DENVER HIV RESOURCES PLANNING COUNCIL
www.dhrpc.org

Denver Transitional Grant Area

Standards of Care
Unit Costs of Service
Quality Management Indicators

Ryan White HIV/AIDS Treatment Modernization Act Part A
Funded Service Categories

Prepared By:
Metro Denver AIDS Services Coalition
Denver HIV Resources Planning Council

Fiscal Year – 2012
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TABLE OF CONTENTS

Document Amendments 2

Acronyms 3

Introduction 4

Common Standards of Care 5

AIDS Pharmaceutical Assistance (local) 32

Early Intervention Services 35

Emergency Financial Assistance 45

Food Bank/Home Delivered Meals 47

Home and Community – Based Health Services 49

Housing Services 53

Medical Case Management 55

Medical Transportation Services 58

Mental Health Services 59

Oral Health Care 65

Outpatient/Ambulatory Medical Care 69

Substance Abuse Services Outpatient 78

Appendix: Directive Funded Categories

- Drug Reimbursement 82
- Housing Services: Recently Released Incarcerated RRI Screening Tool 85

Appendix: Unfunded Services

- Health Insurance Premium and Cost Sharing Assistance 89
- Home Health Services 93
- Substance Abuse Services Inpatient 96

Document Amendments

Listed below are the amended standards modified for each fiscal year, to view a more in depth description of the amendments view the process summary.

View the 2011 Process Summary

2011	2012	2013
Amended February 11, 2011 Amended (page 92) March 2011 Amended Document April, 2011 (Removed NMCM and Added Current Substance Abuse Outpatient) Amended August 2011, Common Standards Amended August 2011, EFA Amended August 2011, HIPCSA Amended August 2011, MCM Amended August 2011, MHS Amended August 2011, Oral Health Amended August 2011, Substance Abuse (out) Amended August 2011, EIS Amended August 2011, Home and Community		

ACRONYMS

ADAD	Alcohol and Drug Abuse Division
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
CAC	Certified Addictions Counselor
CARE Act	Comprehensive AIDS Resources Emergency Act
CBI	Colorado Bureau of Investigations
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CM	Case Manager
DORA	Department of Regulatory Agencies
FB	Food Bank
HDM	Home Delivered Meals
HIV	Human Immunodeficiency Virus
ID	Infectious Disease
MDASC	Metro Denver AIDS Services Coalition
QM	Quality Management
Ryan White HIV/AIDS Program	The Ryan White HIV/AIDS Treatment Modernization Act
SOC	Standards of Care
TGA	Transitional Grant Area
UCS	Unit Cost of Service

INTRODUCTION

Purpose

This document was prepared by the Metro Denver AIDS Services Coalition (MDASC). MDASC is a committee of the Denver HIV Resources Planning Council with an open membership consisting of Ryan White HIV/AIDS Treatment Modernization Act Part A funded service providers and participants. This document was established to:

- Define standards of care, unit costs, and quality management indicators for Ryan White HIV/AIDS Treatment Modernization Act Part A funded service categories.

- Provide the Mayor's Office of HIV Resources with information to assist in evaluating services funded through the Ryan White HIV/AIDS Treatment Modernization Act Part A.

Definition of *Standard of Care*

The minimum level or standard of care that agencies must follow in the provision of Ryan White HIV/AIDS Treatment Modernization Act Part A funded services.

Definition of *Unit Cost of Service*

The unit of service indicates how providers define how many service units are delivered to a participant for billing and documentation purposes.

Definition of *Quality Management Indicator*

An indicator is a measure used to determine, over time, an organization's performance of a particular element of care.

Review of *the Document*

MDASC reviews the standards of care, unit costs of service, and quality management indicators on an as needed basis through a sub-committee structure. Revisions are endorsed by the entire committee and final approval is obtained from the Denver HIV Resources Planning Council.

Common Standards of Care

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

Requirement	Indicator	Data Source
Providers will ensure appropriate screening and reassessment of all participants to determine eligibility.	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.
	Participant must qualify as low income, less than or equal to 400 percent of Federal Poverty Level. [2]	**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.
	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 "payor 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] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part I: Universal Standards (Draft August 2010)-Section B; RW Part B 2616(B): Part A and B Guidance

[2] 400% is not proscribed by HRSA. This number was chosen to match the current Part B income limit for insurance and ADAP.

Requirement	Indicator	Data Source
	Participant can demonstrate residence within the Denver Transitional Grant Area (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.
	Document that all staff involved in eligibility determination have participated in a comprehensive training in eligibility determination requirements.	**Personnel file** of all staff involved in eligibility determination demonstrates that he/she has completed a comprehensive training in eligibility determination requirements.
	Ensure agency client level data reporting is consistent with funding requirements, and demonstrates that eligible participants are receiving allowable services.	**Participant's file and CAREWare** data demonstrate that participants receive only allowable services.
Every participant's legal name will be documented and used in the creation of the eURN in CAREWare.	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.
Every participant file will have documentation of a Signed Grievance Procedures.	Each participant should sign the provider's grievance procedure.	**Participant's file** contains a copy of the grievance procedure, or other documentation that the participant has received the procedures, is signed by the participant.

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

Requirement	Indicator	Data Source
Providers shall eliminate barriers to service and ensure provision of services in a setting accessible to low-income individuals with HIV.	Medical care, pharmaceuticals, case management and home health care shall provide a minimum of 40 hours access to services per week including after 5:00 p.m. and weekends as appropriate.	**DOHR Contract** will include the Scope of service description, and the hours of service will be posted in a prominent place within the agency.
	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.
	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.
	Appropriate accommodations shall be made to meet language or other needs such as illiteracy, visual or hearing impairment.	**Provider's Policies and Procedures** demonstrate how they provided services to those needing special accommodations.
	Provider will ensure that the facility is accessible by public transportation or provide for transportation.	**Site visit** inspection of agency facility.

[3] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part I: Universal Standards (Draft August 2010)-Section A; RW Part A 2605 (a)(7)(A-C); RW Part B 2617 (b)(7)(B)(i-iii); RW Part B ADAP 2616(c)(4-5); 2602(b)(2)(G); 2617(b)(7)(A)

Requirement	Indicator	Data Source
	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.
Provider shall implement structured and ongoing efforts to obtain input from participants in the design and delivery of services.	Provider will maintain file of materials documenting Consumer Advisory Board (CAB) membership and meetings, including minutes.	**Provider's Files** demonstrate CAB membership and meeting minutes.
	Provider will maintain visible suggestion box or other participant input mechanism.	**Site visit** inspection of agency facility.
	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.
Provider shall allow for the provision of services regardless of an individual's ability to pay for the service.[4]	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.

[4] Confirm that this is limited by the income guidelines in the Eligibility Standard.

Requirement	Indicator	Data Source
	Provider will maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from participants, with documentation of complaint review and decision reached.	**Provider's files** will document individuals refused services with reasons for refusal specified; include in file any complaints from participants, with documentation of complaint review and decision reached.
Providers will ensure provision of services regardless of the current or past health condition of the individual to be served	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.
	Maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from participants, with documentation of complaint review and decision reached.	**Provider's files** will document individuals refused services with reasons for refusal specified; include in file any complaints from participants, with documentation of complaint review and decision reached.

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

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

Requirement	Indicator	Data Source
Staff and supervisors are qualified to provide the necessary services to participants.	Staff and Supervisors have the appropriate licensure, education and experience.	**Personnel file** has proof of licensure and/or education appropriate for the specific position**.**
Initial orientation and training shall be given to new direct service staff.	Initial orientation and training should include at least 20 hours of training during the first 6 months of employment on the following: cultural competency, basic HIV/AIDS information, Ryan White Care Act Part A services and other funding sources, provider's policy and procedures, other government programs, psychological issues, and standards and requirements. Training can be internal and external to the organization.	**Personnel File** demonstrates the type, amount (minutes or hours) and date of orientation and training each staff receives both internally and externally.
Staff should receive the following training annually.	Every staff handling confidential information will receive an annual training concerning HIPAA and Confidentiality.	**Personnel file** demonstrate the type and amount of training each staff received both internally and externally.
	Every staff receives annual training on OSHA regulations and Universal Precautions.	**Personnel file** demonstrates the type and amount of training each staff received both internally and externally.

Requirement	Indicator	Data Source
	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.
Each provider has a volunteer training program appropriate to support each volunteer position.	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.
Staff or volunteers working with participants are to be screened in accordance with state and local laws.	Background checks must be obtained as required by state and local laws.	**Personnel or Volunteer file** contains background checks.
Staff or volunteers transporting participants will have a valid Colorado driver's license and proof of insurance.	Providers will ensure that they have a current valid driver's license and current insurance information for each staff or volunteers who transports participants.	**Personnel or Volunteer File** contains a copy of a valid driver's license for those staff or volunteers who transport participants.

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

Requirement	Indicator	Data Source
Each provider will have written policies on Quality Management, including how data will be used to improve each funded program.	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.
Each provider will have written policies on Quality Management, including how data will be used to improve each funded program.	Each provider will adopt a quality improvement system (Chronic Care Model or other) to guide work plans and other quality management activities.	**Provider's Reports** documents the use of a quality improvement system.

