Assistance

Service Category Definition: Emergency Financial Assistance (EFA) is the provision of short-term payments to agencies or the establishment of voucher programs when other resources are not available to help with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), transportation, and medication. Part A and Part B programs must allocate, track and report these funds under specific service categories as described in Eligible Individuals and Allowable Uses of Funds for Discretely Defined Categories of Services (Policy No. 10-02). **Source:** 2012 Annual RSR Instruction Manual

Unit of Service: 1 Unit = Any assistance request (including denied requests)

Requirement	Indicator	Data Source
A. Participant eligibility is based on income level. **Participants between 0-400 percent of Federal Poverty Level (FPL)** are eligible for financial and housing assistance not exceed $800 for the current fiscal year. Of this amount up to $400 maximum may be used for hotel stays. If DOHR projects a shortfall of funds in this service category, EFA for those at 186-400 percent of FPL will be placed on hold. If a participant is denied support they should be prioritized for funds, once funds become available. Important Note: The $400 maximum for hotel stays is not additional funds; it is simply the maximum amount available for that benefit. * EFA funds may not be used for clothing, direct cash payments, or dental, optical or vision care.	**A. 1.** Phone: $35 per month maximum.	**Participant's file** contains documentation.
	A. 2. Water: Charges may not be in collections ^.	**Participant's file** contains documentation.
	A. 3. Utilities: Charges may not be in collections ^.	**Participant's file** contains documentation.
	A. 4. Medical: Payments can be made for medical premiums and pharmacy copayments secondary to ADAP, but charges may not be in collections.	**Participant's file** contains documentation.
	A. 5. Insurance: Payments can be made for medical premiums and pharmacy copayments secondary to ADAP, but charges may not be in collections.	**Participant's file** contains documentation.
	A. 6. Hotel Stays: $400 maximum may be used for Hotel Stays.	**Participant's file** contains documentation. The file does not contain reimbursement for clothing, dental, optical or vision care. The file has no evidence of direct cash payments to clients.

Requirement	Indicator	Data Source
B. Providers will have structured procedures for participants to gain assistance, deny requests and handle inappropriate use of funds. Eligibility criteria will be applied equally to all participants regardless of service provider.	**B. 1.** The participant and the provider will develop a complete plan using the EFA Three Month Planning tool to empower clients in their ability to create a plausible budget. The provider will give the client a list of financial planning resources when creating the EFA Three Month Planning tool.	**Participant's file** contains a copy of the EFA Three Month Planning Tool (s).
	B. 2. A participant can be suspended from EFA for misrepresentation of expenses, income or other rule violations for three months. The agency suspending the participant must notify the single payer within three working days of the suspension effective date.	**Participant's file** shows adherence to the provider's procedures, Emergency Financial Standards, and documentation of misrepresentation of expenses, income or other rule violations.
C. Distributed checks must insure that needs are met and limit possibilities of fraud.	**C. 1.** Checks for emergency financial assistance will be issued by the contracted single payer provider.	**Participant's file** contains a copy of the check issued by the single payer provider.
	C. 2. Checks will be issued to the vendor. Checks cannot be payable or issued to participants.	**Participant's file** contains a copy of the properly written check
	C. 3. A copy of the check is placed in the participant's file.	**Participant's file** contains a copy of the check
	C. 4. Approved check request will be completed within three working days from the referral from agencies.	**Participant's file** demonstrates that the check request was completed in a timely manner.

^ DOHR and the single payer agency will develop a policy on how service providers access the single payer system for Emergency Financial Assistance.

Food Bank and Home Delivered Meals

HRSA Service Category Definition: Food bank and home-delivered meals involve the provision of actual food or meals. It does not include finances to purchase food or meals, but may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items and household cleaning supplies should also be included in this item. The provision of food or nutritional supplements by someone other than a registered dietician should be included in the item as well.
Source: 2012 Annual RSR Instruction Manual

Unit of Service: 1 Unit = 1 Meal

Requirement	Indicator	Data Source
A. Staff and Volunteer Training	**A. 1.** Staff or volunteers involved in food preparation and, or food distribution will complete a food safety class equivalent to State of Colorado standards.	**Personnel and Volunteer file** documents staff and volunteer training hours.
	A. 2. Supervisory staff will make every attempt to stay current with the latest information on HIV and nutrition by attending trainings on an annual basis. Information will be accessible to both staff and volunteers.	**Personnel file** demonstrates topic specific training.
B. Food services is formulated around the participant's specific needs and government standards.	**B. 1.** Income must be at or below 300 percent of FPL (agencies may implement stricter requirements).	**Participant's file** documents income level of participant.
	B. 2. The level of service provided will depend upon each participant's documented need.	**Participant's file** documents the participant's individual needs.
	B. 3. If a provider is ever faced with the need to create a waiting list, it will first refer participants out to other agencies. Agencies will make every attempt to avoid creating waiting lists. If growth restrictions become inevitable, then programs will serve those most in need based on overall health.	**Provider's policies and procedures** demonstrate how waiting lists and referrals are managed.

Requirement	Indicator	Data Source
	B. 4. Programs will meet all City and County of Denver and State of Colorado grocery and/or restaurant health code regulations whether or not the program is subject to mandatory inspections. All programs will undergo voluntary health inspections a minimum of every two years.	**Voluntary inspection** results.
	B. 5. Food services are meant to supplement participants' nutritional needs, not be the sole source of nutrition.	**Participant's file** demonstrates services provided.
C. Food banks shall make sure their services are convenient and convenient for their participants.	**C. 1.** Food banks hours will be accessible to participants with variable schedules.	**Scope of services description** in contract and posted hours of service.
D. Home delivered means shall meet the participant's nutritional and life needs.	**D. 1.** Participants will be given a delivery time period within which they can expect to receive their meals.	**Provider's policies and procedures** address communication and standards around delivery of food.
	D. 2. Meals will have a minimum average of 900-1,100 calories per meal.	**Provider's menus** demonstrate each meal's average calories.
	D. 3. Meals will average the following nutritional content: 15-40 percent protein; 35-55 percent carbohydrate; and no more than 30 percent fat, depending on the individual participant's dietary needs.	**Provider's menus** demonstrate each meal's nutritional content.
	D. 4. A registered dietician reviews the provider's menu to ensure it meets the participants' nutritional needs.	**Documentation** that registered dietician signed off on the menu.

Home and Community-based Health Services

HRSA Service Category Definition: Home and Community Based Health (HCHS) includes skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. **Source:** 2012 Annual RSR Instruction Manual

Unit of Service: 1 Unit = 2 Hours

Requirement	Indicator	Data Source
A. Participant eligibility is determined by medical necessity per the clinical health care professional responsible for the participant's HIV care.	**A. 1.** A referral must be made by the clinical health care professional stating the specific reason and need for services and projected length of service.	**Participant's file** documents a referral from a clinical health care professional.
B. Every participant shall have an intake interview and needs assessment to collect data important for care.	**B. 1.** An intake interview shall be scheduled within one week of referral or request for services.	**Participant's** Procedures demonstrate how intake interviews are scheduled to ensure compliance with the time frame.
	B. 2. The biopsychosocial assessment ensures that the participant has MCM and is a patient of a primary care physician. If participant is not currently getting these services, referrals are made or if there is a reason for them not receiving these services this reason is justified.	**Participant's file** shows that the participant has a medical case manager and primary care physician or that these referrals have been made within a one month time period.
	B. 3. Initial assessment of participant's functional capacity and health needs will be completed within one month of the intake interview.	**Participant's file** has initial assessment with all necessary information completed within the one month time period.
C. Every participant shall have a Home Care Plan which guides their care.	**C. 1.** The Home Care Plan is created in collaboration with the clinical health care professional responsible for the individual's HIV care and the participant's MCM.	**Participant's file** contains a Home Care Plan which is signed by both the participant's clinical health care professional and MCM.

