Part A
Standards of Care

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Acronyms

ADA	Americans with Disabilities Act
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CAB	Community Advisory Board
CARE Act	Comprehensive AIDS Resources Emergency Act
CBC	Complete Blood Count
CD4	Cluster of differentiation 4
CFR	Code of Federal Regulations
CM	Case Manager
DHHS	Department of Health and Human Services
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
HAB	HIV/AIDS Bureau
HCHS	Home and Community-based Health Services
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HRSA	Health Resources and Service Administration
LTC	Linkage to Care
MCM	Medical Case Management
MDASC	Metro Denver AIDS Services Coalition
MH	Mental Health
MSM	Men who have sex with men
OBH	Office of Behavioral Health
OMB	Office of Management and Budget
PDSA	Plan, Do, Study, Act
PVD	Peripheral Vascular Disease
RSR	Ryan White Services Report
RTD	Regional Transportation District
RW	Ryan White
RWHAP	Ryan White HIV/AIDS Program
SBIRT	Screening, Brief Intervention, and Referral to Treatment
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 processes 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 service category definition, SOC, and unit costs of service on an annual basis. In 2015, MDASC identified SOC that needed revision to comply with changes in State of Colorado behavioral health standards, to resolve service delivery issues, or align with national medical standards of care. Potential changes were generated in workgroups and reviewed by MDASC for content. The Leadership Committee reviewed the revised SOC prior to their placement on the DHRPC meeting agendas to ensure completeness. Final approval for each SOC was obtained in the monthly DHRPC meetings.

Common Standards of Care

Documentation and Eligibility Screening

Standard I: Documentation and Eligibility Screening- Providers must have systems in place that meet the requirements outlined in HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A (April 2013) – Section B. 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.

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.

	• 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 with eligibility determination have participated in a comprehensive training in eligibility determination requirements.	**Personnel file** of all staff involved with eligibility determination demonstrates that he/she has completed a comprehensive training in eligibility determination requirements.
	A. 5. Ensure agency's 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 participant receives 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, and is signed by the participant.

Access to Care

Standard II: *Access to care*- Providers must have systems in place that meet the requirements outlined in HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A (April 2013) – Section A. Participants should be supported in having system-wide access to services and barriers to service should be eliminated.

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 access 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.

	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 provide services to those needing special accommodations.
	A. 5. Provider will ensure that the facility is accessible by public transportation or provides 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 regarding 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.

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; included in file are any complaints from participants, with documentation of complaint review and decision reached.
D. Providers will ensure provision of services regardless 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; included in file are 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**.**
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 (RW) 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 that 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** demonstrates 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.
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 volunteer who transports participants.	**Personnel or Volunteer File** contains a copy of a valid driver’s license for those staff or volunteer who transport participants.

Quality Management

Standard IV: Quality Management: Providers are responsible for ongoing quality management programs to improve funded programs, as well as to offer regular feedback to staff to help promote performance improvement and quality care. Providers must have systems in place that meet the requirements outlined in HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A (April 2013) – Section D.		
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.
	A. 2. Each provider will adopt a quality improvement system (Chronic Care Model, PDSA Cycle, or other) to guide work plans and other quality management activities.	**Provider's Reports** documents the use of a quality improvement system.
B. Each provider will have a Quality Management Plan (Quality resources, example plans, and free web training available at NationalQualityCenter.org).	**B. 1.** Each provider will have a quality plan, which includes: • A quality statement; • Quality improvement infrastructure (how and who); • Performance measures, including but not limited to, all Denver TGA Part A quality measures required for each funded category, and how performance measures will be measured and data collected. • Annual quality goals; • Engagement of stakeholders (e.g. staff, collaborative partners, consumers); • How the plan will be evaluated and revised.	**Provider's Reports** documents the use of a quality plan.
	B. 2. Quality plan is updated annually**.**	**Provider's Reports** document quality plan revisions.
C. Provider will document quality management activities, including at least one quality improvement project focused on evaluating or improving HIV program services.	**C. 1.** Quality management activities (e.g. quality committee meetings, internal quality assurance audits, quality improvement project meetings) will be documented including: • Agenda, • Date of meeting, • Minutes from each meeting, • List of those in attendance.	**Provider's files and reports** document quality management activities.
D. Provider will assure compliance with relevant	**D. 1.** Provider will conduct quality assurance activities as needed to comply	**Provider's files and reports** document quality assurance

Requirement	Indicator	Data Source
service category definitions and TGA SOC.	with Denver TGA SOC.	activities.

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.
	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 agency's facility.
C. All hard copy materials and records shall be securely maintained by the Provider.	**C. 1.** Records and hard copy materials are 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 demonstrate compliance.
D. All participants shall be informed of their confidentiality rights 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 confidentiality rights 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.) Providers must have systems in place that meet the requirements outlined in the HRSA/HAB Divisions of Metropolitan HIV/AIDS Programs & Division of State HIV/AIDS Programs National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal – Part A and B (April 2013) – Section C.		
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.
	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 payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.	**B. 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.
	B. 2. Have employee policies that include: • 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.

Limitations and Unallowable Uses of Part A Funding

<table>
<tr><td colspan="3">Standard VII Limitations on, and Unallowable Uses of Part A Funding: Providers must have systems in place that meet the requirements outlined in the HRSA/HAB Divisions of Metropolitan HIV/AIDS Programs National Monitoring Standards - Fiscal Part A (April 2013), Sections A and B.</td></tr>
<tr><th>Requirement</th><th>Indicator</th><th>Data Source</th></tr>
<tr><td rowspan="2">A. Provider will prepare project budget and track expenses (including administrative expenses) with sufficient detail.</td><td>A. 1. Budget is prepared with sufficient detail to identify administrative expenses.</td><td>Provider's DOHR Contract Budget provides sufficient detail to identify administrative expenses.</td></tr>
<tr><td>A. 2. Expenditures are reported by line item within service category, with sufficient detail, and identify administrative expenses.</td><td>Providers Monthly Invoices to DOHR will provide sufficient detail and supporting documentation.</td></tr>
<tr><td>B. Providers may use indirect costs as part or all of their 10 percent administration costs. To do so, providers must include indirect costs (capped at 10 percent) only where the grantee has a certified DHHS negotiated indirect cost rate using the Certification of Cost Allocation Plan or Certificate of Indirect Costs, which has been reviewed by the HRSA/HAB Project Officer.</td><td>B. 1. Providers who choose to use indirect cost as part or all of their 10 percent administration costs must obtain and keep on file a federally approved DHHS-negotiated Certificate of Cost Allocation Plan or Certificate of Indirect Costs. Provider must submit a current copy of the certificate to the grantee.</td><td>Provider's files contain a current copy of the federally approved DHHS-negotiated Certificate of Cost Allocation Plan or Certificate of Indirect Costs.</td></tr>
<tr><td rowspan="2">C. Providers must ensure that budgets do not include unallowable costs.</td><td>C. 1. Providers will ensure that budgets and expenditures do not include unallowable costs.</td><td>Provider's budgets and financial expense reports will include sufficient detail to document that they do not include unallowable costs.</td></tr>
<tr><td>C. 2. Providers will provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs.</td><td>Provider's budgets and financial expense reports will include sufficient detail to document that they do not include unallowable costs.</td></tr>
<tr><td rowspan="2">D. Providers will not use Part A funds to purchase or improve land, or to purchase, construct, or permanently improve any building or other facility, (other than minor remodeling).</td><td>D. 1. Providers will ensure that budgets and expenditures do not include unallowable costs.</td><td>Provider's budgets and financial expense reports will include sufficient detail to document that they do not include unallowable costs.</td></tr>
<tr><td>D. 2. Providers will provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs.</td><td>Provider's budgets and financial expense reports will include sufficient detail to document that they do not include unallowable costs.</td></tr>
</table>