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

Requirement	Indicator	Data Source
Providers shall have written Policies and Procedures addressing participant confidentiality which are compliant with HIPAA.	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.
	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.
	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.
The Provider's physical set up ensures that services are provided in a private area.	Areas in which participant contact occurs allow exchange of confidential information in a private manner	**Site visit** inspection of agencies facility.
All hard copy materials and records shall be securely maintained by the Provider.	Records, hard copy materials maintained under double lock (in locked files and in locked areas) secure from public access.	**Site Visit** observation**.**
	Each computer is password protected and staff/volunteers must change passwords every 120 days.	**Provider's Policies and Procedures** on confidentiality demonstrates compliance.
All participants shall be informed of their rights to confidentiality at intake.	Documentation signed and dated by participant acknowledging participant was informed of his/her right to confidentiality.	**Participant's file** contains a signed statement that the participant was informed of their rights confidentiality at intake.
There should be no release of participant information without a signed, dated participant release.	There should be a signed, dated Release of Information form specific to HIV/AIDS, TB, STD, 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.

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

Requirement	Indicator	Data Source
Providers must demonstrate structured and ongoing efforts to avoid fraud, waste and abuse (mismanagement) in any federally funded program.	Medicare/Medicaid providers must have a Corporate Compliance Plan.	**Provider's Policies and Procedures** document the Corporate Compliance Plan (Medicare/Medicaid providers only).
	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.
	Non-profit providers must have bylaws and board policies.	**Provider's Policies and Procedures** document board bylaws and policies.
	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.
Providers will document how employees (as individuals or entities) are prohibited from soliciting or receiving remuneration for inducing referrals of items or services covered by Medicare, Medicaid, or any other federally funded program	Providers will maintain documentation of: • Service contracts that discourage agency payments for service referral. • Key employee background checks. • Recruitment practices that prohibit exorbitant signing bonuses. • Audit findings on internal controls. • Procurement policies with conflict of interest clauses. • Prohibition of higher charges for Medicare/Medicaid services. • Compliance audits or compliance checks.	**Provider's Policies and Procedures and Files** document the prohibition for receiving remuneration for inducing referrals of items or services covered by Medicare, Medicaid, or any other federally funded program

[5] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part I: Universal Standards (Draft August 2010)-Section C; 42 USC1320a; 42 USC13207b(b); Part A and B Notice of Grant Award Standard Terms; Part A and B Assurances

Requirement	Indicator	Data Source
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.	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.
	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.
Providers will document how employees (as individuals or entities) are prohibited from soliciting or receiving remuneration for inducing referrals of items or services covered by Medicare, Medicaid, or any other federally funded program	Providers will maintain documentation of: • Service contracts that discourage agency payments for service referral. • Key employee background checks. • Recruitment practices that prohibit exorbitant signing bonuses. • Audit findings on internal controls. • Procurement policies with conflict of interest clauses. • Prohibition of higher charges for Medicare/Medicaid services. • Compliance audits or compliance checks.	**Provider's Policies and Procedures and Files** document the prohibition for receiving remuneration for inducing referrals of items or services covered by Medicare, Medicaid, or any other federally funded program
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.	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.

Requirement	Indicator	Data Source
	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.
Providers will document how employees (as individuals or entities) are prohibited from soliciting or receiving remuneration for inducing referrals of items or services covered by Medicare, Medicaid, or any other federally funded program	Providers will maintain documentation of: • Service contracts that discourage agency payments for service referral. • Key employee background checks. • Recruitment practices that prohibit exorbitant signing bonuses. • Audit findings on internal controls. • Procurement policies with conflict of interest clauses. • Prohibition of higher charges for Medicare/Medicaid services. • Compliance audits or compliance checks.	**Provider's Policies and Procedures and Files** document the prohibition for receiving remuneration for inducing referrals of items or services covered by Medicare, Medicaid, or any other federally funded program
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.	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.

Requirement	Indicator	Data Source
	Have employee policies that include: • Background checks obtained as required by state and local laws. • Discouraging the hiring of persons with a criminal record related to Medicare or Medicaid fraud. • The hiring of persons being investigated by Medicare or Medicaid. • Large signing bonuses.	**Provider's Policies and Procedures** document hiring process.
Providers offering Medicaid/Medicare billable services, will document that they have a Compliance Plan/employee standard of conduct that distinguishes and describes conduct that merits agency penalties from conduct that represents a possible felony.	Provider will have in place policies and procedures that: • Delineate penalties and disclosure procedures for conduct deemed to be felonies. • Include and describe the safe harbors[6] laws. • Include the reporting of non-compliance with the policy.	**Provider's Policies and Procedures, Compliance Plan, Employee standard of Conduct** will address consequences for non-compliance.

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

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

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

Requirement	Indicator	Data Source
Provider will prepare project budget and track expenses with sufficient detail to allow identification of administrative expenses	Budget is prepared with sufficient detail to identify administrative expenses.	**Provider's DOHR Contract Budget** provides sufficient detail to identify administrative expenses.
	Expenditure reports are prepared with sufficient detail to identify administrative expenses.	**Providers Monthly Invoices** to DOHR provide sufficient detail to identify administrative expenses.
Providers will have appropriate systems in place to assure compliance with Ryan White unallowable cost policy.	All budgets and expenses will be tracked in sufficient detail to document that they do not include the following unallowable costs: 1. No uses of Part A funds to purchase or improve land, or to purchase, construct, or permanently improve any building or other facility, (other than minor remodeling). 2. No cash payments to service recipients 3. No use of Part A funds to develop materials designed to promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual. 4. No use of Part A funds for the purchase of vehicles without written Grants Management Officer (GMO) approval	**Providers DOHR Contract Budget and Monthly Invoices** will be tracked in sufficient detail to document that they do not include the identified unallowable costs.

[7] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Sections A and B; RW Part A 2604 (H)(3) A-B; Part A Manual II 2 A-B; RW Part A 2604(h)(4) A-B; RW Part A 2604 (i); RW Part A 26504 (i); RW 2684 General Provisions; Conditions of Notice of Grant Award; DSS Outreach Policy; Part A Manual; 45CFR 93; Conditions of Notice of Grant Award; Parham letter 2.3.09

Requirement	Indicator	Data Source
Providers will have appropriate systems in place to assure compliance with Ryan White unallowable cost policy.	5. No use of Part A funds for: • Non-targeted marketing promotions or advertising about HIV services that target the general public (poster campaigns for display on public transit, TV or radio public service announcements, etc.) • Broad-scope awareness activities about HIV services that target the general public 6. No use of Part A funds for outreach activities that have HIV prevention education as their exclusive purpose 7. No use of Part A funds for influencing or attempting to influence members of Congress and other Federal personnel No use of Part A funds for foreign travel	**Providers DOHR Contract Budget and Monthly Invoices** will be tracked in sufficient detail to document that they do not include the identified unallowable costs.

Standard VIII Income from fee for services: Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section C.[8]

Requirement	Indicator	Data Source
Providers must document the use of Part A and third party funds to maximize program income from third party sources and ensure that Ryan White is the payor of last resort. Third party funding sources include: • Medicaid • State Children's Health Insurance Programs (SCHIP) • Medicare (including the Part D prescription drug benefit) and • Private insurance	Have policies and procedures documenting the requirement that Ryan White be the payor of last resort and how that requirement is met.	**Provider's Policies and Procedures** document the requirement that Ryan White be the payor of last resort and how that requirement is met.
	Provide staff training on the requirement that Ryan White be the payor of last resort and how that requirement is met.	**Personnel file** indicates that staff have been trained on Ryan White payor of last resort policies and procedures.
	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.
	Carry out internal reviews of files and billing system to ensure that Ryan White resources are used only when a third party payor is not available	**Provider Files and/or Participant's file** will document an internal review process which ensures that Ryan White resources are used only when a third party payor is not available.
	For medical providers: establish and maintain medical practice management systems for billing	**Provider's Medical Practice Management System for billing.**

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

Requirement	Indicator	Data Source
Providers will document billing and collection from third party payors, including Medicare and Medicaid, so that payor of last resort requirements are met.	Provider will have established billing and collection policies and procedures.	**Provider's Policies and Procedures** will document the billing and collection procedures.
	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.
	Provider will have documentation of accounts receivable.	**Provider's Billing and Collection System** will document accounts receivable.
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	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
Provider must document retention of program income derived from Ryan White-funded services and use of such funds in one or more of the following ways: • Funds added to resources committed to the project or program, and used to further eligible project or program objectives • Funds used to cover program costs [*Note:* Program income funds are not subject to the federal limitations on administration (10%), quality management (5%), or core services (75% minimum). For example, all program income can be spent on administration of the Part A program]	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

Standard IX Imposition of Participant Charges: Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section D.[9]

Requirement	Indicator	Data Source
Providers must document policies and procedures that specify charges to participants for services.	Policies and procedures must document sliding fee discount policy.	**Provider's Policies and Procedures** document a sliding fee discount policy.
	Policies and procedures must document current fee schedule.	**Provider's Policies and Procedures** document a current fee schedule.
	Participant's files/records must document sliding fee eligibility applications.	**Participant's File** includes sliding fee eligibility applications.
	Participant's files/records must document fees charged to and paid by participants.	**Participant's File** documents fees charged to and paid by participants.
	Policies and procedures must document process for charging, obtaining, and documenting participant charges through a medical practice information system, manual or electronic.	**Provider's Policies and Procedures** documents process for charging, obtaining, and documenting participant charges through a medical practice information system, manual or electronic.