Requirement	Indicator	Data Source
	C. 2. The Home Care Plan should document the projected length of Home Care Plan and how the participant will be transitioned to other funding sources if applicable.	**Participant's file** contains a Home Care Plan that establishes length of care and transition plan.
	C. 3. The Home Care Plan will demonstrate how the participant will get medical care at least once every six months.	**Participant's file** contains Home Care Plan which demonstrates connections to medical care.
	C. 4. Development of a Home Care Plan is based on the initial assessment and meets the participant's needs and preferences. The plan will be completed within two weeks of the assessment.	**Participant's file** contains Home Care Plan that is completed within the required timeframe.
	C. 5. The Home Care Plan contains goals which define how the participant needs are met through home care.	**Participant's file** contains Home Care Plan with appropriate goals.
	C. 6. Home Care Plans contains objectives for each goal, stating how the participant will reach the goals. Objectives are measurable and achievable, and are updated at least every six months.	**Participant's file** contains Home Care Plan with measurable and updated objectives.
	C. 7. Each participant's needs are reassessed every six months. This reassessment is documented in updates to the Home Care Plan at least every six months	**Participant's file** documents that the Home Care Plan is updated every six months.
D. Progress notes shall be completed after every significant contact with participant. Significant contact is defined as contact over 15 minutes or that is significant to care.	**D. 1.** Progress notes demonstrate that the Home Care Plan is being implemented and followed or revised to meet the participant's changing needs.	**Participant's file** contains progress notes related to the Home Care Plan.
E. Service documentation shall be completed after each service provided and will document that only allowable services were delivered, as specified in the Service Category Definition.	**E. 1.** Establish and maintain a program and client recordkeeping system to document the types of home services provided, dates provided, location of service, and signature of the professional who provided the service at each visit.	**Participant's file** documents services provided, date, location and staff signature.

Requirement	Indicator	Data Source
F. Discharge shall be documented and proper referrals made if applicable.	**F. 1.** Discharge from home care provider will be completed at the request of the participant, a provider, transition into another funding source, or at death; using pre-established provider guidelines and criteria. Participants should be referred to appropriate providers upon discharge when appropriate.	**Participant's file** states the reason for discharge and that proper referrals are made.
G. Caseload	**G. 1.** Caseload size will be determined by individual providers. Caseload sizes shall be routinely assessed by supervisor.	**Provider's policies and procedures** and **Report** from Provider on caseloads.

Home and Community-based Health Services Quality Measures		
Quality Measures	**Indicator**	**Data Source**
Home care provider Quality Measures	**HCHS QM 1.** 85 percent of participants will have at least one primary care appointment within the last six months.	**Participant's file** for those who have been in service for over six months.
	HCHS QM 2. 90 percent of participants will have a current Home Care Plan signed by their clinical health care professional and MCM.	**Participant's file** contains updated Home Care Plan.
	HCHS QM 3. 95 percent of participants have been assessed and counseled for medical adherence.	**Participant's file** demonstrates that adherence has been assessed and appropriate referrals made if necessary.

Housing Services

HRSA Service Category Definition: Housing services are short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that provides some type of medical or supportive services (such as residential substance abuse or mental health services, residential foster care, or assisted living residential services) and housing that does not provide direct medical or supportive services but is essential for an individual or family to gain or maintain access to and compliance with HIV–related medical care and treatment.

Housing funds cannot be in the form of direct cash payments to recipients for services and cannot be used for mortgage payments. Short term or emergency assistance is understood as transitional in nature and for the purposes of moving or maintaining an individual or family in a long-term, stable living situation. Therefore, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintaining, a long-term, stable living situation. **Source:** 2012 Annual RSR Instruction Manual

Unit of Service: 1 Unit = Any assistance request (including denied requests)

Requirement	Indicator	Data Source
A. Participant eligibility is based on income level. **Participants between 0-400 percent of FPL** are eligible for financial and housing assistance not exceed $800 for the current fiscal year. Of this amount up to $400 maximum may be used for hotel stays. If DOHR projects a shortfall of funds in this service category, Housing Assistance, those at 186-400 percent of FPL will be placed on hold. If a participant is denied support they should be prioritized for funds, once funds become available. **Important Note:** The $400 maximum for hotel stays is **NOT** additional funds; it is the maximum amount available for that benefit.	**A. 1.** Participant's proof of income.	**Participant's file** shows proof that the participant meets this income standard.
	A. 2. Hotel stays: $400 maximum may be used for hotel stays.	**Participant's file** contains documentation.

Requirement	Indicator	Data Source
B. Providers will have structured procedures for participants to gain assistance, deny requests and handle inappropriate use of funds. Eligibility criteria will be applied equally to all participants regardless of service provider.	**B. 1**. The participant and the provider will develop a complete plan using the EFA Three Month Planning tool to empower clients in their ability to create a plausible budget and stabilize the participant's housing situation. The provider will give the client a list of financial planning resources when creating the EFA Three Month Planning tool.	**Participant's file** contains a copy of the EFA Three Month Planning Tool (s).
	B. 2. A participant can be suspended from Housing Services for misrepresentation of expenses, income or other rule violations for three months. The agency suspending the participant must notify the single payer within three working days of the suspension effective date.	**Participant's file** shows adherence to the provider's procedures and EFA standards. **Participant's file** shows adherence to the provider's procedures, Emergency Financial Standards, and documentation of misrepresentation of expenses, income or other rule violations.
C. Distributed checks must insure that needs are met and limit possibilities of fraud.	**C. 1.** Checks for emergency housing assistance will be issued by the contracted single payer provider.	**Participant's file** contains a copy of the check issued by the single payer provider.
	C. 2. Checks will be issued to the vendor. Checks cannot be payable or issued to participants.	**Participant's file** contains a copy of the properly written check.
	C. 3. A copy of the check is placed in the participant's file.	**Participant's file** contains a copy of the check.
	C. 4. Approved check request will be completed within three working days from the referral from agencies.	**Participant's file** demonstrates the check request was completed in a timely manner.

Medical Case Management

HRSA Service Category Definition: Medical case management (MCM) services, including treatment adherence, are a range of client-centered services that link clients with health care, psychosocial, and other services provided by trained professionals, including both medically credentialed and other health care staff. The coordination and follow-up of medical treatments are a component of MCM. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the needs and personal support systems of the client and other key family members. MCM includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: 1) initial assessment of service needs; 2) development of a comprehensive, individualized medical service plan; 3) coordination of services required to implement the plan; 4) client monitoring to assess the efficacy of the plan; 5) periodic re-evaluation and adaptation of the plan, at least every six months, as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of case management, including face-to-face meetings, telephone calls, and any other forms of communication. **Source:** 2012 Annual RSR Instruction Manual

Unit of Service: 1 Unit = 30 Minutes or less

Requirement	Indicator	Data Source
A. Scheduling and access to services.	**A. 1.** Participant will begin the eligibility screening/ admissions process within one week of the initial contact or be placed on a waiting list and filtered into a caseload as soon as a space becomes available.	**Provider's Policies and Procedures** demonstrate their intake process per the regulations and how waiting lists are managed.
	A. 2. No participant shall be placed on a waiting list for over two weeks from the initial contact without being given a list of other medical case management providers.	Provider's Policies and Procedures demonstrate how waiting lists and referrals are managed.
B. Every participant shall have an intake interview and needs assessment to collect data important for care.	**B. 1.** Participants shall schedule an intake interview within two weeks of assignment to a medical case manager.	**Participant's file** will demonstrate an intake interview was conducted within two weeks of assignment.
	B. 2. Initial assessment of a participant's functional and cognitive capacity, health, strengths, abilities, mental health, substance abuse, resources, and needs will be completed within one month of the intake interview.	**Participant's file** has initial assessment with all necessary information completed within the one month time period.