E. Providers will not provide cash payments to service recipients.	**E. 1.** Providers will ensure that budgets and expenditures do not include unallowable costs.	**Provider's policies** will document the prohibition of the use of RW funds for cash payments to service recipients.
	E. 2. Providers will provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs.	**Provider's policies** will document the prohibition of the use of RW funds for cash payments to service recipients.
	E. 3. Providers will maintain documentation of policies that prohibit use of RW funds for cash payments to service recipients.	**Provider's policies** will document the prohibition of the use of RW funds for cash payments to service recipients.
F. Providers will not use Part A funds to develop materials designed to promote, or encourage, intravenous drug use, or sexual activity, whether homosexual, or heterosexual.	**F. 1.** Providers will ensure that budgets and expenditures do not include unallowable costs.	**Provider's budgets and financial expense reports** will include sufficient detail to document that they do not include unallowable costs.
	F. 2. Providers will provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs.	**Provider's budgets and financial expense reports** will include sufficient detail to document that they do not include unallowable costs.
G. Providers will not use Part A funds to purchase vehicles without written Grants Management Officer approval.	**G. 1.** Providers will ensure that budgets and expenditures do not include unallowable costs.	**Provider's budgets and financial expense reports** will include sufficient detail to document that they do not include unallowable costs.
	G. 2. Providers will provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs.	**Provider's budgets and financial expense reports** will include sufficient detail to document that they do not include unallowable costs.
	G. 3. If vehicle purchase is needed, seek grantee assistance in obtaining written grants management officer approval and maintain document in file.	**Provider's budgets and financial expense reports** will include sufficient detail to document that they do not include unallowable costs.
H. Providers will not use 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, television, or radio public	**H. 1.** Providers will ensure that budgets and expenditures do not include unallowable costs.	**Provider's program plan and budget narrative** will describe planned use of any advertising or marketing activities.
	H. 2. Providers will provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs.	**Provider's program plan and budget narrative** will describe planned use of any advertising or marketing activities.

service announcements, etc.)	**H. 3.** Providers will prepare a detailed program plan and budget narrative that describes planned use of any advertising or marketing activities.	**Provider's program plan and budget narrative** will describe planned use of any advertising or marketing activities.
I. Providers will not use Part A funds for outreach activities that have HIV prevention education as their exclusive purpose.	**I. 1.** Providers will ensure that budgets and expenditures do not include unallowable costs.	**Provider's program plan** will demonstrated how outreach goes beyond HIV prevention education to include testing and early entry into care.
	I. 2. Providers will provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs.	**Provider's program plan** will demonstrated how outreach goes beyond HIV prevention education to include testing and early entry into care.
	I. 3. Providers will provide a detailed program plan of outreach activities that demonstrates how the outreach goes beyond HIV prevention education to include testing and early entry into care.	**Provider's program plan** will demonstrated how outreach goes beyond HIV prevention education to include testing and early entry into care.
J. Providers will not use Part A funds for influencing or attempting to influence members of Congress or other Federal personnel.	**J. 1.** Providers will ensure that budgets and expenditures do not include unallowable costs.	**Provider's personnel manual and employee orientation** will include information on regulations that forbid lobbying with federal funds.
	J. 2. Providers will provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs.	**Provider's personnel manual and employee orientation** will include information on regulations that forbid lobbying with federal funds.
	J. 3. Providers will include in personnel manual and employee orientation information on regulations that forbid lobbying with federal funds.	**Provider's personnel manual and employee orientation** will include information on regulations that forbid lobbying with federal funds.
K. Providers will not use Part A funds for foreign travel.	**K. 1.** Providers will ensure that budgets and expenditures do not include unallowable costs.	**Provider file** will document all travel expenses paid by Part A funds.
	K. 2. Providers will provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs.	**Provider file** will document all travel expenses paid by Part A funds.
	K. 2. Providers will maintain a file documenting all travel expenses paid by Part A funds.	**Provider file** will document all travel expenses paid by Part A funds.

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 HRSA/HAB Divisions of Metropolitan HIV/AIDS Programs National Monitoring Standards - Fiscal Part A (April 2013) – Section C.

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 RW is the payer of last resort. Third party funding sources include: 1. Medicaid, 2. Children's Health Insurance Programs, 3. Medicare (including the Part D prescription drug benefit), and 4. Private insurance.	**A. 1.** Have policies and procedures documenting the requirement that RW be the payer of last resort and how that requirement is met.	**Provider's Policies and Procedures** document the requirement that RW be the payer of last resort and how that requirement is met.
	A. 2. Provide staff training on the requirement that RW be the payer of last resort and how that requirement is met.	**Personnel file** indicates that staff have been trained on RW 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 review of files and billing systems to ensure that RW 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 RW 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.

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 RW-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 HRSA/HAB Divisions of Metropolitan HIV/AIDS Programs National Monitoring Standards - Fiscal Part A (April 2013) – Section D.		
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 manual or electronic medical practice information system.	**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** demonstrate 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 RW services based on percent of patient's annual income.	**C. 1.** Providers must have in place a fee discount policy that caps total annual charges for RW 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; • Seven percent for patients with incomes between 200 percent and 300 percent of FPL; • Ten percent for patients with incomes greater than 300 percent of FPL.	**Provider's Policies and Procedures** document a fee discount policy that caps total annual charges for RW 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; • Seven percent for patients with incomes between 200 percent and 300 percent of FPL; • Ten 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 RW services based on percent of patient's annual income.

Fiscal Management

Standard X Financial Management: Providers must have systems in place that meet the requirements outlined in the HRSA/HAB Divisions of Metropolitan HIV/AIDS Programs National Monitoring Standards - Fiscal Part A (April 2013) – Sections E and F.		
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	**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.

	records, including monitoring and reporting, program performance, financial reports, and retention and access requirements; • Purpose of termination and enforcement and purpose of closeout procedures.	
B. Provider will maintain comprehensive budgets and reports.	**B. 1.** Provider will maintain comprehensive budgets and reports with sufficient detail to account for RW funds by service category, administrative costs and 75/25 rule, and to delineate between multiple funding sources and show program income.	**Provider's Policies and Procedures, Reports, and Accounting System.** The following will be reviewed: • Accounting policies and procedures; • RW 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 the RW program.
	B. 2. Provider will submit a line-item budget with sufficient detail to permit review and assessment of proposed use of funds for the management and delivery of the proposed services.	**Provider's Policies and Procedures, Reports, and Accounting System.** The following will be reviewed: • Accounting policies and procedures; • RW 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 the RW program.
	B. 3. Provider will document all requests for approval of budget revisions.	**Provider's Policies and Procedures, Reports, and Accounting System.** The following will be reviewed: • Accounting policies and procedures; • RW 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 the RW program.
C. Provider must track and report on tangible nonexpendable personal property, including exempt property, purchased directly with RW 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).	**C. 1.** 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.	**Provider's files document the** following: • A current, complete, and accurate asset inventory list; • A depreciation schedule that lists purchases of equipment by funding source
D. Title to supplies to be vested in the recipient upon acquisition, with the provision that if there is a residual inventory of unused supplies exceeding $5,000 in total aggregate value upon termination or completion of the program, and the supplies are not needed for any other federally-sponsored program, the recipient shall: • Retain the supplies for use on non-federally sponsored activities or sell them; • Compensate the federal government for its share contributed to purchase of supplies.	**D. 1.** Provider must develop and maintain a current, complete, and accurate supply and medication inventory list.	**Provider's Policies, Procedures and Reports document** a current, complete, and accurate supply and medication inventory list.