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

Requirement	Indicator	Data Source
Provider's policies and procedures must document that no charges are imposed on participants with incomes below 100% of the Federal Poverty Level (FPL)	Provider's policy and procedures document that the sliding fee discount policy and schedule do not allow participants below 100% 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% of FPL to be charged for services
	Participant files demonstrate that the policy is being consistently followed.	**Participant's Files** demonstrates that the charges are not assessed on participants with incomes below 100% of the FPL.
Provider's policies and procedures must document that charges to participants with incomes greater than 100% of poverty are based on a discounted fee schedule and a sliding fee scale. The policies must cap total annual charges for Ryan White services based on percent of patient's annual income.	Providers must have in place a fee discount policy that caps total annual charges for Ryan White services based on percent of patient's annual income, as follows: • 5% for patients with incomes between 100% and 200% of FPL. • 7% for patients with incomes between 200% and 300% of FPL. • 10% for patients with incomes greater than 300% of FPL .	**Provider's Policies and Procedures** document a fee discount policy that caps total annual charges for Ryan White services based on percent of patient's annual income, as follows: • 5% for patients with incomes between 100% and 200% of FPL. • 7% for patients with incomes between 200% and 300% of FPL. • 10% for patients with incomes greater than 300% of FPL.
	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.
	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.

Requirement	Indicator	Data Source
	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.
	Participant files demonstrate that the policy is being consistently followed.	**Participant's File** demonstrates that the policy is being followed and caps total annual charges for Ryan White services based on percent of patient's annual income.

Standard X Fiscal Management: Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Sections E and F.10

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

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

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

Standard XI Cost Principles: Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section G.[11]

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

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

Standard XII Auditing Requirements. Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section H.[12]

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

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

Standard XIII Matching or Cost Sharing Funds: Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section I.[13]

Requirement	Indicator	Data Source
Providers who provide matching or cost sharing funds must report these funds to DOHR and meet the verification process.	Providers who provide matching or cost sharing funds meet the following verification process: 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). • Are apportioned in accordance with appropriate federal cost principles. Include volunteer services, if used, that 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.	**Provider's Financial Documentation** will include and make available for review: • Annual comprehensive budget. • Documentation of all in-kind and other contributions to Ryan White program. • Documentation of other contributed services or expenses.

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

Requirement	Indicator	Data Source
	• 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).	

Standard XIV Fiscal Procedures: Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section K. [14]

Requirement	Indicator	Data Source
Provider has policies and procedures for handling revenues from the Ryan White grant, including program income.	Establish policies and procedures for handling Ryan White revenues including program income.	**Provider's Policies and Procedures**, detailed chart of accounts and general ledger will be made available for grantee review upon request.
	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.

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

Requirement	Indicator	Data Source
Providers will grant access to payroll records, tax records, and invoices with supporting documentation to show that expenses were actually paid appropriately with Ryan White funds.	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.
Providers will document employee time and effort, with charges for the salaries and wages of hourly employees.	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.
Provider's fiscal staff have responsibility for: • Ensuring adequate reporting, reconciliation, and tracking of program expenditures • Coordinating fiscal activities with program activities (*For example, the program and fiscal staff's meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures, formula and supplemental unobligated balances, and program income)* • Having an organizational and communications chart for the fiscal department	Providers will maintain: • Program and fiscal staff resumes and job descriptions. • Staffing Plan and grantee budget and budget justification. • Provider's organizational chart.	**Provider's documents and files demonstrate:** • Program and fiscal staff resumes and job descriptions. • Staffing Plan and grantee budget and budget justification. • Provider's organizational chart.

AIDS PHARMACEUTICAL ASSISTANCE (LOCAL)

Service Category Description AIDS Pharmaceutical Assistance (local): includes local pharmacy assistance programs implemented by Part A, B, and/or C grantees that provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds, Part B base award funds, and/or Part C grant funds. Local pharmacy assistance programs are **not** funded with ADAP earmark funding.

Unit of Service: 1 unit = 1 filled prescription

Requirement	Indicator	Data Source
Provider must ensure that participant falls under the income requirement.	Income must be at or below 400% of the Federal Poverty Level (agencies can implement stricter requirements).	**Participant's file** demonstrates that participant's income level qualifies them for services.
Every participant served by an infectious disease (ID) pharmacy and/or a drug reimbursement program should expect these programs to provide the following:	Each prescription is filled correctly.	**Participant's file** does not state any incorrectly filled prescriptions.
	Each prescription includes proper indications and dosing.	**Participant's file** does not state any incorrectly filled prescriptions.
	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.
	Counsel each participant on how his/her medication should be taken and any possible side effects with a mandatory 5 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.

Requirement	Indicator	Data Source
	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.
	Provide prescription label directions and participant medication information in Spanish whenever appropriate.	**Provider's policies and procedures** demonstrate how the provider overcomes language barriers.
	Utilize an equitable screening process to establish a participant's eligibility into the program.	**Provider's policies and procedures**
	Ensure and maintain participant confidentiality.	**Provider's policies and procedures** are in compliance with HIPAA Regulations.
	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**
Provider works to establish relationships with other health professionals and drug companies to ensure the best services are given to the participant.	Supply participant refill history directly to participant's health provider whenever possible or requested.	**Provider's policies and procedures** demonstrates how this in done in compliance with HIPAA Regulations.
	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.

Requirement	Indicator	Data Source
	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.
	Access drug company sponsored patient assistance programs for medications and participants not covered by the drug reimbursement program whenever possible.	**Provider** can demonstrate how they utilize drug company sponsored assistances
Drug Reimbursement Quality Measures	100% of patients will have a drug profile in the pharmacy.	**Participant's file** review.
	All of prescriptions are filled properly.	**Participant's file** and **Provider Report** on properly filled prescriptions.

EARLY INTERVENTION SERVICES

Service Category Description

HRSA Definition:

Early Intervention Services (EIS) include identification of individuals at points of entry and access to services and provision of:

- HIV Testing and Targeted counseling
- Referral services
- Linkage to care
- Health education and literacy training that enable participants to navigate the HIV system of care

Denver Part A Implementation clarification:

HIV Testing and Labs 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 and Reengagement. Each program has its own set of standards.

Unit of Service: 1 Unit = 30 Minutes or less

Early Intervention Services Linkage Program

Requirement	Indicator	Data Source
EIS Linkage will be coordinated with existing services.	Establish linkage agreements with testing sites and Key Points of Entry where Part A is not funding testing but is funding referral and access to care and education, system navigation services. Key points of entry defined in legislation: • Emergency rooms • Substance abuse and mental health treatment programs • Detoxification centers, • Detention facilities • Clinics regarding sexually transmitted disease • Homeless shelters • HIV disease counseling and testing sites Additional points of entry include: • Public health departments • Health care points of entry specified by eligible areas • Federally Qualified Health Centers • Entities such as Ryan White Part C and D grantees • Needle Exchange Programs	**Provider's records** will document linkage agreements.

Requirement	Indicator	Data Source
EIS Linkage is utilized to connect those not in care to the services they need to manage their HIV/AIDS	Participants eligible for EIS Linkage are those who meet one or more of the following: • HIV+ individuals who have never linked to care. • HIV+ individuals who are new to the TGA and need assistance linking to care.	**Participant's file** will demonstrate that the participant is eligible for EIS.
	Participants eligible for EIS Linkage 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.
	EIS should not last longer than three months unless a barrier is identified and documented that shows services continue past the three month period.	**Participant's file** Shows that services last no longer than three months unless barriers are clearly identified to justify need to continue in EIS.
	Participant will be linked and successfully attend a medical appointment within 90 days of entry into EIS. Best practice will link the participant as soon as possible, preferably within 30 days. As part of this referral, a release of information should be established between the EIS provider and medical provider.	**Participant's file** will document the date of the medical appointment attended by the participant which 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 refused by participant the reason is documented.
	If appropriate, a referral to a medical case management provider will occur within 15 days of entering EIS. As part of this referral, a release of information should be established between the EIS provider and case management provider.	**Participant's file** will document linkage referral to medical case management within 15 days and contain a release of information signed by the participant. If not appropriate for referral or if release of information is refused by participant the reason is documented.

Requirement	Indicator	Data Source
Every participant shall have an initial screening* to collect data important for proper referrals.	Provider shall schedule an initial screening interview within two business days of a positive diagnosis or within one week of an identified need.	**Participant's file** will demonstrate an initial screening interview was scheduled within two days of a positive diagnosis or within one week of an identified need.
	Initial screening interview will document the referral source/points of entry to the EIS program.	**Participant's file** will document referral source or point of entry to the EIS program.
	During the initial screening interview the staff will work with the participant to gather all eligibility data (income, residency, insurance status, HIV status, and legal name).	**Participant's file** contains copies of the necessary eligibility data.
	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.

Requirement	Indicator	Data Source
Every participant shall have a Referral Plan* which guides their EIS.	The Referral Plan will demonstrate how the participant's needs (identified in their initial screening interview), will be met through Part A and other service providers.	**Participant's file** contains Referral Plan which demonstrates connections to proper services.
	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.
	The Referral Plan will document referrals made to medical care provider, medical case management and supportive services, and outcomes of the referrals.	**Participant's file** contains Referral plan which documents referrals made and outcomes of the referrals.
	If health and system literacy needs are identified in the initial screening, the Referral Plan will contain a plan for health education designed to help individuals navigate and understand the HIV system of care.	**Participant's file** contains Referral plan which documents Health literacy, education, and/or navigation plan, as needed.
	If at the end of three months, EIS services are continued, a new Referral Plan should be established for existing needs.	**Participant's file** contains a revised Referral Plan with documented progress and new referrals if necessary.
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)	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.