Requirement	Indicator	Data Source
C. An Acuity Assessment shall be completed for each participant to determine "Level of CM".	**C. 1.** Every participant should be assessed at intake or within 30 days of initiating CM services, utilizing the TGA CM Acuity Assessment Tool.	**Participant's file** documents compliance.
	C. 2. Every participant should be re-assessed for acuity as life changes indicate or at a minimum every six months.	**Participant's file** documents compliance.
D. Annual adherence assessment.	**D. 1.** Every participant should be assessed for adherence to their HIV medication at least annually, utilizing an approved tool.	**Participant's file** will contain an annual assessment of adherence to their HIV medication.
E. Adherence counseling	**E. 1.** If an adherence barrier is identified during the adherence assessment, the MCM should provide adherence counseling and collaborate with the medical provider to assure alignment of the adherence message.	**Participant's file** documents date and content of adherence discussion.
F. Every participant shall have an Individual Service Plan which guides their care.	**F. 1.** The Individual Service Plan will demonstrate how the participant will get medical care at least once every six months, or as medically indicated.	**Participant's file** contains Individual Service Plan which demonstrates connections to medical care.
	F. 2. Development of an Individual Service Plan is based on the initial and ongoing assessment and meets the participant's needs and preferences. The plan will be completed within two weeks of the assessment.	**Participant's file** contains Individual Service Plan that is completed within the required timeframe.
	F. 3. The Individual Service Plan demonstrates that the participant is linked to all appropriate services needed.	**Participant's file** documents all referrals.
	F. 4. The Individual Service Plan contains goals which define what the participant needs to achieve in the MCM.	**Participant's file** contains Individual Service Plan with appropriate goals.
	F. 5. Individual Service Plans contains objectives for each goal, stating how the participant will reach the goals. Objectives are measurable and achievable, and are updated at least every six months.	**Participant's file** contains Individual Service Plan with measurable and updated objectives.

Requirement	Indicator	Data Source
	F. 6. Individual Service Plans must include a prevention component addressing any high risk sexual and drug use behavior.	**Participant's file** demonstrates a secondary prevention component in service plan or states that no need exists.
	F. 7. Each participant's needs are reassessed every six months. This reassessment is documented in updates to the Individual Service Plan at least every six months.	**Participant's file** documents that the Individual Service Plan is updated every six months.
G. Progress notes shall be completed after every significant contact with participant. Significant contact is defined as contact over 15 minutes or it is significant to care.	**G. 1.** Progress notes demonstrate that the Individual Service Plan is being implemented and followed or revised to meet the participant's changing needs.	**Participant's file** contains progress notes related to the Individual Service Plan.
H. MCM collaboration and coordination with medical providers.	**H. 1.** MCM will coordinate and collaborate with the medical provider on an ongoing basis based on the intensity of the client's medical need. This coordination may take the form of shared service planning, acuity assessment, phone and secure email communication, and case conferences.	**Participant's file** documents compliance.
I. Discharge shall be documented and proper referrals made if applicable.	**I. 1.** Discharge from MCM will be completed at the request of the participant, a provider, or at death; using pre-established provider guidelines and criteria. Participants should be referred to appropriate providers upon discharge when appropriate.	**Participant's file** states the reason for discharge and that proper referrals are made.
J. Caseload	**J. 1.** Caseload size will be determined by individual providers. Caseload sizes shall be routinely assessed by supervisor.	**Provider's policies and procedures** and **Report** from provider on caseloads.

MCM Quality Measures		
Quality Measures	**Indicator**	**Data Source**
MCM QM 1. Care Plan (Individual Service Plan)	**MCM QM 1.** Percentage of MCM patients, regardless of age, with a diagnosis of HIV who had a medical case management care plan developed and/or updated two or more times in the measurement year Goal: 75 percent	***Data Source:*** Patient's file, practice management system **Monitoring:** Use HAB Performance Measures. MCM Measures **Numerator:** Number of MCM patients who had a MCM care plan developed and/or updated two or more times that are at least three months apart in the measurement year **Denominator:** Number of MCM patients, regardless of age, with a diagnosis of HIV who had at least one MCM encounter in the measurement year **Exclusions:** 1) MCM patients who initiated MCM services in the last six months of the measurement year. 2) MCM patients who were discharged from MCM services prior to six months of service in the measurement year **Frequency of collection:** Yearly at annual site visit
MCM QM 2. Gap in HIV medical visits	**MCM QM 2.** Percentage of MCM patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last six months of the measurement year, that is documented in the MCM record. Goal: <15 percent	***Data Source:*** Patient's file, practice management system or CAREWare **Monitoring:** Use HAB Performance Measures. MCM Measures **Numerator:** Number of MCM patients in the denominator who did not have a medical visit in the last six months of the measurement year, that is documented in the MCM record **Denominator:** Number of MCM patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first six months of the measurement year **Exclusions:** MCM patients who died at any time during the measurement year **Frequency of collection:** Yearly at annual site visit

MCM QM 3. HIV medical visit frequency	**MCM QM 3.** Percentage of MCM patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each six month period of the 24-month measurement period with a minimum of 60 days between medical visits Goal: 62 percent* * This has not been previously measured, therefore the baseline will need to be established before an accurate measure can be obtained.	**Data Source:** Patient's file, practice management system or CAREWare **Monitoring:** Use HAB Performance Measures. MCM Measures **Numerator:** Number of MCM patients in the denominator who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior six-month period and the last medical visit in the subsequent six-month period **Denominator:** Number of MCM patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first six months of the 24-month measurement period **Exclusions:** MCM patients who died at any time during the 24-month measurement period **Frequency of collection:** Yearly at annual site visit
MCM QM 4. Medical Self-Management	**MCM QM 4.** Percentage of MCM patients, regardless of age, with a diagnosis of HIV who were assessed for Medical Self-Management. Goal: 85 percent	**Data Source:** Patient's file, practice management system **Monitoring:** Local process measure **Numerator:** Number of MCM patients in the denominator who were assessed for Medical Self-Management in the 12-month measurement period **Denominator:** Number of MCM, regardless of age, with a diagnosis of HIV with a MCM visit in the 12-month measurement period **Exclusions:** MCM patients who died at any time during the 12-month measurement period. MCM patients who were new to MCM services during the 12-month measurement period **Frequency of collection:** Yearly at annual site visit

Medical Transportation Services

HRSA Service Category Definition: Medical transportation services are conveyance services provided, directly, or through voucher, to a client to enable him or her to access health care services. **Source:** 2012 Annual RSR Instruction Manual

Medical transportation is classified as a support service and is used to provide transportation for eligible Ryan White HIV/AIDS Program clients to core medical services and support services. Medical transportation must be reported as a support services in all cases, regardless of whether the client transported to a medical core service or to a support service.