Cost Principles

Standard XI Cost Principles: Providers must have systems in place that meet the requirements outlined in the HRSA/HAB Divisions of Metropolitan HIV/AIDS Programs National Monitoring Standards - Fiscal Part A (April 2013) – Section G.

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.
	A. 2. Ensure fiscal staff familiarity with applicable federal regulations.	**Provider Policies and Procedures and Budgets** will conform to federal cost principles.

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<td rowspan="2">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 Federal cost principles and the terms and conditions of the award. Costs are 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.</td>
<td>B. 1. Providers must have in place policies and procedures to determine allowable and reasonable costs.</td>
<td>Provider's Policy and Procedure will document procedures to determine allowable and reasonable costs.</td>
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<td>B. 2. Providers must have reasonable methodologies for allocating costs among different funding sources and RW categories.</td>
<td>Provider's Policy and Procedure will document methodologies for allocating costs among different funding sources and RW categories.

Make available to the grantee very detailed information on the allocation and costing out of expenses for services provided.</td>
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<td>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 RW 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.</td>
<td>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.</td>
<td>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.</td>
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Auditing Requirements

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<td colspan="3"><u>Standard XII Auditing Requirements.</u> Providers must have systems in place that meet the requirements outlined in the <u>HRSA/HAB Divisions of Metropolitan HIV/AIDS Programs National Monitoring Standards - Fiscal Part A (April 2013) – Section H.</u></td>
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<th>Requirement</th>
<th>Indicator</th>
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<tr>
<td>A. Recipients and sub-recipients of RW funds that are institutions of higher education or other non-profit organizations (including hospitals) are subject to audit</td>
<td>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</td>
<td>Provider Documentation
Provider will submit the audit and management letter to the grantee.

Any reportable conditions will be addressed in DOHR monitoring</td>
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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 $750,000 per year in federal grants.	the auditor; • Submit the audit and management letter to the grantee.	recommendations for the Provider through the Recommended Improvement Plan and/or Compliance Plan.
B. Based on criteria established by the grantee, sub grantees or sub-recipients of RW funds that are small programs (i.e. receive less than $750,000 per year in federal grants) may be subject to audit as a major program (i.e. a program that receives more than $750,000 in aggregate federal funding).	**B. 1.** Provider will: • Prepare and provide auditor with financial and other documents required to conduct a major program audit (e.g. income and expense reports that include payer of last resort verification, timesheets, general ledger, etc.); • Comply with contract audit requirements on a timely basis.	**Provider Documentation** is made available to an auditor in a timely manner.
C. Selection of auditor is based on policies and procedures established by the Board of Directors (if nonprofit).	**C. 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 and will be made available to grantee on request.

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 HRSA/HAB Divisions of Metropolitan HIV/AIDS Programs National Monitoring Standards - Fiscal Part A (April 2013) - Section I.

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; • Are not part of another federal award contribution (unless authorized); • Are part of the approved budget; • Are part of unrecovered indirect cost (if applicable);	**Provider's Financial Documentation** will include and make available for review: • Annual comprehensive budget. • Documentation of all in-kind and other contributions to RW program. • Documentation of other contributed services or expenses.

	• 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 HRSA/HAB Divisions of Metropolitan HIV/AIDS Programs National Monitoring Standards - Fiscal Part A (April 2013) - Section K.

Requirement	Indicator	Data Source
A. Provider has policies and procedures for handling revenues from the RW grant, including program income.	**A. 1.** Establish policies and procedures for handling RW 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.
B. Provider has in place policies and procedures that allow the grantee prompt and full access to financial, program, and	**B. 1.** Policies and procedures are available for review.	**Provider's Policies and Procedures** and access to records will be made available to grantee upon request.

management records and documents as needed for program and fiscal monitoring and oversight.	**B. 2.** Grantee has prompt and full access to financial, program, and management records and documents as needed for program and fiscal monitoring and oversight.	**Provider's Policies and Procedures** and access to records will be made available to grantee upon request.
C. Providers will grant access to payroll records, tax records, and invoices with supporting documentation to show that expenses were actually paid appropriately with RW funds.	**C. 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.
D. Providers will provide timely, properly documented invoices to assist grantee to periodically track the accounts payable process from date of receipt of invoices to date the checks are deposited.	**D. 1.** Provide timely, properly documented invoices.	**Provider's files and documentation** will show invoices are timely and properly documented.
	D. 2. Comply with contract conditions.	**Provider's files and documentation** will show invoices are timely and properly documented.
E. Providers will document employee time and effort, with charges for the salaries and wages of hourly employees.	**E. 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.
F. Provider's fiscal staff have responsibility to: • Ensure adequate reporting, reconciliation, and tracking of program expenditures; • Coordinate fiscal activities with program activities (e.g., the program and fiscal staff's meeting schedule and how fiscal staff share information with program staff regarding	**F. 1.** Providers will maintain: • Program and fiscal staff resumes and job descriptions; • Staffing Plan, 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, grantee budget, and budget justification; • Provider's organizational chart.

contractor expenditures, formula and supplemental unobligated balances, and program income); • Have an organizational and communications chart for the fiscal department.		

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 RW 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:** 2015 Annual RSR Instruction Manual.

Units 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 B.1. to B. 9.	**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** demonstrate an equitable screening process.
	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** demonstrate an accessible program information source.
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** demonstrate 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 assistance.

Case Management

HRSA Service Category Definition: Case management (CM) services (non-medical) include advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments. **Source:** 2015 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.

Requirement	Indicator	Data Source
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.
	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,	**Participant's file** documents referrals made. If the participant refuses the referral, this should be documented.

Requirement	Indicator	Data Source
	medical, medications; • medical self-management; • mental health; • substance abuse; and • housing.	
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.
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. The Individual Service Plan 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.

Requirement	Indicator	Data Source
	F. 6. The Individual Service Plan 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. This reassessment is documented in updates to the Individual Service Plan.	**Participant's file** documents that the Individual Service Plan is updated annually or as indicated by life events.
G. Progress notes shall be completed after every significant contact with the 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	**Participant's file** documents compliance.

Requirement	Indicator	Data Source
	on an "as needed basis." Coordination may take the form of shared service planning, acuity assessment, phone and secure email communication, and case conferences.	
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 were 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.**

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:** 2015 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	**Provider's records** will document linkage agreements.