Requirement	Indicator	Data Source
EIS will ensure that participant has engaged with medical care six months after close date from EIS.	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.
	If participant has not engaged in medical care, EIS staff will coordinate with medical care provider and/or Medical Case Manager to assure that outreach to participant is taking place. If needed, 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 re-enaged in EIS if they have fallen out of medical care. If participant refuses to reengage the file documents the participant's reason.
EIS Linkage Quality Measures	85% of participants determined eligible for EIS will have attended a medical appointment within 90 days of becoming a participant of an EIS program.	**Participant's file** documents a medical appointment for those within 90 days.
	85% of participants determined eligible for EIS will be assigned to a Medical Case Manager within 90 days of becoming a participant of an EIS program if appropriate.	**Participant's file** documents an assignment of a Medical Case Manager within 90 days or a reason that a Medical Case Manager is not needed.
	75% of EIS participants will still be engaged in medical care six months after their close date.	**Participant's file** will document engagement in medical care six months after close date.

Early Intervention Services Reengagement Program

Requirement	Indicator	Data Source
EIS Reengagement is utilized to identify and reengage participant who have fallen out of medical care.	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 and 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** will demonstrate that the participant is eligible for EIS.
EIS Reengagement providers should have strategies and protocols in place to search for participants who have disengaged from care.	Providers have a documented set of procedures they utilize to find and reengage EIS Reengagement participants.	**Provider's procedures** demonstrate their protocol for reengaging participants. **Participant's file** will demonstrate reengagement efforts in progress notes.
Length of EIS Reengagement	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 unless a barrier is identified and documented that shows services continue past the three month period.	**Participant's file** will demonstrate that referrals are made in a timely manner or documentation exists to explain why services continue past three months.

Requirement	Indicator	Data Source
When a re-engagement participant is found they shall have an initial screening* interview to collect data important for proper referrals.	Provider will assess the reasons why the participant disengaged from care and identify barriers that might cause disengagement in the future.	**Participant's file** complete in initial screening interview identifying reason for current and possible future disengagement
	During the initial screening interview the staff will work with the participant to gather all eligibility data (income, residency, insurance status, HIV status, and legal name).	**Participant's file** contains copies of the necessary eligibility data.
	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.
When a participant is found the EIS provider will create Reengagement Plan* with the participant on how they will stay engaged in care.	The Reengagement Plan will demonstrate how the participant's needs (identified in their initial screening interview), will be met through Part A and other service providers to prevent further disengagement.	**Participant's file** contains Reengagement Plan which demonstrates connections to proper services.
	The plan will be completed within one weeks of the screening.	**Participant's file** contains Reengagement Plan that is completed within the required timeframe.
	The Reengagement Plan will document referrals made to healthcare, medical case management and supportive services, and outcomes of the referrals.	**Participant's file** contains Reengagement Plan which documents referrals made and outcomes of the referrals.
	If health and system literacy needs are identified in the Initial screening, the Reengagement Plan will contain a plan for health education designed to help individuals navigate and understand the HIV system of care.	**Participant's file** contains Reengagement Plan which documents Health literacy, education, and/or navigation plan, as needed.
	If at the end of three months, EIS Reengagement services are continued, new plan should be established for existing needs	**Participant's file** contains a revised Reengagement Plan with documented progress and new referrals if necessary.

Requirement	Indicator	Data Source
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)	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.
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.	EIS staff will follow-up with medical provider six months after 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.
	If participant has not engaged in medical care, EIS staff will coordinate with medical care provider and/or Medical Case Manager to assure that outreach to participant is taking place. If needed, EIS staff will work to reengage participant in EIS.	**Participant's file** documents outreach coordination efforts and demonstrate who will work to engage participant. If needed, file will demonstrate that participant is reengaged in EIS if they have fallen out of medical care. If participant refuses to reengage the file documents the participant's reason.
EIS Reengagement Quality Measures	65% of participants determined eligible for EIS will be found.	**Participant's file** shows that the participant was contacted successfully by the provider.
	75% of participants found will have attended a medical visit within 90 days of being found.	**Participant's file** documents a medical visit.
	75% of EIS participants will still be engaged in medical care six months after their close date.	**Participant's file** will document engagement in medical care six months after close date.

Scenarios to assist with clarifying the intent of this service category:

1) Person contacts medical care on their own (self-linked), unless a barrier has been identified requiring additional assistance, this person is not eligible for EIS Services.
2) Person is new to Denver, but was actively engaged in care somewhere else. Eligible, but may not need 3 months of EIS service. Connect person to services and evaluate if there are other needs that will be addressed on the Referral Plan. Needs on Referral plan would determine how long the person stays in EIS.
3) EIS staff from DH connect a person to EIS staff from CHIP. Assure ROI exists (if possible). Transfer EIS to CHIP, discharge from DH. At 6 months, DH would call CHIP to assure the person stayed in service. Both DH and CHIP can count this participant as EIS, but not all standards requirements would apply (to DH—like screening and referral plan).
4) Person is due for an appointment next month and provider calls to remind patient of their visit. Although this is a legitimate "Retention" effort, this is not an EIS Reengagement effort because the person was not out of care.
5) Person has missed their regularly scheduled appointment and it has now been 8 months since their last appointment and has a history of no-shows. The patient does have a re-scheduled appointment set for next month. This person may qualify for EIS Reengagement if there are known barriers to accessing care (Systemic, eligibility, insurance, psychosocial, etc.). This will be a judgment call for the EIS provider.
6) Person has been in jail or prison and is not connected to medical care. This person could be a linkage client if they tested positive in the jail or prison system or a reengagement client if the person was once connected but has fallen out of care.

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*Tools available to assist with meeting above requirements:

1. Initial Screening and Referral Form
2. Substance Abuse and Mental Illness Symptom Screener.

EMERGENCY FINANCIAL ASSISTANCE

Service Category Description

Emergency financial assistance is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

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

Requirement	Indicator	Data Source
Participant eligibility is based on income level. Participants between 0-125% of FPL are eligible for assistance not to exceed $600 for current fiscal year. Of this amount up to $400 maximum may be used for housing (see Housing Services p. 53 for eligibility). The following restrictions and procedures apply:	Phone: $35/monthly maximum, current bill only	**Participant's file** contains a copy of the bill.
	Water: amount of current billing cycle only	**Participant's file** contains a copy of the bill.
	Utilities: current service only	**Participant's file** contains a copy of the bill.
	Medical: Can pay co-pays on meds and doctor's visits, can't be in collections.	**Participant's file** contains a copy of the bill.
	Insurance: Medical insurance premiums	**Participant's file** contains a copy of the bill.
	Hotel Stays: One week maximum	**Participant's file** contains a copy of the bill.
	No clothing covered	**Participant's file** contains no reimbursement for clothing.
Providers will have structured procedures for participants to gain assistance, deny requests and handle inappropriate use of funds.	The participant requesting assistance should provide information as to the purpose of the assistance, a copy of the bill to be paid, identifying the specific item and vendor to be paid. The participant should supply to the case manager the cause of the shortfall as well as a plan of action to ensure that the situation does not become an ongoing process in which the participant can never recover.	**Participant's file** shows adherence to the provider's procedures and Emergency Financial Standards.

Requirement	Indicator	Data Source
	Medical Case Manager will update the participant's service plan to include goals and objectives to stabilize the participants Income and/or household budgeting.	**Participant's file** contains an updated Service Plan with Income and/or appropriate budgeting goals and objectives.
	If a participant's request is denied, the participant should be given the opportunity to appeal to the respective case management provider. The reconsideration should be based on the broader appeal guidelines that apply to all provider activities in relation to direct participant service provision.	**Participant's file** shows adherence to the provider's procedures and Emergency Financial Standards.
	Case management agencies have the opportunity to appeal single payer decisions.	**Provider's policies and procedures** outline the appeal procedures.
	If a participant is suspended from services due to misrepresentation of expenses or income or fraudulent behavior, any case management provider can suspend that participant, give a timeframe for the suspension, report the suspension and timeframe to the single payer, and the suspension will be honored across all case management agencies.	**Participant's file** shows adherence to the provider's procedures and Emergency Financial Standards.
Distributed checks must insure that needs are met and limit possibilities of fraud.	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.
	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
	A copy of the check is placed in the participant's file.	**Participant's file** contains a copy of the check
	Approved check request will be completed within 3 working days from the referral from agencies.	**Participant's file** demonstrates that the check request was completed in a timely manner.

FOOD BANK/HOME DELIVERED MEALS

Service Category Description

Food Bank and Home Delivered Meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. This includes vouchers to purchase food.

Unit of Service: 1 Unit = 1 Meal

Requirement	Indicator	Data Source
Staff and Volunteer Training	Staff or volunteers involved in food preparation and or food distribution will complete a food safety class equivalent to State of Colorado standards	**Personnel and Volunteer file** documents staff and volunteer training hours.
	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.
Food services is formulated around the participants specific needs and government standards	Income must be at or below 300% of the Federal Poverty Level (agencies may implement stricter requirements).	**Participant's file** documents income level of participant.
	The level of service provided will depend upon each participant's documented need.	**Participant's file** documents the participant's individual needs.