Unit of Service:
1 Unit = 1 bus trip (bus trip = one ticket)
1 Unit = Cab Voucher (1 one-way voucher)
1 Unit = 1 vehicle mileage reimbursement

Requirement	Indicator	Data Source
A. Transportation allows participants to connect to HIV-related health and support services who do not have the means to access them on their own or need vehicle mileage reimbursement assistance	**A. 1.** Transportation funds shall be used in a manner that is most cost effective and appropriate for the participant.	**Provider's Policies and Procedures** demonstrate how transportation funds are delivered and how they ensure cost effectiveness.
	A. 2. Transportation services should be delivered to participants with transportation barriers to access HIV-related health and support services.	**Participants file** documents barriers and how transportation funds are used to access HIV-related health and support services.
	A. 3. Distribution of transportation service must document: client name or other identifier, type of distribution (cab voucher, mileage reimbursement or bus ticket), units distributed, date and purpose. Cab vouchers must include trip origin and destination. Mileage reimbursement must include: a) trip origin and destination; b) Google Map, MapQuest, etc. documentation of trip distance; c) signed certification by destination HIV-related service provider confirming destination; and amount of reimbursement provided.	Participant's file documents the distribution of the transportation service.

B. Mileage Reimbursement	**B. 1.** A system of reimbursement that does not exceed the federal per-mile reimbursement rates.	**Providers Procedures** and **documentation** Vehicle mileage is reimbursed **after the trip** at the federal per-mile reimbursement rate.
B. Utilize RTD discount purchase programs.	**B. 1.** Transportation services will be purchased at a discount rate from RTD when possible.	**Providers Procedures** and **documentation** transportation services are purchased at discounted rate.

Mental Health Services

HRSA Service Category Definition: Mental health services are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. They are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers. **Source:** 2012 Annual RSR Instruction Manual

Unit of Service: 1 unit = 30 Minutes or less (this includes communication and documentation time)

Requirement	Indicator	Data Source
A. Providers of Mental Health Services must have the proper qualifications and expertise to deliver services.	**A. 1.** Mental health services can be provided by a psychiatrist; licensed psychologist; licensed psychiatric nurse; or licensed clinician: licensed marriage and family therapist, licensed professional counselor, licensed clinical social worker, doctor of philosophy, or doctor of psychology.	**Personnel file** contains copies of diplomas or other proof of licensure.
	A. 2. Mental health services are provided by unlicensed registered clinicians or graduate level student interns with appropriate supervision per licensure or internship regulations.	**Personnel file** contains proof identifying them as a student, copies of diplomas or other proof of degree.

Requirement	Indicator	Data Source
B. Providers of Mental Health Services will utilize a mandatory disclosure form in compliance with Colorado Mental Health statutes.	**B. 1.** Therapeutic disclosure will be reviewed and signed by all participants and must be compliant with Colorado Mental Health statutes. At a minimum, the disclosure must include: 1. therapist's name; 2. degrees, credentials, certifications, and licenses; 3. business address and business phone; 4. DORA description and contact information; 5. treatment methods and techniques; 6. options for second opinion, option to terminate therapy at any time; 7. statement that in a professional relationship, sexual intimacy is never appropriate and should be reported to DORA; 8. information about confidentiality and the legal limitations of confidentiality; 9. Space for the participant and therapist's signature and date.	**Participant's file** contains a Therapeutic disclosure signed by the participant.
C. Treatment will be offered in a timely manner.	**C. 1.** If the participant is in immediate crisis, they will be seen immediately or a proper referral will be made.	**Participant's file** provides documentation of the participant's initial request for services, as well as the referrals provided**.**

Requirement	Indicator	Data Source
D. A biopsychosocial assessment will begin at the first session if need is ongoing.	**D. 1.** The biopsychosocial assessment will be completed within the first two sessions for all participants seeking ongoing treatment and will include, but is not limited to: the presenting problem, a medical and psychiatric history, family history, treatment history, cultural issues, spiritual issues when pertinent, a brief psychosocial history, and a diagnosed mental health illness or condition.	**Participant's file** contains complete biopsychosocial assessment**.**
E. Every participant shall have a treatment plan which guides their care (non- psychiatric care).	**E. 1.** Development of a treatment plan, based on the biopsychosocial assessment, indicating the participant's needs and preferences will be completed by the third session.	**Participant's file** contains treatment plan that is completed within the required timeline.
	E. 2. Treatments plan contains goals which define what the participant expects to achieve in the treatment relationship.	**Participant's file** contains treatments plan with goals.
	E. 3. Treatment plan contains objectives for each goal stating how the participant will reach the goals. Objectives are measurable, reasonable, achievable and updated every three months.	**Participant's file** contains treatments plan with appropriate objectives.
	E. 4. Reassess participants' needs, document progress and update treatment plan every three months.	**Participant's file** includes treatment plans which are updated at least every three months.
	E. 5. Treatment plan includes the number of sessions to be conducted in the next three months.	**Participant's file** contains current treatment plan indicating the estimated number of sessions to be conducted.
	E. 6. Treatment plan contains an estimated discharged date that is updated every three months, if necessary.	**Participant's file** contains current treatment plan indicating an estimated discharge date.

Requirement	Indicator	Data Source
F. Every participant shall have an ongoing treatment plan which guides their care (psychiatric care).	**F. 1.** Development of a treatment plan, based on the biopsychosocial assessment, indicating the participant's needs and preferences will be documented in the progress notes.	**Participant's file** contains progress notes including treatment plans.
	F. 2. Treatment plan addresses presenting issues and refers to other services, if appropriate.	**Participant's file** contains treatments plan reflecting the participant's needs.
	F. 3. Each participant's needs are reassessed on each visit. Any change in condition is documented and the treatment plan is updated appropriately.	**Participant's file** includes treatment plans which are updated every session.
	F. 4. If a medication is prescribed that has the potential to interact negatively with the participant's HIV drugs, the reason for this decision is documented and a plan for monitoring of the participant's health is included in the treatment plan.	**Participant's file** includes treatment plan that explains why medications known to have negative interactions with HIV medication are prescribed and a plan to monitor the participant's health.
G. Progress notes shall be completed after every significant contact with participant. Significant contact is defined as contact over 15 minutes or that is significant to care.	**G. 1.** Progress notes demonstrate that the treatment plan is being implemented and followed or revised to meet the participant's changing needs.	**Participant's file** contains progress notes related to service plan.
	G. 2. Before prescription of medication, the benefits and risks of the treatment is assessed both in terms of the participant's mental health and HIV status. Potential benefits and risks of the treatment are discussed with the patient and/or another person responsible for the patient, and this discussion is documented in the progress notes. (Psychiatry only)	**Participant's file** contains progress notes outlying benefits and risks and that these were discussed with the participant.

Requirement	Indicator	Data Source
H. Discharge shall be documented and proper referrals made if applicable.	**H. 1.** Discharge from mental health services will be completed at the request of the participant, the mental health provider, or at death; using pre-established provider guidelines and criteria. Participants should be referred to appropriate provider upon discharge if appropriate.	**Participant's file** states reason for discharge and that proper referrals were made.
I. Providers will follow ethical and legal requirements	**I. 1.** Providers will act in accordance with mental health statutes, DORA regulations, and respective provider codes of ethics.	**Participant's file** demonstrates compliance with ethical and legal requirements. **DORA Disciplinary Actions** will be check to ensure mental health professionals are registered with DORA and have not committed any ethical violations.