Requirement	Indicator	Data Source
	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; • RW Part C and D grantees; • Syringe Exchange Programs.	
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** demonstrates 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.

Requirement	Indicator	Data Source
	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** documents 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** documents 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.
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** documents 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** documents 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.

Requirement	Indicator	Data Source
	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 in EIS.	**Participant's file** documents outreach coordination efforts and demonstrate who will work to engage participant. If needed, file will demonstrate that the 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.

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

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 would likely prevent them from continuing to engage in healthcare.	**Participant's file** demonstrates that the participant is eligible for EIS.
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** demonstrates 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** documents initial screening interview and identifies reason for current and possible future disengagement.

Requirement	Indicator	Data Source
	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.
	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.

*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 one-time or 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 under 2.6 in DSS Program Policy Guidance No. 2 (formerly Policy No. 97-02).

It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of RW HIV/AIDS Program funds for these purposes will be the payer of last resort, and for limited amounts, use and periods of time. Continuous provision of an allowable service to a client should be reported in the applicable service category. **Source:** 2015 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 to 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	**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

Requirement	Indicator	Data Source
the maximum amount available for that benefit. EFA funds may not be used for clothing, direct cash payments, or dental, optical or vision care.		vision care. The file has no evidence of direct cash payments to clients.
B. Providers will have structured procedures for participants to gain EFA assistance, deny EFA 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 a plan using 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 involves 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: 2015 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 files** document 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 (home delivered meals, food bank, and food vouchers) are formulated around the participant's specific needs and government standards.	**B. 1.** Income must be at or below 400 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 for participants.	**C. 1.** Food bank hours will be accessible to participants with variable schedules.	**Scope of services description** in contract and posted hours of service.
D. Home delivered meals 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 caloric and nutritional content to meet the individual participant's dietary needs.	**Provider's menus** demonstrate each meal's average caloric and 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:** [2015 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 participant's HIV care and MCM.	**Participant's file** contains a Home Care Plan which is signed by both the participant's clinical health care professional and MCM.
	C. 2. The Home Care Plan should document the projected length of care 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.

Requirement	Indicator	Data Source
	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's needs are met through home care.	**Participant's file** contains Home Care Plan with appropriate goals.
	C. 6. The Home Care Plan contains objectives for each goal, stating how the participant will reach the goal. 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.
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.

Requirement	Indicator	Data Source
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.

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:** 2015 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 to 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.	**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
Important Note: The $400 maximum for hotel stays is **NOT** additional funds; it is the maximum amount available for that benefit.		
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 a plan using 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's 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 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:** [2015 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 while receiving MCM.	**Participant's file** contains Individual Service Plan with appropriate goals.
	F. 5. The Individual Service Plan 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. The Individual Service Plan 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.

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:** 2015 Annual RSR Instruction Manual.

Medical transportation is classified as a support service and is used to provide transportation for eligible RW 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:** 2015 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 (staff, supervisors, contractors and peers) will have a clear understanding of their job definition and responsibilities.	**A. 1.** Evidence of HIV-specific education for each clinical professional staff member managing the clinical care of RW Part A clients.	Employee files
B. Providers will ensure appropriate screening and reassessment of all clients to determine eligibility every six months.	**B. 1.** Verification of the client's HIV status should be from a medical provider (i.e. lab work results or a letter on letterhead signed by medical staff personnel). Verification of the client's residency within the TGA. Client is informed of the client confidentiality and grievance policy at first face to face contact and annually, thereafter.	Client File/Chart
C. Providers of mental health services must have the proper qualification and expertise to deliver services.	**C. 1.** Mental health services can be provided by a psychiatrist, licensed psychologist, licensed psychiatric nurse, licensed clinician, licensed marriage and family therapist, licensed professional counselor, licensed clinical social worker, doctor of philosophy, or doctor of psychology. Mental health services are provided by unlicensed registered clinicians or graduate level student interns with appropriate supervision per licensure or internship regulations.	Staff File/Chart

Requirement	Indicator	Data Source
D. Providers of mental health services will utilize a mandatory disclosure form in compliance with Colorado mental health statutes.	**D. 1.** Therapeutic disclosure will be reviewed and signed by all clients and must be compliant with Colorado Mental Health statutes. At a minimum, the disclosure must include: • therapist's name; • degrees, credentials, certifications, and licenses; • business address and business phone; • DORA description and contact information; • treatment methods and techniques; • option for second opinion; • option to terminate therapy at any time; • statement that in a professional relationship, sexual intimacy is never appropriate and should be reported to DORA; • information about confidentiality and the legal limitations of confidentiality; • space for the client and therapist's signature and date.	Client File/Chart
E. Treatment will be offered in a timely manner.	**E. 1.** Treatment will be offered within 15 business days from the time of referral, if the client is not in crisis. If the client is in immediate crisis, they will be seen immediately or proper referrals will be made.	Client File/Chart
F. A biopsychosocial assessment will begin at the first session and be completed by the second session.	**F. 1.** The biopsychosocial assessment will be completed within the first two sessions for all clients 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; • brief psychosocial history; and • diagnosed mental health illness or condition.	Client File/Chart
G. A mental status exam/assessment will be completed before the fourth session.	**G. 1.** The mental status exam/assessment will be completed within the first three sessions for all clients seeking ongoing treatment.	Client File/Chart

Requirement	Indicator	Data Source
H. Every client shall have a treatment plan which guides their care (non-psychiatric care).	**H. 1.** The treatment plan, based on the biopsychosocial assessment and mental status exam/assessment indicating the client's needs and preferences, will be completed by the fourth session.	Client File/Chart
	H. 2. The treatments plan contains goals which define what the client expects to achieve in the treatment relationship.	
	H. 3. The treatment plan contains objectives for each goal stating how the client will reach the goals. Objectives are measurable, reasonable, and achievable.	
	H. 4. The treatment plan is updated every six months. Reassessments will include client needs, document progress and updates. Treatment plan includes the number and frequency of sessions to be conducted in the next six months.	
	H. 5. The treatment plan contains an estimated discharged date.	
I. Every client shall have a treatment plan which guides their care (psychiatric care).	**I. 1.** The treatment plan, based on the biopsychosocial assessment and mental status exam/assessment indicating the client's needs and preferences, will be completed by the third session and documented in progress notes.	Client File/Chart
	I. 2. The treatment plan contains goals which define what the client expects to achieve in the treatment relationship. Treatment plan contains objectives for each goal stating how the client will reach the goals. Objectives are measurable, reasonable, and achievable.	
	I. 3. Progress notes are updated every visit.	
	I. 4. If prescribing a medication that has the potential to interact negatively with the client's HIV drugs, the reason for this decision is documented and a plan for monitoring of the client's health is included in the treatment plan.	