Requirement	Indicator	Data Source
	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.
	Programs will meet all City 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.
	Food services are meant to supplement participants' nutritional needs, not be the sole source of nutrition.	**Participant's file** demonstrates services provided.
Food banks shall make sure their services are convenient and convenient for their participants	Food banks hours will be accessible to participants with variable schedules.	**Scope of services description** in contract and posted hours of service.
Home delivered means shall meet participant's nutritional and life needs	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.
	Meals will have a minimum average of 900-1100 calories per meal.	**Provider's menus** demonstrate each meal's average calories.
	Meals will average the following nutritional content: 15-40% protein; 35-55% carbohydrate; and no more than 30% fat, depending on the individual participant's dietary needs.	**Provider's menus** demonstrate each meal's nutritional content.
	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

Service Category Description

Home and Community Based Health 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. Inpatient hospitals services, nursing home and other long term care facilities are **NOT** included.

Unit of Service: 1 Unit = 2 Hours

Requirement	Indicator	Data Source
Participant eligibility is determined by medical necessity per the clinical health care professional responsible for the participant's HIV care.	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.
Every participant shall have an intake interview and needs assessment to collect data important for care.	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.
	The biopsychosocial assessment ensures that the participant has medical case management 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.

Requirement	Indicator	Data Source
	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.
Every participant shall have a Home Care Plan which guides their care.	The Home Care Plan is created in collaboration with the clinical health care professional responsible for the individual's HIV care and the participant's medical case manager.	**Participant's file** contains a Home Care Plan which is signed by both the participant's clinical health care professional and medical case manager.
	The Home Care Plan should document the projected length of Home Care Plan and how the participant will be transitioned to other funding sources if applicable.	**Participant's file** contains a Home Care Plan that establishes length of care and transition plan.
	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.
	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.
	The Home Care Plan contains goals which define how the participant needs are met through home care.	**Participant's file** contains Home Care Plan with appropriate goals.
	Home Care Plans contains objectives for each goal, stating how the participant will reach the goals. Objectives are measurable and achievable, and are updated at least every six months.	**Participant's file** contains Home Care Plan with measurable and updated objectives.

Requirement	Indicator	Data Source
	Each participant's needs are reassessed every 6 months. This reassessment is documented in updates to the Home Care Plan at least every 6 months.	**Participant's file** documents that the Home Care Plan is updated every six months.
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)	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.
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).	Establish and maintain a program and client recordkeeping system to document the types of home services provided, dates provided, the location of the service, and the signature of the professional who provided the service at each visit.	**Participant's file** documents services provided, date, location and staff signature.
Discharge shall be documented and proper referrals made if applicable.	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.
Caseload	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.**

Requirement	Indicator	Data Source
Home care provider Quality Measures	85% of participants will have at least one primary care appointment within the last 6 months.	**Participant's file** for those who have been in service for over six months.
	90% of participants will have a current Home Care Plan signed by their clinical health care professional and medical case manager.	**Participant's file contains updated Home Care Plan.**
	95% of participants have been assessed and counseled for medical adherence.	**Participant's file** demonstrates that adherence has been assessed and appropriate referrals made if necessary.

HOUSING SERVICES

Service Category Description

Housing Services are the provision of 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 does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

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

Requirement	Indicator	Data Source
Participant eligibility is based on income level. Participants between 0-125% of FPL are eligible for financial assistance not to exceed $600 for current fiscal year. Of this amount up to $400 maximum may be used for housing. The following restrictions and procedures apply:	Participant's proof of income.	**Participant's file** shows proof that the participant meets this income standard.
	Hotel Stays: One week maximum	**Participant's file** contains a copy of the bill.
Providers will have structured procedures for participants to gain assistance, deny requests and handle inappropriate use of funds.	The participant requesting assistance should provide information as to the purpose of the assistance, a copy of the bill to be paid, identifying the specific item and vendor to be paid. The participant should supply to the case manager the cause of the shortfall as well as a plan of action to ensure that the situation does not become an ongoing process in which the participant can never recover.	**Participant's file** show adhere to the providers procedures
	Medical Case Manager will update the participant's service plan to include goals and objectives to stabilize the participants housing situation.	**Participant's file** contains an updated Service Plan with Housing goals and objectives.

Requirement	Indicator	Data Source
	Funds cannot be used for deposits.	**Participant's file** shows adherence to the provider's procedures and Emergency Financial Standards.
	If a participant's request is denied, the participant should be given the opportunity to appeal to the respective case management provider. The reconsideration should be based on the broader appeal guidelines that apply to all provider activities in relation to direct participant service provisions.	**Participant's file** shows adherence to the provider's procedures and Emergency Financial Standards.
	Case management agencies have the opportunity to appeal single payer decisions.	**Provider's policies and procedures** outline the appeal procedures
	If a participant is suspended from services due to misrepresentation of expenses or income or fraudulent behavior, any case management provider can suspend that participant, give a timeframe for the suspension, report the suspension and timeframe to the single payer, and the suspension will be honored across all case management agencies.	**Participant's file** shows adherence to the provider's procedures and Emergency Financial Standards.
Distributed checks must insure that needs are met and limit possibilities of fraud.	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.
	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
	A copy of the check is placed in the participant's file.	**Participant's file** contains a copy of the check
	Approved check request will be completed within 3 working days from the referral from agencies.	**Participant's file** demonstrates that the check request was completed in a timely manner.

MEDICAL CASE MANAGEMENT

Service Category Description

Medical case management services must be provided by trained professionals, including both medically credentialed and other health care staff who provide a range of client-centered services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through an ongoing assessment/reassessment of the client and other key family members' needs and personal support systems. Medical case management may also include 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 care plan; (3) coordination of services required to implement the care plan; (4) continuous client monitoring to assess the efficacy of the care plan; and (5) periodic reevaluation and adaptation of the care plan, at least every 6 months, as necessary during the enrollment of the client

Unit of Service: 1 Unit = 30 Minutes or less

Requirement	Indicator	Data Source
Scheduling and access to services.	Participant will begin the eligibility screening/ admissions process within one week of the initial contactor 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.
	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.
Every participant shall have an intake interview and needs assessment to collect data important for care.	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.

Requirement	Indicator	Data Source
	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.
Annual adherence assessment.	Every participant should be assessed for adherence to their HIV medication at least annually.	**Participant's file** will contain an annual assessment of adherence to their HIV medication.
Every participant shall have an Individual Service Plan which guides their care.	The Individual Service Plan will demonstrate how the participant will get medical care at least once every six months.	**Participant's file** contains Individual Service Plan which demonstrates connections to medical care.
	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.
	The Individual Service Plan demonstrates that the participant is linked to all appropriate services needed.	**Participant's file** documents all referrals.
	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.
	Individual Service Plans contains objectives for each goal, stating how the participant will reach the goals. Objectives are measurable and achievable, and are updated at least every six months.	**Participant's file** contains Individual Service Plan with measurable and updated objectives.

Requirement	Indicator	Data Source
	Individual Service Plans must include a prevention component addressing any HIV transmission and/or high risk behavior.	**Participant's file** demonstrates a secondary prevention component in service plan or states that no need exists.
	Each participant's needs are reassessed every 6 months. This reassessment is documented in updates to the Individual Service Plan at least every 6 months.	**Participant's file** documents that the Individual Service Plan is updated every six months.
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)	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.
Discharge shall be documented and proper referrals made if applicable.	Discharge from case management 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.
Caseload	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.**
Case Management Quality Measures	85% of participants will have at least one primary care appointment within the last 6 months.	**Participant's file** for those who have been in service for over six months.
	75% of participants will submit their lab results to their medical case manager.	**Participant's file** contains lab results dated within the last year.
	75% of participants will make progress (completing greater than 30% of objectives) on their Individual Service Plan.	**Participant's file** for those who have been in service for over six months.
	85% of participants will have an annual assessment of their level of self management.	**Participant's file** contains annual self management assessment

MEDICAL TRANSPORTATION SERVICES

Service Category Description

Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Unit of Service:
1 Unit = 1 bus trip (bus trip = an average of 5 tokens)
1 Unit = Cab Voucher (1 one-way voucher)

Requirement	Indicator	Data Source
Transportation allows participants to connect to serves who do not have the means to access them on their own.	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.
	Transportation services should be delivered to participants with transportation barriers to any of the core services, including medical, dental, mental health therapy, substance abuse treatment, and medical case management.	**Participant's file** documents barriers and how transportation funds are used for core services.
Utilize RTD discount purchase programs.	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

Service Category Description

Mental health services are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers. Mental Health Services include the following: Biopsychosocial assessments; Treatment planning; Psychotherapeutic treatment (Individual sessions, Couple sessions, Family sessions, Group sessions, and Case consultations); Crisis intervention; Psychiatric services other services as deemed clinically appropriate.

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

Requirement	Indicator	Data Source
Providers of Mental Health Services must have the proper qualifications and expertise to deliver services.	Mental health services can be provided by a Psychiatrist; licensed Psychologist; licensed Psychiatric Nurse; or licensed Clinician: L.M.F.T., L.P.C., L.C.S.W, PhD or PsyD.	**Personnel file** contains copies of diplomas or other proof of licensure.
	Mental health services are provided by unlicensed registered clinicians or graduate level student interns with appropriate supervision per licensure or internship regulations.	**Personnel file** contains proof identifying them as a student, copies of diplomas or other proof of degree.