Mental Health Quality Measures		
Quality Measures	**Indicator**	**Data Source**
A. Mental Health Quality Measure (non-psychiatric)	**MH QM A. 1.** 65 percent of participants attend the identified number of mental health appointments (as stated in the previous two treatment plan).	**Participant's file** documents number of identified appointments and the appointments kept and missed. Appointments canceled a day in advance and rescheduled will not count as missed appointment.
	MH QM A. 2. 65 percent of participants will make progress (completing greater than 30 percent of objectives) on their Individual Service Plan.	**Participant's file,** for those who have been in service for over six months, will document that the participant is making progress on their treatment plan goals.
	MH QM A. 3. A minimum of 75 percent of participants will self-report that they are accessing primary care every six months.	**Participant's file** documents that medical care was received and **Provider's report.**

B. Mental Health Quality Measures (psychiatric)	**MH QM B. 1.** Less than 5 percent of participants have had psychiatric hospitalizations in the last six months.	**Provider Report** or **Participant file** demonstrate percentages.
	MH QM B. 2. Less than 5 percent of participants have had psychiatric emergency room visits in the last six months.	**Provider Report** or **Participant file** demonstrate percentages.
	MH QM B. 3. 95 percent of participants have been assessed and counseled for adherence.	**Participant's file** demonstrates that adherence has been assessed and counseling given if needed.

Oral Health Care

HRSA Service Category Definition: Oral health (dental) care includes diagnostic, preventive, and therapeutic services provided by a dental health care professional licensed to provide health care in the State or jurisdiction, including general dental practitioners, dental specialists, and dental hygienists, as well as licensed and trained dental assistants. **Source:** 2012 Annual RSR Instruction Manual

Part A Clarification: Oral health care includes emergency, diagnostic, preventive, basic restorative (including removable partial and complete prosthetics, limited oral surgical and limited endodontic services.

Unit of Service: 1 Unit = Visitation of any duration

Requirement	Indicator	Data Source
A. Providers of dental care services must have the proper qualification(s) and expertise to deliver services.	**A. 1.** Dentists must be licensed to practice dentistry by the State of Colorado.	**Staff file** contains copies of diplomas or other proof of degree or licensure. Any outcomes passed by the State Board will be in the Dentist's file.
	A. 2. If a provider utilizes the services of dental students, these students must be supervised according to their program guidelines and work under the license of a provider's dentist.	**Provider's policies and procedures** demonstrate how students are supervised to ensure high levels of quality.
B. Treatment will be offered in a timely and appropriate manner.	**B. 1.** Provider can demonstrate that waiting list procedure properly manages the wait time for new participants.	**Provider's policies and procedures** demonstrate how the provider handles waiting lists. **Participant's file** shows that there are no unnecessarily delays in getting services.
	B. 2. Provider determined emergencies will be addressed or referred to another provider within 36 hours.	**Participant file** demonstrates that emergencies are addressed in timely manner and document that the patient was seen by the referred provider and follow up was completed. **Provider's procedures** outline how emergencies are handled in a timely manner.

Requirement	Indicator	Data Source
C. A comprehensive oral evaluation will be conducted at the first non-emergent appointment and will be ongoing if necessary.	**C. 1.** The participant's presenting complaint, concerns and expectations should be considered by the dentist.	**Participant's file** contains a signed and dated oral evaluation containing the participant's presenting complaint.
	C. 2. Dental, psychological, and behavioral histories are considered by the dentist to identify medications and predisposing conditions that may affect diagnosis and management of the oral health condition. This should be updated, at least annually.	**Participant's file** contains signed, dated oral evaluation which includes relevant histories.
	C. 3. An assessment of general medical needs and histories are conducted and if the participant is not in primary care, the provider will help the participant access care. This should be updated at least annually.	**Participant's file** contains a medical needs evaluation and a referral to primary care if necessary.
	C. 4. A comprehensive oral, head and neck exam is conducted including an intra-oral exam evaluating for HIV associated lesions.	**Participant's file** contains signed, dated oral evaluation including a head and neck exam.
	C. 5. Radiographs may include panoramic, bitewings and selected periapical films are conducted as treatment indicates.	**Participant's file** contains signed, dated oral evaluation, including appropriate diagnostic tools.
	C. 6. Complete periodontal exam or periodontal screening record. This should be updated annually.	**Participant's file** contains signed, dated oral evaluation, including periodontal exam or record.
	C. 7. A comprehensive pain assessment, as clinically indicated.	**Participant's file** contains signed, dated oral evaluation including pain assessment.
D. Every participant shall have a treatment plan which guides their care.	**D. 1.** For non-emergent care, the treatment plan should be completed after the evaluation and before the first treatment.	**Participant's file** contains treatment plan that is completed and documents the medical necessity of restorative care.

Requirement	Indicator	Data Source
	D. 2. Treatment plan will be updated when participant's condition changes.	**Participant's file** contains updated treatment plans.
E. Progress notes shall be completed after every contact with participant.	**E. 1.** Progress notes demonstrate that the treatment plan is being implemented and followed or revised to meet the participant's changing dental, medical, and psychological/behavioral needs.	**Participant's file** contains progress notes related to treatment plan.
	E. 2. Progress notes demonstrate that the participant's medical needs are being addressed and/or proper referrals are made.	**Participant's file** demonstrates that the dentist takes in consideration the participant's general medical condition and makes referrals as appropriate.
	E. 3. A six month or shorter hygiene recall schedule will be used to monitor any changes.	**Participant's file** contains progress notes showing attempt to schedule appointments in compliance with indicator.
	E. 4. Progress notes demonstrate that the participant received oral health education at least once in the measurement year.	**Participant's file** contains progress notes showing participant received oral health education.
F. Discharge shall be documented and proper referrals made if applicable.	**F. 1.** Discharge from dental care services will be completed at the request of the participant, the dental care provider, or at death; using pre-established provider guidelines and criteria. Participants should be referred to appropriate provider on discharge, if appropriate.	**Participant's file** states reason for discharge and that proper referrals are made.
G. Providers will follow ethical and legal requirements.	**G. 1.** Providers will act in accordance with American Dental Association's Principles of Ethics and Code of Professional Conduct, and respective agencies code of ethics.	**Participant's file** demonstrates the provider is acting ethically and in the best interest of the participant.

Requirement	Indicator	Data Source
	G. 2. Any treatment performed shall be with concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment.	**Participant's file** shows proper treatment is given based on the dentist's professional opinion.

Oral Health Quality Measures		
Requirement	**Indicator**	**Data Source**
Oral Health Quality Measures	**OH QM 1.** Review current medications and drug compliance with 100 percent of participants each visit.	**Participant's file** documents a review of current medications at each visit.
	OH QM 2. Provide appropriately timed hygiene appointments for active patients every three to six months as needed.	**Participant's file** documents frequency of hygiene appointments.
	OH QM 3. 65 percent of participants with a Phase 1 treatment plan completed that plan within 12 months.	**Participant's file** documents completion of Phase 1 treatment plan for those who have been in service for over twelve months. Outreach and failure to follow through by clients will be documented and excluded from analysis.

Outpatient Ambulatory Medical Care[10]

HRSA Service Category Definition: Outpatient/ambulatory medical care include the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner, or other health care professional certified in their jurisdiction to prescribe antiretroviral therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **Source:** 2012 Annual RSR Instruction Manual

Unit of Service: 1 Unit = 1 Service

Requirement	Indicator	Data Source
A. Practices should assure that patients have timely access to medical care consistent with clinical guidelines released by the U.S. Department of Health and Human Services (http://www.aidsinfo.nih.gov/Guidelines/default.aspx) and the Infectious Disease Society of America (http://www.hivma.org/HIV_Guidelines).	**A. 1.** Practices will have policies and procedures to handle care requests for patients new to the practice. Ideally, patients who disclose their HIV infection and symptoms will be able to speak with a medical professional capable of assisting the patient to obtain medically appropriate care.	**Provider's policies and procedures** indicate how new patients will be admitted to the practice.
	A. 2. Practices will have policies and procedures that facilitate timely, medically appropriate care. Ideally, practices will be able to see acutely symptomatic patients with HIV infection the "same day" or will facilitate appropriate referral to urgent care or the emergency department.	**Provider's policies and procedures** indicate how emergent, urgent and acute needs of established patients are managed.