Requirement	Indicator	Data Source
J. Referrals, made to services related to the service plan, shall be documented and in a timely manner.	**J. 1.** Referrals to qualified practitioners and/or services will occur, if clinically indicated. If the client is in immediate crisis, they will be seen immediately or proper referrals will be made.	Client file/chart
K. Progress notes shall be completed after every contact with the client.	**K. 1.** Progress notes should be a written chronological record, documented at every contact with the client.	Client file/chart
	K. 2. Progress notes should document any change in physical, behavioral, cognitive and functional condition, and action taken by staff to address the clients changing needs.	
	K. 3. 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.	
L. Upon termination of active Mental Health services, a client case is closed and contains a closure summary documenting the case disposition.	**L. 1.** Discharge summaries shall be completed within five business days after discharge and documented in progress notes. Records shall contain a written discharge summary to include, but not limited to the following information, <u>where applicable:</u> • 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 clients responses to medications; • medications recommended and prescribed at discharge; • documentation of referrals and recommendations for follow up care; • information regarding the death of the client.	Client file/chart

Requirement	Indicator	Data Source
M. Providers will assess client adherence to mental health services.	**M. 1.** Providers will document appointment adherence and monitor clients for participation in mental health services. A list of appointments and "no-show" should be documented.	Client file/chart
N. Provider will assess client adherence to HIV medical appointments.	**N. 1.** Providers will document appointment adherence to HIV medical appointments. Documentation of at least one medical visit every 12 months will be documented.	Client file/chart
O. Provider will assess client adherence to HIV medications.	**O. 1.** Provider will document medication adherence to HIV medications.	Client file/chart

Oral Health Care

HRSA Service Category Definition: Oral health 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:** 2015 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.

Requirement	Indicator	Data Source
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 unnecessary 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 a timely manner and documents 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.
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.

Requirement	Indicator	Data Source
	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.
	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.

Requirement	Indicator	Data Source
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.
	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.

Outpatient Ambulatory Medical Care[2]

HRSA Service Category Definition: Outpatient/ambulatory medical care includes 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 who is certified in their jurisdiction to prescribe antiretroviral therapy in an outpatient setting. 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

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

and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **Source:** 2015 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 Referenced by DHHS as Primary Care Guidelines and the Infectious Disease Society of America.	**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 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. Practices should ensure access to providers with HIV expertise sufficient to meet the needs of their patients. 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.
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), how to schedule appointments, and 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

Requirement	Indicator	Data Source
		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 HIV diagnosis or unknown; duration of HIV infection; 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; psychiatric history; history of latent tuberculosis and/or last screening test; status of vaccines, including tetanus, pneumococcal, hepatitis A and B, HPV, influenza, meningococcal, varicella zoster; last eye exam; last oral exam; current medications and supplements (prescription and over-the-counter); allergies; assessment for substance use including tobacco; sexual history; high risk behaviors; race and ethnicity; sex and sexual identity; birthplace and travel history; diet and exercise; housing status; employment status; plans for having children; significant family medical history; depression screening; domestic violence screening; relationship status; disclosure of HIV status to partner; social support. For pediatric patients: maternal obstetric and birth history, legal guardianship for minors. See additional detail in Appendix A.	**Patient's file** will contain a comprehensive HIV-related history.
E. Clinicians should perform a **baseline review of systems,** comprehensive physical examination, and follow up examinations when appropriate.	**E. 1.** A complete review of systems with special attention to HIV-related issues should be performed. 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); skin; lymph	**Patient's file** will contain documentation of a comprehensive HIV-related exam at baseline.

Requirement	Indicator	Data Source
	nodes; abdominal exam; anogenital exam; breast and pelvic exam (women); neuropsychiatric exam. See additional detail in Appendix B.	
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); 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). Additional details in Appendix C	**Patient's file** will contain documentation of laboratory assessments and screening tests 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.
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. For all patients: annual blood pressure check; fasting glucose; fasting lipids. Consider annual digital rectal exam. CD4 and HIV viral load as clinically indicated – often every 6 months. Annual depression screening. STI screening: • syphilis screening annually for all sexually active, more frequently at high risk; • Chlamydia trachomatis screening annually for all women greater than 15 and less than 25; sexually active MSM and high risk women greater than 25 years;	**Patient's file** will contain documentation of laboratory assessments and screening tests 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
	• gonorrhea screening annually for sexually active MSM and high-risk women. Women of child-bearing age should be routinely assessed for their plans regarding pregnancy. Targeted age and gender appropriate cancer screening and additional periodic screenings for high risk patients are also recommended. See details in Appendix D.	
I. Clinicians should perform interval visits to monitor care every six months for clinically stable patients and more frequently 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 ART, 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 ART 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 ART. The clinician should review the benefits and risks of treatment for each individual patient.	**Patient's file** will demonstrate that if ART is chosen that it is done so being consistent with current ART 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.

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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. **Source:** 2015 Annual RSR Instruction Manual.

Unit of Service: 1 unit = Individual or group encounter

Clarification of Service Category: Psychosocial Support Services are offered as one-on-one sessions or in a group setting for people living with HIV and affected individuals (partners, friends, and/or family of a person living with HIV) to enhance social support, self-efficacy, self-advocacy, and reduce social isolation. One-on-one or group sessions are not intended to address highly complex behavioral health or case management issues. If these arise, then referrals should be made to more appropriate services.

Requirement	Indicator	Data Source
A. Psychosocial providers may offer individualized sessions to reduce the participant's sense of social isolation.	**A. 1.** Psychosocial support participants will receive one-on-one sessions to: a) Develop and enhance social and communication skills; b) improve sense of self efficacy; c) improve self-advocacy skills; d) improve coping skills; and e) reduce feelings of social isolation and stigma.	Providers will document one-on-one support services in the client file. Documentation includes: date of encounter, duration, topics discussed, and activities conducted during one-on-one sessions.
B. Psychosocial providers may conduct group sessions to reduce the participant's sense of social isolation.	**B. 1.** Psychosocial group participants will receive group sessions to: a) Develop and enhance social and communication skills; b) improve sense of self efficacy; c) improve self-advocacy skills; d) improve coping skills; and e) reduce feelings of social isolation and stigma.	Providers will maintain group records which include: dated sign-in sheets; number of participants attended; name and title of group facilitators; location of group; copies of materials or handouts; summary of topics discussed; and activities conducted during group sessions.
C. Psychosocial support sessions will have established ground rules to guide behavior, discussion, and ensure a safe environment.	**C. 1.** Facilitator(s) and session participants will develop and use ground rules, that at a minimum cover: confidentiality, safety, interpersonal relations, preferred communication styles, grievance procedures, description of session (what it is and what it is not), and mandatory reporting, if applicable.	Providers will maintain a copy of the ground rules with the sessions' records.