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

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

Requirement	Indicator	Data Source
	Treatment plan includes the number of sessions to be conducted in the next three months.	**Participant's file** contains current treatment plan indicating the estimated number of sessions to be conducted.
	Treatment plan contains an estimated discharged date that is updated every three months if necessary.	**Participant's file** contains current treatment plan indicating an estimated discharge date.
Every participant shall have an ongoing treatment plan which guides their care (psychiatric care).	Development of a treatment plan, based on the biopsychosocial assessment, indicating the participant's needs and preferences will be documented in the progress notes.	**Participant's file** contains progress notes including treatment plans.
	Treatment plan address presenting issues and refer to other services if appropriate.	**Participant's file** contains treatments plan reflecting the participant's needs.
	Each participant's needs are reassessed on each visit. Any change in condition is documented and the treatment plan is updated appropriately.	**Participant's file** includes treatment plans which are updated every session.
	If a medication is prescribed that has the potential to interactions negatively with the participant's HIV drugs, the reason for this decision is documented and a plan for monitoring of the participant's health is included in the treatment plan.	**Participant's file** includes treatment plan that explains why medications known to have negative interactions with HIV medication are prescribed and a plan to monitor the participant's health.
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)	Progress notes demonstrate that the treatment plan is being implemented and followed or revised to meet the participant's changing needs.	**Participant's file** contains progress notes related to service plan.

Requirement	Indicator	Data Source
	Before prescription of medication the benefits and risks of the treatment is assessed both in terms of the participant's mental health and HIV status. Potential benefits and risks of the treatment are discussed with the patient and/or another person responsible for the patient, and this discussion is documented in the progress notes. (Psychiatry only)	**Participant's file** contains progress notes outlying benefits and risks and that these were discussed with the participant.
Discharge shall be documented and proper referrals made if applicable.	Discharge from mental health services will be completed at the request of the participant, the mental health provider, or at death; using pre-established provider guidelines and criteria. Participants should be referred to appropriate provider upon discharge if appropriate.	**Participant's file** states reason for discharge and that proper referrals were made.
Providers will follow ethical and legal requirements	Providers will act in accordance with mental health statutes, Department of Regulatory Agencies (DORA) regulations, and respective provider codes of ethics.	**Participant's file** demonstrates compliance with ethical and legal requirements. **DORA Disciplinary Actions** will be check to ensure mental health professionals are registered with DORA and have not committed any ethical violations.

Requirement	Indicator	Data Source
Mental Health Quality Measures (non-psychiatric)	65% of participants attend the identified number of mental health appointments (as stated in the previous two treatment plan).	**Participant's file** documents number of identified appointments and the appointments kept and missed. *Appointments canceled a day in advance and rescheduled will not count as missed appointment.*
	65% of participants will make progress (completing greater than 30% of objectives) on their Individual Service Plan.	**Participant's file,** for those who have been in service for over six months, will document that the participant is making progress on their treatment plan goals.
	A minimum of 75% of participants will self-report that they are accessing primary care every six months.	**Participant's file** documents that medical care was received and **Provider's report.**
Mental Health Quality Measures (psychiatric)	Less than 5% of participants have had psychiatric hospitalizations in the last six months.	**Provider Report** or **Participant file** demonstrate percentages.
	Less than 5% of participants have had psychiatric emergency room visits in the last six months.	**Provider Report** or **Participant file** demonstrate percentages.
	95% of participants have been assessed and counseled for adherence.	**Participant's file** demonstrates that adherence has been assessed and counseling given if needed.
	90% of patients with AIDS are prescribed HAART.	**Patient's file and/or provider's report** demonstrates HAART prescription for patients with AIDS (history of a CD4 T-cell count below 200 cells/mm3 or other AIDS-defining condition2).

ORAL HEALTH CARE

Service Category Description

Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Unit of Service: 1 Unit = Visitation of any duration

Requirement	Indicator	Data Source
Providers of dental care services must have the proper qualification(s) and expertise to deliver services.	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.
	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.
Treatment will be offered in a timely and appropriate manner.	Provider can demonstrate that waiting list procedure properly manages the wait time for new participants.	**Provider's policies and procedures** demonstrate how the provider handles waiting lists. **Participant's file** shows that there are no unnecessarily delays in getting services.
	Provider determined emergencies will be addressed or referred to another provider within 36 hours.	**Participant file** demonstrates that emergencies are addressed in timely manner. **Provider's procedures** outline how emergencies are handled in a timely manner.

Requirement	Indicator	Data Source
A comprehensive oral evaluation will be conducted at the first non-emergent appointment and will be ongoing if necessary.	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.
	Dental and psychological/ 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.
	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.
	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.
	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.
	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.
	A comprehensive pain assessment.	**Participant's file** contains signed, dated oral evaluation including pain assessment.

Requirement	Indicator	Data Source
Every participant shall have a treatment plan which guides their care.	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 in the required timeline.
	Treatment plan will be reviewed at least annually and updated when participant's condition changes.	**Participant's file** contains updated treatment plans.
Progress notes shall be completed after every significant contact with participant.	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.
	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.
	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.
	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
Discharge shall be documented and proper referrals made if applicable.	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.
Providers will follow ethical and legal requirements.	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.
	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.
Dental Quality Measures	Review current medications and drug compliance with 100% of participants each visit.	**Participant's file** documents a review of current medications at each visit.
	Provide appropriately timed hygiene appointments for active patients every three to six months as needed.	**Participant's file** documents frequency of hygiene appointments.
	65% of participants with a Phase 1 treatment plan completed that plan within 12 months.	**Participant's file** documents completion of Phase 1 treatment plan for those who have been in service for over twelve months.

OUTPATIENT/AMBULATORY MEDICAL CARE[15]

Service Category Description

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 his or her jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the PHS's guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

Unit of Service: 1 Unit = 1 Service

Requirement	Indicator	Data Source
Practices should assure that patients have timely access to medical care.	Practices will have policies and procedures to handle care requests for patients new to the practice. Ideally, patients who disclose HIV + status 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.
	Practices will have policies and procedures that facilitate timely, medically appropriate care. Ideally, practices will be able to see acutely symptomatic HIV + patients "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.

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

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

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

Requirement	Indicator	Data Source
Clinicians should order appropriate periodic laboratory assessments and screening tests.	Specific laboratory assessments and screening tests appropriate for the specific needs of the patient's conditions are ordered and followed up on in an appropriate manner. Including: CBC (annually), CD4 and HIV viral load repeated at 3 – 6 month intervals; annual syphilis screening, annual STI screening for high risk patients, Pap smear (women only).	**Patient's file** will contain documentation of laboratory assessments and screening tests for appropriate to the patient's condition, or medical rationale for why tests were not done, which would include documentation of recent testing in another facility.
Clinicians should perform interval visits to monitor care every 6 months for clinically stable patients and more frequent for less clinically stable patients.	Interval visits should address the treatment plan and patients needs. Frequency of visits should be appropriate to the clinical stability of the patient. In addition to problem-focused history, physical exam and laboratory assessments interval visits should document risk reduction, high risk behaviors, and for those taking HAART an assessment of side-effects, response to therapy and assessment of adherence. Identified problems should have a plan to manage including follow up.	**Patients file** will show documentation of interval visits and will show documentation of recommended interval follow-up.
Clinicians should prescribe a HAART regimen that is best able to delay disease progression, prolong survival, and maintain quality of life through maximal viral suppression	Clinicians should follow current evidence-based guidelines when initiating or changing anti-retroviral drug therapy. The clinician should involve the patient in the decision-making process when determining whether to implement ARV therapy. The clinician should review the benefits and risks of treatment for each individual patient.	**Patient's file** will demonstrate that if HAART therapy is chosen that it is done so being consistent with current ARV guidelines.

Requirement	Indicator	Data Source
The patient's vaccination status should be assessed.	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.
Clinicians should assess patient's oral health needs at least annually.	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.
Healthcare teams should use tracking strategies and outreach patients who have not received recommended care.	At a minimum, practices should recall patients who have not been seen for a medical follow up visit in the last 6 months.	**Provider's policies and procedures** outline strategies to recall patients.

Quality Measures	Indicator	Data Source
Two or more medical visits within last year	Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year Goal: 75%	**Patient's file, practice management system or CareWare** **Monitoring** Use HAB Group 1 measure[3]: **Numerator:** Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP, in an HIV care setting two or more times at least 3 months apart during the measurement year **Denominator:** Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year **Exclusions:** Patients newly enrolled in care during last six months of the year

Quality Measures	Indicator	Data Source
PCP Prophylaxis	Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm who were prescribed PCP prophylaxis Goal: 90%	**Patient's file, practice management system or CareWare** **Monitoring** Use HAB Group 1 measure[3]: **Numerator:** Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm who were prescribed PCP prophylaxis **Denominator:** Number of HIV-infected clients who: had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and had a CD4 T-cell count below 200 cells/mm **Exclusions:** Patients with CD4 T-cell counts below 200 cells/mm repeated within 3 months rose above 200 cells/mm Patients newly enrolled in care during last three months of the measurement year

Quality Measures	Indicator	Data Source
Retention in care	Retention in Care: Percent of patients out of care who receive outreach to re-establish care. Goal: 80%	**Monitoring** **Numerator:** Patients from the denominator with one or more attempts to outreach to re-establish care. **Denominator:** HIV-infected patients who are not listed as moved or gone elsewhere in the medical record AND last visit date is > 6 months prior to the audit date. **Exclusions:** Patients with last visit date<6 months prior to audit date.
Tobacco use assessment	Tobacco use assessment: Percentage of adult and adolescent patients with whom tobacco use was discussed during the past year. Goal: 90%	**Monitoring** Use New York State Measure[4]: **Numerator:** Number of patients from the denominator that have documentation of tobacco use status **Denominator:** HIV-infected clients who had a medical visit in the last year.