[10] The Outpatient Ambulatory Medical Care Standards and Quality Measures were reviewed and revised by a subcommittee of the Ryan White Part A medical providers, facilitated by Kathy Reims M.D.

Requirement	Indicator	Data Source
B. Patients should have access to information about how to obtain care and health information.	**B. 1.** Patients should understand how to access emergency services (24-hour phone access), and how to schedule appointments, how to obtain results of laboratory or other diagnostic screening results.	**Provider's procedures** demonstrate how they educate patients about how to access care and health information.
C. Access to inpatient care.	**C. 1.** Outpatient clinicians who do not provide inpatient care should have a network of practitioners with whom they can communicate easily should their patients require hospitalization.	**Provider's reports** demonstrate that the practice has clinicians with active admitting privileges or have procedures which demonstrate the process by which patients can receive hospital care.
D. Clinicians should obtain an HIV related history at baseline and update it as appropriate to care.	**D. 1.** Components of a complete HIV-related history should include: Date of diagnosis or unknown; history of antiretroviral therapy and any details about response to therapy, side effects and known drug resistance; recall of lowest CD4 or unknown; documentation of request for previous medical records; prior HIV-associated infections; other medical illnesses including cardiovascular disease, malignancies, diabetes mellitus, hepatic disease or renal disease that might affect therapy; status of vaccines, including tetanus, pneumococcal, hepatitis A and B; current medications and supplements (prescription and over-the-counter); medication allergies; assessment for substance use including tobacco; sexual history; housing status, employment status; plans for having children; significant family medical history; depression screening, domestic violence screening.	**Patient's file** will contain a comprehensive HIV-related history.

Requirement	Indicator	Data Source
E. Clinicians should perform a **baseline** comprehensive physical examination and follow up examinations when appropriate.	**E. 1.** Components of a comprehensive HIV-related physical baseline exam include: Vital signs; height and weight; body habitus; oropharynx; cardiopulmonary including evidence of peripheral vascular disease (PVD); lymph nodes; abdominal exam; anogenital exam; breast and pelvic exam (women) (2 components); neurological exam.	**Patient's file** will contain documentation of a comprehensive HIV-related exam at baseline.
F. Clinicians should perform a comprehensive physical examination **annually.**	**F. 1.** Components of a comprehensive HIV-related physical annual exam include: Vital signs; height and weight; body habitus; oropharynx; cardiopulmonary including evidence of PVD; lymph nodes; abdominal exam; anogenital exam; breast and pelvic exam (women) (2 components); neurological exam.	**Patient's file** will contain documentation of an annual comprehensive HIV-related exam.
G. Clinicians should order appropriate laboratory assessments and screening tests at **initiation** of care.	**G. 1.** Specific laboratory assessments and screening tests appropriate for the specific needs of the patient's conditions are ordered and followed up on in an appropriate manner. Including: confirmation of HIV status; complete blood count (CBC); CD4, viral load, chemistry panel, appropriate TB screening, Hepatitis screen for A, B and C, syphilis screen, other STI screening for high risk patients, serologic screening for Toxoplasma gondii, and Pap smear (women only).	**Patient's file** will contain documentation of laboratory assessments and screening tests for appropriate to the patient's condition, or medical rationale for why tests were not done, which would include documentation of recent testing in another facility.

Requirement	Indicator	Data Source
H. Clinicians should order appropriate periodic laboratory assessments and screening tests.	**H. 1.** Specific laboratory assessments and screening tests appropriate for the specific needs of the patient's conditions are ordered and followed up on in an appropriate manner. Including: CBC (annually), CD4 and HIV viral load repeated at three to six month intervals; annual syphilis screening, annual STI screening for high risk patients, and Pap smear (women only).	**Patient's file** will contain documentation of laboratory assessments and screening tests for appropriate to the patient's condition or medical rationale for why tests were not done, which would include documentation of recent testing in another facility.
I. Clinicians should perform interval visits to monitor care every six months for clinically stable patients and more frequent for less clinically stable patients.	**I. 1.** Interval visits should address the treatment plan and patient's needs. Frequency of visits should be appropriate to the clinical stability of the patient. In addition to problem-focused history, physical exam and laboratory assessments interval visits should document risk reduction, high risk behaviors, and for those taking HAART an assessment of side-effects, response to therapy and assessment of adherence. Identified problems should have a plan to manage including follow up.	**Patients file** will show documentation of interval visits and will show documentation of recommended interval follow-up.
J. Clinicians should prescribe a HAART regimen that is best able to delay disease progression, prolong survival, and maintain quality of life through maximal viral suppression	**J. 1.** Clinicians should follow current evidence-based guidelines when initiating or changing anti-retroviral drug therapy. The clinician should involve the patient in the decision-making process when determining whether to implement ARV therapy. The clinician should review the benefits and risks of treatment for each individual patient.	**Patient's file** will demonstrate that if HAART therapy is chosen that it is done so being consistent with current ARV guidelines.
K. The patient's vaccination status should be assessed.	**K. 1.** Clinicians should assess the vaccine status of all patients and immunize according to current guidelines.	**Patient's file** will have evidence of documentation of current immunization status.

Requirement	Indicator	Data Source
L. Clinicians should assess patient's oral health needs at least annually.	**L. 1.** Clinicians should ascertain whether their patients have a regular oral health provider and should refer all HIV-infected patients for annual hygiene and intraoral examinations, including dental caries and soft-tissue examinations.	**Patients file** will show documentation of referral for oral health care within the last 12 months.
M. Healthcare teams should use tracking strategies and outreach to patients who have not received recommended care.	**M. 1.** At a minimum, practices should recall patients who have not been seen for a medical follow up visit in the last six months.	**Provider's policies and procedures** outline strategies to recall patients.

Outpatient Ambulatory Care Quality Measures		
Quality Measure	**Indicator**	**Data Source/Frequency**
QM 1: HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year Goal: 86 percent	***Data Source:*** Patient's file, practice management system or CAREWare ***Monitoring:*** Use HAB Performance Measures Core Measure ***Numerator:*** Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year ***Denominator:*** Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year and who are still receiving HIV care at that site. ***Frequency of collection:*** *2 times per year, utilizing CAREWare* **Exclusions:** Patients who died at any time during the measurement year
QM 2: Prescription of HIV Antiretroviral Therapy	Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year Goal: 76 percent	***Data Source:*** Patient's file, practice management system or CAREWare **Monitoring:** Use HAB Performance Measures, Core Measure **Numerator:** Number of patients from the denominator prescribed HIV antiretroviral therapy during the measurement year **Denominator:** Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year and who are still receiving HIV care at that site ***Frequency of collection:*** *2 times per year, utilizing CAREWare* **Exclusions:** Patients who died at any time during the measurement year

QM 3: HIV Medical Visit Frequency	Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits. Goal: 62 percent	***Data Source:*** Patient's file, practice management system or CAREWare **Monitoring:** Use HAB Performance Measures, Core Measure **Numerator:** Number of patients in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period **Denominator:** Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 24-month measurement period and who are still receiving HIV care at that site **Exclusions:** Patients who died at any time during the 24-month measurement period ***Frequency of collection:*** *2 times per year, utilizing CAREWare* **Exclusions** Patients who died at any time during the measurement year
QM 4: Gap in HIV Medical Visits	Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year Goal: <15 percent	***Data Source:*** Patient's file, practice management system or CAREWare **Monitoring:** Use HAB Performance Measures. Core Measure **Numerator:** Number of patients in the denominator who did not have a medical visit in the last 6 months of the measurement year **Denominator:** Number of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first 6 months of the measurement year and who are still receiving HIV care at that site ***Frequency of collection:*** *2 times per year, utilizing CAREWare* **Exclusions:** Patients who died at any time during the measurement year.