Requirement	Indicator	Data Source
	C. 2. Ground rules are in written form and verbally discussed at each session.	Providers will maintain a copy of the ground rules with the sessions' records.
D. The structure, content and logistics of psychosocial support groups will be based on the participants' needs and interests identified through formative evaluation or group discussion.	**D. 1.** To ensure groups are responsive to the needs of clients, facilitator(s) and/or agency should conduct formative evaluations or group discussions which consider the following: a) location, b) length of meeting, c) time of day, d) meeting frequency, e) minimum and maximum number of participants, f) topics of conversation, g) meeting content, h) meeting structure, i) ground rules, j) need for supplemental media or other resources to enhance content, k) need for transportation, food or child care, l) if applicable, how to recruit new members, m) if applicable, when and how to end the group, if no longer needed, n) whether affected individuals and/or partners are permitted to attend the group sessions.	Formative evaluation findings or minutes of discussion on the group's structure, content and logistics are on file at the provider's agency and made available to participants.
E. Psychosocial support sessions may be open for people living with HIV regardless of whether they are current service recipients at the agency providing the service.	**E. 1.** Psychosocial support providers will collaborate with DOHR to develop policies and procedures to comply with eligibility criteria but also permit attendance for people living with HIV and affected individuals in need of social support.	Provider's policies and procedures describe how eligibility will be determined for participants and how service utilization will be documented.
F. Psychosocial service providers may develop up-to-date, medically accurate print or electronic media for people living with HIV that supplement session.	**F. 1.** Medical information included in print or electronic media will be reviewed by a medical professional for accuracy and linkage to support group content.	Programs will maintain the following required documentation for print or electronic media for review at site visit: copies of media produced and number distributed.

Requirement	Indicator	Data Source
G. Wrap-around services may be used to enhance participation in one-on-one or group sessions.	**G. 1.** Psychosocial service providers may provide food, transportation, or child care to enhance participation in one-on-one or group sessions.	Providers will document the use of food, transportation, or child care in the sessions' records, and as documented in the budget.
H. Facilitators will receive ongoing orientation, training, supervision and clinical supervision.	**H. 1.** Facilitators will be given orientation prior to providing services.	Orientation curriculum on file at provider agency and evidence that the facilitators received training.
	H. 2. All facilitators will be supervised by qualified program staff.	Evidence that facilitators received supervision and evidence of facilitators' application.
	H. 3. Supervisor routinely evaluates psychosocial services.	Signed and dated form on file that outlines responsibilities, obligations, and liabilities of each facilitator.
	H. 4. Facilitators will receive training so they can help participants improve their communication skills, sense of self efficacy, self-advocacy, coping skills, and reduce feelings of social isolation and stigma. Trainings to be considered include: HIV 101; legal and ethical issues, including discrimination; facilitator self-care; referrals; stigma; boundaries; crisis management; safety; use of self; conflict management; coping skills; facilitation and group process; and communication skills.	Provider will have on file evidence of facilitators' training, such as date of training or certificate.
I. It is recommended that sessions should be facilitated by trained peer and trained professional (master's level preferred), It is encouraged that facilitators be reimbursed for their time and at least one facilitator be living with HIV.	**I. 1.** The facilitator(s) are culturally aware and have training or experience in group process, facilitation and communication skills.	Personnel file demonstrates facilitators' experience and/or training.

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. They include limited support of acupuncture services to HIV-positive clients, provided the client has received a written referral from his or her primary health care provider and the service is provided by certified or licensed practitioners and/or programs, where ever State certification or licensure exits. **Source:** 2015 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 (e.g., suboxone, buprenorphine, naloxone, methadone, naltrexone)
- Neuro-psychiatric pharmaceuticals; and
- Relapse prevention

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 (staff, supervisors, contractors and peers) will have a clear understanding of their job definition and responsibilities.	**A. 1.** Evidence of HIV-specific education for each clinical professional staff member managing the clinical care of clients.	Employee files
B. Providers will perform appropriate screening and reassessment of all clients to determine eligibility every six months.	**B. 1.** Verification of the client's HIV status should be from a medical provider (i.e. lab work results or a letter on letterhead signed by medical staff personnel). Verification of the client's income and residency within the TGA. Client is informed of the client confidentiality and grievance policy at first face to face contact.	Client File/Chart

Requirement	Indicator	Data Source
C. Providers of substance abuse services must have the proper qualification and expertise to deliver services.	**C. 1.** In order to practice as a substance abuse counselor, one must qualify to perform the service under current OBH regulations. Psychiatric services must be provided by a psychiatrist or licensed psychiatric nurse.	Staff File/Chart
D. Standards of supervision will be in compliance with Office of Behavioral Health (OBH) regulations.	**D. 1.** Standards of supervision will be in compliance with OBH regulations (Sections 21.330.1; 21.330.7; 21.330.71; 21.330.72; 21.330.73; 21.330.74).	Provider policy and procedures.
E. Providers of Substance Abuse Services will utilize a mandatory disclosure form in compliance with Colorado mental health statutes.	**E. 1.** Therapeutic disclosure will be reviewed and signed by all clients and must be compliant with the Colorado Mental Health statutes. At a minimum, the disclosure must include: • therapist's name; • degrees, credentials, certifications and licenses; • business address and business phone; • OBH description and contact information; treatment methods and techniques; • options for second opinion; • option to terminate therapy at any time; • statement that in a professional relationship, sexual intimacy is never appropriate and should be reported to OBH; • information about confidentiality and the legal limitations of confidentiality; • space for the client and therapist's signature and date.	Client File/Chart
F. Treatment will be offered in a timely manner.	**F. 1.** Treatment will be offered within 15 business days from the time of referral, if the client is not in crisis. If the client is in immediate crisis, they will be seen immediately or proper referrals will be made.	Client File/Chart

Requirement	Indicator	Data Source
G. A comprehensive evidence-based or best practices assessment shall be completed upon admission and no later than seven business days of admission into services.	**G. 1.** Assessment will be completed upon admission and no later than seven business days of enrollment into services. The file contains an assessment completed in compliance with OBH regulations. The assessment shall be documented in the client record, and at a minimum include the following information, where 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 client 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	Client File/Chart

Requirement	Indicator	Data Source
	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	
H. An initial Service Plan shall be developed with the client following an identified assessment(s).	**H. 1.** Initial Service Plan is based on the assessment.	Client File/Chart
	H. 2. Initial Service Plan identifies: type of services, frequency of services, and duration of services.	
	H. 3. An initial service plan shall be formulated to address the immediate needs of the client and referrals are initiated within twenty-four hours of assessment.	
	H. 4. The service plan shall be developed no later than 15 business days after assessment and signed by both clinician and client.	
	H. 5. Service plans include specific and measurable goals based on the assessment.	
	H. 6. Service plans contain specific, measurable, attainable objectives that relate to the goals and have realistic expected date(s) of achievement.	
	H. 7. Service plans include appropriate referrals to qualified practitioners when co-occurring disorders are identified.	

Requirement	Indicator	Data Source
I. All service plans will be updated and reviewed on a regular basis.	**I. 1.** Service plan revisions shall be completed and documented when there is a change in the clients' level of functioning or service needs and no later than: • Opioid Medication Assisted Treatment: every three months; • Outpatient: every six months.	Client File/Chart
	I. 2. The service plan review shall include documentation of: progress made in relation to planned treatment outcomes and any changes in the client's treatment focus.	
	I. 3. If prescribing a medication that has the potential to interact negatively with the client's HIV drugs, the reason for this decision is documented and a plan for monitoring of the clients health is included in the treatment plan, if clinically indicated.	
J. Referrals made to services related to the service plan shall be documented and in a timely manner.	**J. 1.** Referrals to qualified practitioners and/or services will occur, if clinically indicated. If the client is in immediate crisis, they will be seen immediately or proper referrals will be made.	Client file/chart
K. Progress notes shall be completed after every contact with the client.	**K. 1.** Progress notes should be a written chronological record, documented after every contact with the client.	Client file/chart
	K. 2. Progress notes should document any change in physical, behavioral, cognitive and functional condition, and action taken by staff to address the clients changing needs.	