Quality Measures	Indicator	Data Source
Tobacco cessation counseling	Tobacco Cessation Counseling: Number of patients who used tobacco products who received tobacco cessation counseling. Goal: 85%	**Numerator:** Number from the denominator who received tobacco cessation counseling **Denominator:** HIV-infected clients who used tobacco products at least once within the measurement year and who had a medical visit at least once in the last year

References

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3. HRSA/ HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1. http://www.hab.hrsa.gov
4. New York State Department of Health AIDS Institute HIV Quality of Care Program. Adult and adolescent indicators. [internet]. New York: New York State Department of Health AIDS Institute; 2000-2004 [cited 2005 Aug 10]. [3 p]. Available: http://www.hivguidelines.org/quality-of-care/quality-of-care-indicators/new-york-state/

SUBSTANCE ABUSE SERVICES OUTPATIENT

Service Category Description

Substance abuse services - outpatient is the provision of 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, rendered by a physician or under the supervision of a physician, or by other qualified personnel.
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
- Harm reduction
- Mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse
- Outpatient drug-free treatment and counseling
- Opiate Assisted Therapy
- Neuro-psychiatric pharmaceuticals; and
- Relapse prevention

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
Providers of Substance Abuse Services must have the proper qualification and expertise to deliver services.	In order to practice as a substance abuse counselor, one must qualify to perform the service under current Division of Behavioral Health (DBH) regulations treating substance abuse issues and have training	**Personnel file** contains copies of diplomas or other proof of degree or licensure.

Requirement	Indicator	Data Source
Providers of Substance Abuse Services will utilize a mandatory disclosure form in compliance with Colorado Mental Health statutes (non-psychiatric only).	Therapeutic disclosure will be reviewed and signed by all participants and must be compliant with the Colorado Mental Health statutes. At a minimum, the disclosure must include: 1. therapist's name 2. degrees, credentials, certifications, and licenses 3. business address, business phone 4. ADAD description and contact information 5. treatment methods and techniques 6. options for second opinion, option to terminate therapy at any time 7. statement that in a professional relationship, sexual intimacy is never appropriate and should be reported to ADAD 8. information about confidentiality and the legal limitations of confidentiality 9. space for the participant and therapist's signature and date.	**Participant's file** contains a Therapeutic disclosure signed by the participant.
Treatment will be offered in a timely manner.	The first session will occur within 3 weeks from the time of referral, if the participant is not is crisis. Participant can choose to stay on a waiting list longer than three weeks if they desire.	**Participant's file** provides documentation of the participant's initial request for services, as well as the first session**.**

Requirement	Indicator	Data Source
	If the participant is in immediate crisis, they will be seen immediately or proper referrals will be made.	**Participant's file** provides documentation of the participant's initial request for services, as well as the first substance abuse session or 3 referrals**.**
A biopsychosocial assessment will begin at the first session if need is ongoing.	Biopsychosocial will be completed in compliance with DBH regulations.	**Participant's file** contains complete biopsychosocial assessment in compliance with DBH regulations.
Every participant shall have a treatment plan which guides their care.	Treatment plan will be completed in compliance with DBH regulations.	**Participant's file** contains treatment plan in compliance with DBH regulations.
Progress notes shall be completed after every significant contact with participant.	Progress notes will be completed in compliance with DBH regulations.	**Participant's file** includes progress notes in compliance with DBH regulations.
Discharge shall be documented and proper referrals made if applicable.	Discharges will be documented in compliance with DBH regulations.	**Participant's file** will demonstrate compliance with DBH regulations around discharges**.**
Caseload	Caseloads policies will be compliance with DBH regulations.	**Report from Provider on Caseloads** will demonstrate compliance**.**
Providers will follow ethical and legal requirements	Providers will act in accordance with mental health statutes, Department of Regulatory Agencies (DORA) regulations, and respective provider codes of ethics.	**Participant's file** demonstrates compliance with ethical and legal requirements. **DORA Disciplinary Actions** will be check to ensure substance abuse professionals are registered with DORA and have not committed any ethical violations.

Requirement	Indicator	Data Source
Providers will follow ethical and legal requirements	Confidentiality procedures will be compliance with DBH regulations.	**Provider's policies and procedures** demonstrate compliance with**.**
	Standards of supervision will be compliance with DBH regulations or supervisor must have a masters degree in a related field with five years experience in treating substance abuse issues and has training (college or outside) in Pharmacology and	**Provider's policies and procedures** and **Personnel file** will demonstrate compliance**.**
Substance Abuse Quality Measures	65% of participants, who have a co-occurring mental health diagnosis, self report engagement in mental health services.	**Participant's file** contains documentation participant self report of engagement**.** Appointments canceled a day in advance and rescheduled
	65% of participants will make progress (completing greater than 30% of objectives) on their Individual Service Plan.	**Participant's file,** for those who have been in service for over six months, will document that the participant is making progress on their treatment plan goals.
	A minimum of 75% of participants will self-report that they are accessing medical care at least every six months.	**Participant's file** documents that medical care was received**.**

APPENDIX: DIRECTIVE FUNDED CATEGORIES
DRUG REIMBURSEMENT

Service Category Description

The Drug Reimbursement category includes on-going services/programs to pay for approved pharmaceuticals and/or medications for persons with no other payment source and whose income is below 400% of the Federal Poverty Level. Subcategories include:

1. State-Administered AIDS Drug Assistance Program (ADAP): Part A CARE Act-funded and administered program or other state-funded Drug Reimbursement Program.
2. Medications: prescription drugs provided through ADAP to prolong life or prevent the deterioration of health. The definition does not include medications that are dispensed or administered during the course of a regular medical visit or that are considered part of the services provided during that visit. If medications are paid for and dispensed as part of the Emergency Financial Assistance program, they should be reported as such.

Unit of Service: 1 unit = 1 prescription

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

Requirement	Indicator	Data Source
	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.
	Counsel each participant on how his/her medication should be taken and any possible side effects with a mandatory 5 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.
	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.
	Provide prescription label directions and participant medication information in Spanish whenever appropriate.	**Provider's policies and procedures** demonstrate how the provider overcomes language barriers.
	Utilize an equitable screening process to establish a participant's eligibility into the program.	**Provider's policies and procedures**
	Ensure and maintain participant confidentiality.	**Provider's policies and procedures** are in compliance with HIPAA Regulations.
	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**

Requirement	Indicator	Data Source
Provider holds regularly scheduled review committee meetings that include physicians, pharmacists, and participants.	Maintain a formula that is as comprehensive as possible for the treatment of HIV disease by holding regularly scheduled review committee meetings.	**Provider** demonstrates that they hold review committee meetings and have minutes from those meetings on file.
	Respond in a timely manner to issues raised by consumers and/or service providers at the monthly review committee meetings. Input can be from members or from one-time visitors.	**Provider** demonstrates that they hold review committee meetings and have minutes from those meetings on file.
Provider works to establish relationships with other health professionals and drug companies to ensure the best services are given to the participant.	Supply participant refill history directly to participant's health provider whenever possible or requested.	**Provider's policies and procedures** demonstrates how this in done in compliance with HIPAA Regulations.
	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.
	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.
	Access drug company sponsored patient assistance programs for medications and participants not covered by the drug reimbursement program whenever possible.	**Provider** can demonstrate how they utilize drug company sponsored assistances
Drug Reimbursement Quality Measures	100% of patients will have a drug profile in the pharmacy.	**Participant's file** review.
	All of prescriptions are filled properly.	**Participant's file** and **Provider Report** on properly filled prescriptions.

APPENDIX: DIRECTIVE FUNDED CATEGORIES
HOUSING SERVICES: RECENTLY RELEASED INCARCERATED

Service Category Description

Housing Services are the provision of 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 does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

This Standard of Care outlines a special consideration funded by the Planning Council specifically for recently released incarcerated individuals. These standards replace the regular Housing Services Standards only if the provider can show a participant qualifies for this particular set of services. If a participant does quality and receive funds through this special consideration the provider must ensure these Standards of Care are followed and not the regular Housing Services Standard.

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

Requirement	Indicator	Data Source
Provider must show that the participant meets specific requirements to be eligible for this special assistance.	In jail for at lease a six month period of time or served any amount of time in prison.	**Participant's file** documents where and when the participant served time.
	Participant was released from prison or jail within the last three months.	**Participant's file** documents participant's release date.
Participant eligibility is based on income level. Participants between 0-300% of FPL are eligible for financial assistance not to exceed $1000 for current fiscal year. The following restrictions and services apply:	Participant currently receiving another housing subsidy (including but not limited to HOPWA, Section 8, or Shelter Plus Care) are not eligible for Housing assistance.	**Participant's file** shows confirmation that the participant is not currently receiving another subsidy.