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Psychosocial Services

HRSA Service Category Definition: Psychosocial support services are support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Nutrition counseling services provided by a non-registered dietitian are reported in this category, but it excludes the provision of nutritional supplements. **Source:** 2012 Annual RSR Instruction Manual

Unit of Service:
1 unit = Individual or Group session or Newsletter

One-On-One Interactions
Purpose: Psychosocial support service providers may provide one-on-one interventions for people living with HIV that include topics applicable to the target population and focus on empowerment, self-advocacy and medical self-management.

Requirement	Indicator	Data Source
A. Psychosocial providers will offer client-driven medically accurate individualized sessions to help improve quality of life for the participants.	**A. 1.** Psychosocial one-on-one participants will receive support concerning: ▪ access to health and other benefits; ▪ developing coping skills; ▪ reducing feelings of social isolation; ▪ increasing self-determination and self-advocacy	Provision of one-on-one support services is documented in client file, including: date; duration; general topics discussed; activities conducted; and goals and objectives achieved during one-on-one sessions

Groups Purpose: Psychosocial support service providers may provide groups for people living with HIV that include topics applicable to the target population, focusing on empowerment, self-advocacy and medical self-management.

Requirement	Indicator	Data Source
B. Psychosocial providers will offer a client-driven medically accurate group to help improve quality of life for the participants.	**B. 1.** Psychosocial group participants will receive support concerning: ▪ access to health and other benefits; ▪ developing coping skills; ▪ reducing feelings of social isolation; ▪ increasing self-determination and self-advocacy.	Psychosocial group providers will maintain group records which include: dated sign-in sheets; number of participants attended; name and title of group facilitator; location of group; copies of materials or handouts; summary of the topics discussed; activities conducted; goals and objectives achieved during group sessions

Newsletters Purpose: Psychosocial support service providers may develop newsletters for people living with HIV that include topics applicable to the target population and focus on empowerment, self-advocacy and medical self-management.

Requirement	Indicator	Data Source
C. Working collaboratively with peers, the provider will develop a client-driven medically accurate newsletter.	**C. 1.** Medical information included in newsletters must be reviewed by DOHR for accuracy.	Programs will maintain the following required documentation for newsletters: copies of newsletters produced; number distributed; and documentation of medical review and provider approval.
D. Newsletters must meet federal guidelines regarding sexual and drug-related content.	**D. 1.** Text and images in the newsletter must not promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.	Programs will supply a copy of every newsletter to DOHR for review prior to publication.

Nutrition counseling Purpose: Psychosocial support service providers may include nutrition counseling provided by a non-registered dietitian.

Requirement	Indicator	Data Source
E. Working collaboratively with peers, the provider will deliver nutritional counseling by a non-registered dietitian.	**E. 1.** The nutritional counseling should adhere to generally accepted professional practice.	Personnel files should include documentation of the credentials of staff or volunteers delivering nutritional counseling.
	E. 2. Psychosocial funds may not be used for provision of nutritional supplements (nutritional supplements provided by a non-registered dietitian is considered food bank service).	Provision of nutritional counseling is documented in client file, including: date; duration; general topics discussed; activities conducted; goals and objectives achieved during nutritional counseling sessions.

Use of Volunteers Purpose: Providers may use volunteers and peers in order to expand program capacity for psychosocial support services. With harm reduction as a foundation, Psychosocial support services delivered by staff, volunteers and/or peer support help clients access health and benefit information, develop coping skills, reduce feelings of social isolation, and increase self-determination and self-advocacy, and help improve quality of life for the participants.

Requirement	Indicator	Data Source
F. Volunteers and peers will receive appropriate orientation, training and supervision.	**F. 1.** All volunteers and peers who have client contact will be given orientation prior to providing services.	Orientation curriculum on file at provider agency and evidence of volunteers and peers received training.

	F. 2. All volunteers and peers will be supervised by qualified program staff.	Evidence of volunteers and peers received supervision and evidence of volunteer application.
	F. 3. Supervisor routinely evaluates psychosocial support services.	Signed and dated form on file that outlines responsibilities, obligations, and liabilities of each volunteer.

Referral Purpose: Psychosocial support is not intended to address highly complex behavioral health or case management issues. Referrals should be made to a more appropriate service. Referrals should be appropriate to client situation, lifestyle and need.

Requirement	Indicator	Data Source
H. The provider will develop referral resources to make available the full range of additional services to meet the needs of their clients.	**H. 1.** Provider will develop and maintain comprehensive referral lists for full range of services.	Referrals lists will be available for inspections by DOHR.
I. Providers will demonstrate active collaboration with other agencies to provide referrals to the full spectrum of HIV-related and other needed services.	**I. 1.** Provider will collaborate with other agencies and providers to provide effective, appropriate referrals.	Memoranda of Understanding with services providers on file.
J. Each client receiving referral services will receive referrals to those services critical to achieving optimal health and wellbeing.	**J. 1.** The provider will support the client to initiate referrals that were agreed upon by the client and the provider.	The provider will document all referrals.

Substance Abuse Services - Outpatient

HRSA Service Category Definition: Substance abuse services (outpatient) are medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel. **Source:** 2012 Annual RSR Instruction Manual

Funds used for outpatient drug or alcohol substance abuse treatment, including expanded HIV-specific capacity of programs if timely access to treatment and counseling is not available, must be rendered by a physician or provided under the supervision of a physician or other qualified/licensed personnel. Such services should be limited to the following:

- Pre-treatment/recovery readiness programs, such as, the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program
- Harm reduction
- Mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse
- Outpatient drug-free treatment and counseling
- Opiate Assisted Therapy
- Neuro-psychiatric pharmaceuticals; and
- Relapse prevention

Source: HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs, National Monitoring Standards for Ryan White Part A Grantees: Program Part A

Unit of Service:
1 unit = Individual or Group session of 30 minutes or less
1 unit = Methadone or Other Chemical treatment

Requirement	Indicator	Data Source
A. Providers of Substance Abuse must have the proper qualification and expertise to deliver services.	**A. 1.** In order to practice as a substance abuse counselor, one must qualify to perform the service under current DBH regulations. Psychiatric services must be provided by a psychiatrist or licensed psychiatric nurse.	**Personnel file** contains copies of diplomas or other proof of degree or licensure.
B. Standards of supervision will be in compliance with DBH regulations.	**B. 1.** Standards of supervision will be in compliance with DBH regulations or supervisor must have a master's degree in a related field with five years of experience treating substance abuse issues and have training (college or outside) in pharmacology and substance abuse/addiction.	**Provider's policies** and **procedures** and **Personnel file** will demonstrate compliance.