Requirement	Indicator	Data Source
	K. 3. 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.	
L. Discharge shall be documented and proper as applicable.	**L. 1.** Discharge summaries shall be completed as soon as possible after discharge. The agency's policy and procedures shall determine the minimum timeframe for completions. (OBH rule 21.190.62) 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 client'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 client's and/or family's response and attitude regarding discharge; • information regarding the death of the client.	Client file/chart

Requirement	Indicator	Data Source
M. Providers will assess client adherence to substance abuse treatments.	**M. 1.** Providers will document appointment adherence and monitor clients for participation in substance abuse services. A list of appointments and "no-shows" should be documented.	Client file/chart
N. Providers will assess client adherence to HIV medical appointments.	**N. 1.** Providers will document adherence to HIV medical appointments. Documentation of at least one medical visit every 12 months will be documented.	Client file/chart
O. Providers will Document whether client is taking their medication and whether their substance abuse may be a barrier to adherence.	**O. 1.** Providers will document medication adherence to HIV medications. A current list of all HIV medications will be listed and updated as needed.	Client file/chart
P. Providers will assess client HIV medications.	**P. 1.** Providers will document HIV medications. A current list of all HIV medications will be listed and updated as needed.	Client file/chart

Attachments

Appendix A: Baseline HIV History

Past history

- HIV diagnosis: how, where, when, and why was diagnosis was made
- Duration of infection: dates of prior negative tests and/or diagnosis and/or symptoms of acute retroviral syndrome
- HIV-related conditions: infections, malignancies, or other conditions potentially related to HIV (eg, thrush, oral hairy cell leukoplakia, herpes zoster, cervical or anal cancer or dysplasia, *Pneumocystis* pneumonia, or other opportunistic infections, Kaposi sarcoma, lymphoma, neuropathy, anemia, neutropenia, thrombocytopenia [115], and neurocognitive impairment)
- HIV medications: prior use of antiretroviral therapy including prevention for mother-to-child transmission or pre-/postexposure prophylaxis, including specific drugs, duration of therapy, complications or side effects, drug resistance, virologic response, and adherence
- Comorbidities: history of and risk factors for coronary heart disease, dyslipidemia, diabetes mellitus, kidney disease, and osteoporosis
- Psychiatric history: treatment for or symptoms of depression, anxiety, suicidal ideation, or posttraumatic stress disorder: psychiatric hospitalizations
- Sexually transmitted diseases: gonorrhea, chlamydia, pelvic inflammatory disease, chancroid, syphilis, herpes simplex virus, viral hepatitis, HPV, and trichomoniasis, including treatment history and outcome
- Women: gynecologic and obstetric history, plans for future pregnancy, birth control practices, last Pap test, abnormal Pap test ever menstrual history, mammogram (if applicable)
- Pediatric: maternal obstetric and birth history, exposure to perinatal antiretroviral, exposure to infectious diseases, growth and development
- Healthcare maintenance:
  - Latent tuberculosis: history of tuberculosis or tuberculosis exposure and last screening test for latent tuberculosis, with treatment if applicable
  - Immunization history: childhood vaccination, dT or Tdap, hepatitis A and B, HPV, influenza meningococcal, pneumococcal, varicella zoster, and travel vaccinations
  - Last eye exam, including dilated funduscopic exam
  - Last dental visit
- Past medical history: include any hospitalizations, surgeries, blood product receipt not mentioned above
- Family medical history: diabetes, early heart disease, hypertension, cancer

Social history

- Race and ethnicity
- Sex and sexual identity
- Health-related behaviors: tobacco, alcohol, and drug use
- Patient birthplace, residence, and travel history
- History of receipt of blood products, organ transplant, or semen donation
- Employment history
- Pets, diet, and exercise
- Establish mode(s) of infection:
  - Sexual contacts (men, women, both), types of activity, condom use
  - History of injection drug use, shared needles/syringes.
  - History of transfusion or receipt of blood products, especially during 1975–1985. Artificial insemination by an unidentified donor
- Review specific sexual practices, including exposure sites
- Marital/relationship status, partner's health and HIV status, and his or her access to healthcare, including HIV testing, and disclosure of HIV status to partner(s)
- Social support and participation in support groups
- For minors, review legal guardianship

Allergies

Dates and types of reactions.

Medications

- Current medications, including over-the-counter medications
- Use of complementary or alternative therapy or treatment

Abbreviations: HPV, human papillomavirus; HIV, human immunodeficiency virus; dT, diphtheria-tetanus; dTap, tetanus, diphtheria, and pertussis.

Appendix B: Initial Review of Systems and Physical Exam

Initial Assessment—Review of Symptoms	Initial Assessment—Physical Examination
A complete review of systems with special attention to the areas listed below: • General: unexplained weight loss, night sweats, fever, changes in body habitus • Skin: skin discoloration, rash, ulcers, or lesions • Lymph nodes: localized or generalized enlargement of lymph nodes • Eyes: vision change or loss • Mouth: gum disease, ulcers, oral lesions or pain • Cardiopulmonary: chest pain, shortness of breath, palpitations, wheezing, dyspnea, orthopnea • Gastrointestinal: diarrhea, nausea, pain • Endocrinology: symptoms of hyperglycemia, thyroid disease, hypogonadism • Neurologic and psychiatric: persistent and severe headaches, memory loss, loss of concentration, depression, apathy, anxiety, mania, mood swings, lower extremity paresthesias, pain, or numbness, paralysis or weakness, cognitive difficulties, dizziness, seizures, sleep disorders • Genitourinary: dysuria, urethral or vaginal discharge or lesions, hematuria • Orthopedic: hip pain, joint pain, fractures, diagnosis of or risk factors for osteopenia/osteoporosis • Developmental milestones: for infants and young children assess for motor or speech delays	A complete physical examination should be performed on all patients. Additionally, special attention should be paid to the following areas: • Vital signs: including height and weight • General: including body habitus, evidence of obesity, wasting, lipodystrophy, assessment of frailty, and ambulatory ability • Skin: seborrheic dermatitis, ecchymoses, purpura, petechiae, Kaposi sarcoma, herpes simplex or zoster, psoriasis, molluscum contagiosum, onychomycosis, folliculitis, condylomata, cutaneous fungal infections • Lymph nodes: generalized or localized lymphadenopathy • Eye: retinal exudates or cotton wool spots, hemorrhages, pallor, icterus • Oropharynx: oral hairy leukoplakia, candidiasis (thrush, palatal erythema, angular cheilosis), aphthous ulcers, gingivitis, periodontal disease, Kaposi sarcoma, tonsillar or parotid gland enlargement • Cardiovascular: heart exam, peripheral pulses, presence/absence of edema • Chest: lung examination • Breast: nodules, nipple discharge • Abdomen: hepatomegaly, splenomegaly, masses, tenderness • Genitourinary: ulcers, warts, chancres, rashes, abnormal gynecologic exam, discharge • Anorectal: ulcers, warts, fissures, internal or external hemorrhoids, masses, Kaposi sarcoma • Neuropsychiatric: depression, mania, anxiety, signs of personality disorder, difficulties in concentration, attention, and memory, signs of dementia, speech problems, gait abnormalities, focal deficits (motor or sensory), lower extremity vibratory sensation (distal sensory neuropathy, abnormal reflexes)