Requirement	Indicator	Data Source
C. Providers of Substance Abuse Services will utilize a mandatory disclosure form in compliance with Colorado mental health statutes.	**C. 1.** Therapeutic disclosure will be reviewed and signed by all participants and must be compliant with the Colorado Mental Health statutes. At a minimum, the disclosure must include: 1. therapist's name; 2. degrees, credentials, certifications and licenses; 3. business address and business phone; 4. DBH description and contact information; 5. treatment methods and techniques; 6. options for second opinion, option to terminate therapy at any time; 7. statement that in a professional relationship, sexual intimacy is never appropriate and should be reported to DBH; 8. information about confidentiality and the legal limitations of confidentiality; 9. space for the participant and therapist's signature and date.	**Participant's file** contains a Therapeutic disclosure signed by the participant.
D. Treatment will be offered in a timely manner.	**D. 1.** The first session will occur within three weeks from the time of referral, if the participant is not in crisis. Participant can choose to stay on a waiting list longer than three weeks, if they desire. If the participant is in immediate crisis, they will be seen immediately or proper referrals will be made.	**Participant's file** provides documentation of the participant's initial request for services, as well as the first session. **Participant's file** provides documentation of the participant's initial request for services, as well as the first substance abuse session or three referrals.
E. A comprehensive evidence-based or best practices assessment shall be completed as soon as is reasonable upon admission and no later than seven business days of admission into services.	**E. 1.** Assessment will be completed as soon as is reasonable upon admission and no later than seven business days of admission into services. The file contains an assessment completed in compliance with DBH regulations. The assessment shall be documented in the participant record, and at a minimum include the following information, where	**Participant's file** contains evidence that the assessment is completed within seven business days of admission. If that was not considered reasonable, this is clearly documented in the file.

Requirement	Indicator	Data Source
	available and applicable: • Identification and demographic data; • Presenting problem, duration, and readiness for treatment; • Mental health; • Substance use; • Physical and dental health status; • A diagnosis with sufficient supporting criteria and any subsequent changes in diagnosis; • A mental status examination for each participant who is given a diagnosis; • History of involuntary treatment; • Advanced directives; • Capacity for self-sufficiency and daily functioning; • Cultural factors that may impact treatment, including age, ethnicity, linguistic or communication needs, gender, sexual orientation, relational roles, spiritual beliefs, socio-economic status, personal values, level of acculturation or assimilation, and coping skills; • Education, vocational training; • Family and social relationships; • Trauma; • Physical/sexual abuse or perpetration and current risk; • Legal issues; • Issues specific to older adults such as hearing loss, vision loss, strength; mobility and other aging issues; • Issues specific to children and adolescents, such as growth and development, daily activities, legal guardians and need for family involvement and engagement in the child's treatment; • Strengths, abilities, skills, and interests; and • Barriers to treatment.	

Requirement	Indicator	Data Source
F. An initial Service Plan shall be developed with the participant following an identified assessment(s).	**F. 1.** Initial Service Plan is based on the assessment.	**Participant's file** contains a Service Plan based on the assessment.
	F. 2. Initial Service Plan identifies: type of services, frequency of services, and duration of services.	**Participant's file** contains a Service Plan that documents compliance.
	F. 3. An initial service plan shall be formulated to address the immediate needs of the participant within twenty-four hours of assessment.	**Participant's file** contains a Service Plan that documents compliance.
	F. 4. The service plan shall be developed as soon as is reasonable after admission and no later than fourteen business days after assessment.	**Participant's file** contains a Service Plan that documents compliance.
G. The service plan reviews shall be conducted collaboratively by clinician and participant and any service plan revisions shall be completed and documented when there is a change in the participants' level of functioning or service needs.	**G. 1.** Service plan reviews must be conducted collaboratively between clinician and participant. All parties (the participant, legal guardian, and interdisciplinary team members) who participate in plan development, shall sign the plan. The record shall contain documentation whenever a plan is not signed by the participant or participating parties. There shall be documentation that the participant was offered a copy of the plan.	**Participant's file** contains a Service Plan that documents compliance.
	G. 2. Service plan revisions shall be completed and documented when there is a change in the participants' level of functioning or service needs and no later than: • Opioid Medication Assisted Treatment: every three months; • Outpatient: every six months.	**Participant's file** contains a Service Plan that documents compliance.

Requirement	Indicator	Data Source
	G. 3. The service plan review shall include documentation of: progress made in relation to planned treatment outcomes and any changes in the participant's treatment focus.	**Participant's file** contains a Service Plan that documents compliance.
	G. 4. Service plans include specific and measurable goals based on the assessment.	**Participant's file** contains a Service Plan that documents compliance.
	G. 5. Service plans contain specific, measurable, attainable objectives that relate to the goals and have realistic expected date(s) of achievement.	**Participant's file** contains a Service Plan that documents compliance.
	G. 6. Service plans include appropriate referrals to qualified practitioners when co-occurring disorders are identified.	**Participant's file** contains a Service Plan that documents referrals to qualified practitioners when co-occurring disorders are identified.
H. Progress notes shall be completed after every significant contact with the participant.	**H. 1.** Progress notes should be a written chronological record, documented after every significant contact with the participant. Progress notes should document any significant change in physical, behavioral, cognitive and functional condition, and action taken by staff to address the participant's changing needs. Progress notes shall be signed and dated by the author at the time they are written, with at least first initial, last name, degree and or professional credentials.	**Participant's file** contains progress notes which demonstrate compliance.

Requirement	Indicator	Data Source
I. Discharge shall be documented and proper referrals made if applicable.	**I. 1.** Discharge summaries shall be completed as soon as possible after discharge. Records shall contain a written discharge summary to include, but not limited to the following information, where applicable: • reason for admission; • reason for discharge; • primary and significant issues identified during course of services; • diagnoses; • summary of services, progress made, and outstanding concerns; • coordination of care with other service providers; • advance directives developed or initiated during course of services; • summary of medications prescribed during treatment, including the participant's responses to medications; • medications recommended and prescribed at discharge; • summary of legal status throughout the course of services and at time of discharge; • documentation of referrals and recommendations for follow up care; • documentation of the participant's and/or family's response and attitude regarding discharge; and • information regarding the death of the participant.	**Participant's file** will demonstrate compliance with DBH regulations around discharge.
J. Providers will follow ethical and legal requirements.	**J. 1.** Providers will act in accordance with mental health statutes, DORA regulations, and respective provider codes of ethics.	**Participant's file** demonstrates compliance with ethical and legal requirements. **DORA Disciplinary Actions** will be checked to ensure substance abuse professionals are registered with DORA and have not committed any ethical violations.

Requirement	Indicator	Data Source
	J. 2. Confidentiality procedures must be in compliance with Sections 27-65-101. et seq., C.R.S., HIPAA of 1996 and 42 CFR, Part 2.	Provider's policies and procedures demonstrate compliance with Sections 27-65-101. et seq., C.R.S., HIPAA of 1996 and 42 CFR, Part 2.
	J. 3. Standards of supervision will be compliant with DBH regulations or supervisor must have a master's degree in a related field with five years of experience treating substance abuse issues and have training (college or outside) in pharmacology and substance abuse/addition.	Provider's policies and procedures and Personnel file will demonstrate compliance with DBH regulations.

Substance Abuse Services Quality Measures		
Requirement	**Indicator**	**Data Source**
A. Substance Abuse Quality Measures	**SA QM A. 1.** 65 percent of participants, who have a co-occurring mental health diagnosis, self-report engagement in mental health services.	**Participant's file** contains documentation participant self-report of engagement. Appointments canceled a day in advance and rescheduled will not count as missed appointment.
	SA QM A. 4. A minimum of 75 percent of participants will self-report that they are accessing medical care at least every six months.	**Participant's file** documents that medical care was received**.**