Appendix C: Initial Laboratory and Screening

Test	Comment(s)
HIV-disease specific tests	
HIV serology	If diagnosis not previously confirmed and viral load low or undetectable
CD4 cell count and percentage	Assess urgency of antiretroviral therapy and need for OI prophylaxis
Plasma HIV RNA (viral load)	
HIV resistance testing	Genotype preferred for antiretroviral-naive patients or patients not on therapy
HIV-related tests in selected patients	
Coreceptor tropism assay	If use of CCR5 antagonist being considered
HLA B*5701	If use of abacavir being considered
Other laboratory tests	
Complete blood cell count with differential	
Alanine aminotransferase, aspartate aminotransferase, total bilirubin, alkaline phosphatase	Assess for evidence of liver damage, hepatitis, or systemic infection (eg, elevated alkaline phosphatase with some OIs)
Total protein/albumin	High total protein common with untreated HIV infection due to increased immunoglobulin fraction secondary to B-cell hyperplasia; low albumin may indicate nutritional deficiency or nephrotic syndrome
Electrolytes, blood urea nitrogen/creatinine	Assess kidney function; use creatinine to calculate estimated GFR. May consider calcium, magnesium, and phosphorous
Fasting lipid profile and blood glucose	Hemoglobin A1c may be measured
Urinalysis	Assess for evidence of proteinuria, hematuria
Coinfection and comorbidity laboratory tests	
CMV screening	Anti-CMV IgG for patients at low risk of CMV infection
Gonorrhea, chlamydia screening	NAAT testing (preferred) or culture with sites based on exposure history (eg, urine, urethral, vaginal, cervical, rectal, oropharyngeal)
Syphilis screening	Using local protocol (either RPR or treponemal-specific antibody tests)
Screening for latent *Toxoplasma gondii* infection	Anti-*Toxoplasma* IgG
Screening for latent *Mycobacterium tuberculosis* infection	Tuberculin skin test or IGRA. IGRA preferred if history of BCG vaccination.
Varicella virus screening	Anti-varicella IgG if no known history of chickenpox or shingles
Viral hepatitis screening	HBsAg, HBsAb, anti-HBc, HCV antibody, HAV total or IgG antibody. (If HbsAg$^+$, order HBV RNA level; if HCVAb$^+$, order HCV RNA level and HCV genotype)
Tests that may be performed under certain circumstances	
Chest radiography	For patients with evidence of latent *M. tuberculosis* infection. Consider in patients with underlying lung disease for use as comparison in evaluation of future respiratory illness
Cytology: Pap test	Cervical; anal if indicated. Abnormal results require follow-up with colposcopy and high-resolution anoscopy, respectively
Glucose-6-phosphate dehydrogenase	Screen for deficiency in appropriate racial or ethnic groups to avoid use of oxidant drugs
HSV type-specific antibody screening (blood)	HSV-1 and HSV-2 type-specific antibody tests are available (not routinely recommended)
Serum testosterone level	In males with fatigue, weight loss, loss of libido, erectile dysfunction, or depression or who have evidence of reduced bone mineral density. Morning free testosterone preferred.
Trichomoniasis screening	In all HIV$^+$ women

Abbreviations: anti-HBc, hepatitis B core antibody; CMV, cytomegalovirus; HAV, hepatitis A virus; HBsAb, hepatitis B surface antibody; HBsAg, hepatitis B surface antigen; HCV, hepatitis C virus; HSV, herpes simplex virus; HIV, human immunodeficiency virus; GFR, glomerular filtration rate; IgG, immunoglobulin G; IGRA, interferon-γ release assay; NAAT, nucleic acid amplification test; OI, opportunistic infection; RPR, rapid plasma reagin.

Appendix D: Periodic Monitoring and Health Maintenance

Intervention	Recommendation	Comments
Blood pressure check	Perform annually in all patients	
Digital rectal exam	Consider annually in all patients	Inspect for anal warts, malignancy, prostate abnormalities in men
Ophthalmologic exam	Perform dilated exam every 6–12 mo in patients with a CD4 count <50 cells/μL	Exam with tonometry is advised every 2-3 y in all patients ≥50 y
Depression screening	Perform annually in all patients	Use conventional mental health interview or standardized test
Fasting glucose and/ or HbA1c	Perform every 6–12 mo in all patients	Consider testing 1–3 mo after starting or modifying antiretroviral therapy. HbA1c may be used for screening. Consider threshold cutoff of 5.8%. HbA1c level should be performed every 6 mo in patients with diabetes mellitus
Fasting lipid profile	Perform every 6–12 mo in all patients	Consider testing 1–3 mo after starting or modifying antiretroviral therapy
Syphilis serology	Perform annually in patients at risk for STDs	More frequent testing may be indicated in patients at high risk for STDs
Gonorrhea and chlamydia testing	Perform annually in patients at risk for STDs (see text for details)	More frequent testing may be indicated in patients at high risk for STDs. Repeat testing 3 mo later if positive
Hepatitis C testing	Perform annually in patients at risk, eg, injection drug users and MSM	More frequent testing may be indicated in patients at high risk, especially if increase in serum transaminases
Trichomoniasis	Perform annually in all women	Repeat testing 3 mo later if positive
TST or IGRA	Perform at baseline and annually in patients at risk for tuberculosis	No need to repeat in patients with prior positive TST; additional tuberculosis testing may be indicated depending on potential exposure
Colorectal cancer screening	Perform at age 50 y in asymptomatic patients at average risk	More frequent testing is indicated in patients with a history of adenomatous polyps; testing at an earlier age may be advised in patients with a strong family history of colon cancer
Mammography	Perform annually in all women age ≥50 y	Some authorities advise initiation of screening starting at age 40 y based on an individual risk/benefit assessment
Cervical Pap smear	Perform annually in all women after 2 normal Pap tests documented during the first year following HIV diagnosis	
Bone densitometry	Perform baseline exam in postmenopausal women and men age ≥ 50 y	Detection of premature bone loss requires periodic monitoring thereafter; risk factors for premature bone loss include white race, small body habitus, sedentary lifestyle, cigarette smoking, alcoholism, phenytoin therapy, corticosteroid therapy, hyperparathyroidism, vitamin D deficiency, thyroid disease, and hypogonadism
Abdominal ultrasonography	Perform once in men aged 65–75 y who have ever smoked	Screening test for abdominal aortic aneurysm
Patient education	Address regularly in all patients	Issues may include sexual behavior, alcohol and drug counseling, dietary teaching, weight reduction, smoking cessation, and seat belt use.

For information on digital prostate exam, prostate specific antigen, colonoscopy and mammography, see the United States Preventive Services Task Force (http://www.ahrq.gov/clinic/USpstfix.htm).

Abbreviations: HbA1c, hemoglobin A1c; HIV, human immunodeficiency virus; IGRA, interferon-γ release assay; MSM, men who have sex with men; STD, sexually transmitted disease; TST, tuberculin skin test.