Requirement	Indicator	Data Source
	Participant's proof of income.	**Participant's file** shows proof that the participant meets this income standard.
	Cannot be utilized for hotel stays	**Participant's file** demonstrates funds are utilized for appropriate housing per the Standard.
	Cannot be utilized for half-way housing.	**Participant's file** demonstrates funds are utilized for appropriate housing per the Standard.
	Excludes housing owned by and/or operated by friends and/or family	**Participant's file** demonstrates funds are utilized for appropriate housing per the Standard.
	Can be utilized to pay for identification and birth certificates.	**Participant's file** contains invoice or proof of costs for these items if purchases with these funds.
	Funds cannot be used for deposits.	**Participant's file** shows that funds are not used for deposits.
Every participant shall have an intake interview and assessment to collect data important for care.	Participant must have been assessed utilizing the assessment tool developed by the People of Color Leadership Committee. Assessment should be completed before service funds are utilized	**Participant's file** contains completed assessment dated before services are utilized.
	Participant must be assessed for substance abuse issues with a ADAD approved assessment tool administered by a qualified professional (see Substance Abuse Standard of Care). Assessment should be completed within one month from when the participant began services.	**Participant's file** contains completed Substance Abuse assessment dated within one month of service utilization.

Requirement	Indicator	Data Source
	Participant must be assessed for mental health issues with a standardized assessment tool administered by a qualified professional (see Mental Health Standards of Care). Assessment should be completed within one month from when the participant began services.	**Participant's file** contains completed Mental Health assessment dated within one month of service utilization.
Participants in this service will have expectations to be connected to other Part A services.	Participant must participate in therapy or group support classes in order to receive this service.	**Participant's file** demonstrates that they are enrolled and receiving Mental Health or Support Group Services.
	Participant must be assigned to a Case Manager in order to receive this service. Participant cannot change agencies for a six month period while receiving this service.	**Participant's file** demonstrates that they are receiving continuous Case Management services while receiving this service.
	Participant must begin Outpatient Ambulatory Medical Care within one month of beginning the service.	**Participants file** documents that they are in Outpatient Ambulatory Medical Care within one month from the beginning of services.
Providers will have structured procedures for participants to gain assistance, deny requests and handle inappropriate use of funds.	The participant requesting assistance should provide information as to the purpose of the assistance, a copy of the bill to be paid, identifying the specific item and vendor to be paid. The participant should supply to the case manager the cause of the shortfall as well as a plan of action to ensure that the assistance will bridge a gap from their current situation to permanent housing.	**Participant's file** includes the required documentation.
	Case Manager will update the participant’s service plan to include goals and objectives to show an intense focus on securing a permanent housing situation.	**Participant’s file** contains an updated Service Plan with Housing goals and objectives.

Requirement	Indicator	Data Source
	If a participant's request is denied, the participant should be given the opportunity to appeal to the respective case management provider. The reconsideration should be based on the broader appeal guidelines that apply to all provider activities in relation to direct participant service provisions.	**Participant's file** shows adherence to the provider's procedures and Emergency Financial Standards.
	Case management agencies have the opportunity to appeal single payer decisions.	**Provider's policies and procedures** outline the appeal procedures
	If a participant is suspended from services due to misrepresentation of expenses or income or fraudulent behavior, any case management provider can suspend that participant, give a timeframe for the suspension, report the suspension and timeframe to the single payer, and the suspension will be honored across all case management agencies.	**Participant's file** shows adherence to the provider's procedures and Housing Standards.
Distributed checks must insure that needs are met and limit possibilities of fraud.	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.
	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
	A copy of the check is placed in the participant's file.	**Participant's file** contains a copy of the check
	Approved check request will be completed within 3 working days from the referral from agencies.	**Participant's file** demonstrates that the check request was completed in a timely manner.

APPENDIX: UNFUNDED SERVICES
HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE

Service Category Description

Health insurance premium and cost sharing assistance (HIP) is the provision of financial assistance for eligible individuals living with HIV to maintain continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Unit of Service: 1 Unit = 1 Payment

Requirement	Indicator	Data Source
HIP Assistance is used to assist eligible participants to continue their medical insurance coverage. There are two "levels" of assistance based on participant's income level.	Level I: Income must be at or below 200% of Federal Poverty Level. Level II: Income must be between 200- 400% of the Federal Poverty Level.	**Participant's file** will demonstrate that the participant is eligible for the HIP services. The ADAP Application and Health Insurance Assistance Program (HIAP Enrollment Form will be used to collect and screen required information.
	Participants must currently have health insurance or be eligible for health insurance. The insurance plan must include a prescription benefit considered "creditable" (Includes all, or substantially all, of the ADAP formulary medications)	**Participant's file** will demonstrate that the participant is eligible for the HIP services. The ADAP Application and HIAP Enrollment Form will be used to collect and screen required information.
	Participants cannot be Medicaid or Medicare eligible or recipients. Appropriate referrals will be made for participants who are eligible for Medicaid or Medicare. *Exceptions allowed and approved in the Part B program are allowable in Part A.	**Participant's file** will demonstrate that the participant has been screened for Medicaid and Medicare eligibility using the ADAP Application.

Requirement	Indicator	Data Source
Assure timely payment based on program level in which participant is enrolled.	**Level I:** Participants may receive up to $10,000 annually of insurance premium payment, medical and pharmaceutical co-pays and deductibles. **Level II:** Participants may receive up to $8,400 annually of either insurance premium payment or pharmaceutical co-pays. Note: This "level" based service annual limit should apply across funding sources. For example, a participant in Level I would not be eligible to use $5,000 from Part A March-June and then $10K from Part B July-Feb.	**Participant's file** will demonstrate that no more than the established limit was expended.
	All payments made will be made on time. Checks will be issued at a minimum six days prior to their due date. For newly enrolled participants, checks will be issued within three days of receipt of information.	**Participant's file** will demonstrate that payments were made on time.
Assure continued eligibility for and cost effectiveness of HIP Services through annual re-assessment.	Provider will complete an ADAP application, HIAP Enrollment Form, document re-assessment date and required documentation, showing continued eligibility for the service (as defined above).	**Participant's file** will demonstrate that the participant is eligible for services. The ADAP Application and HIAP Enrollment Form will be used to collect and screen required information.
	Must show that assistance is cost-effective. Provider will estimate if the annual cost falls below the maximum allowable - $10,000 for Level I, and $8,400 for Level II	**Participant's file** will demonstrate an estimation of annual costs, including premium costs, with a total falling below the maximum allowable.

Requirement	Indicator	Data Source
Assure appropriate documentation and financial management.	Provider will maintain check stubs for all payments made on an enrollee's behalf.	**Provider files** will demonstrate maintenance of check stubs.
	Provider will be responsible for retrieval of cancelled checks and communication with billing entity should it be necessary to resolve a disputed payment.	**Participant file** will document any communication regarding disputed payments.
	Checks will be issued to the vendor. Checks cannot be payable to participants.	**Provider file** contains a copy of the properly written check
	If checks cannot be cut to the vendor, the participant is not eligible for this service and should be referred to the CDPHE's non-federally funded Insurance program.	**Participant application and/or file** will document the referral
	Conduct an annual cost benefit analysis showing the average cost per participant receiving services in this category	**Provider's Report** will demonstrate the average cost per participant.
	Provide proof that the insurance policy provides comprehensive primary care and formulary with a full range of HIV medications to participants	**Participant's File** will contain a copy of their insurance policy demonstrating compliance with this standard.
	Funds may not be used to cover costs of liability risk pools.	**Participant's File** will demonstrate compliance with this standard.
	When funds are used to cover co-pays for prescription eyewear, provide a physician's written statement that the eye condition is related to HIV infection.	**Participant's File** will demonstrate that funds used for eyewear are only used if the condition is caused by HIV infection.

Requirement	Indicator	Data Source
Assure management of waiting list, if a waitlist is necessary.	Provider will maintain a waiting list based on referral date when needed.	**Provider files** will document the waiting list.
	If a waitlist is in place, provider will notify participants of their position on the waiting list when their application is processed.	**Provider files** will document the waiting list notification.
Outreach to all Ryan White Part A funded service organizations will be conducted yearly.	Provider will document Outreach to providers	**Provider files** will document outreach to all Ryan White Part A funded service organizations.

APPENDIX: UNFUNDED SERVICES
HOME HEALTH SERVICES

Service Category Description

Home Health Services includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

Unit of Service: 1 Unit = 1 Visit

Requirement	Indicator	Data Source
Providers of Home Health Services must have the proper qualification and expertise to deliver services.	Home Health Services providers shall be a licensed medical provider in the State of Colorado and work in coordination with the participant's primary care physician.	**Personnel file** contains copies of diplomas or other proof of degree or licensure.
Every participant shall have a biopsychosocial assessment.	The biopsychosocial assessment shall be scheduled within one week of referral or determination of need.	**Participant's file** will demonstrate biopsychosocial assessment was completed within a week of referral or request for services
	The biopsychosocial assessment ensures that the participant has medical case management 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.
	Biopsychosocial includes a physical examination.	**Participant's file** includes biopsychosocial with a physical examination.

Requirement	Indicator	Data Source
	Biopsychosocial includes a mental status assessment including alertness or orientation and brief summary of thought processes, emotions, and interpersonal qualities.	**Participant's file** includes biopsychosocial with a mental status assessment.
	Biopsychosocial includes psychological assessment including assessing affect, functioning level, coping mechanisms and ability to deal with life and environmental stress.	**Participant's file** includes biopsychosocial with a psychological assessment.
	Biopsychosocial includes nutritional assessment.	**Participant's file** includes biopsychosocial with a nutritional assessment.
Every participant shall have a Home Health Care Plan which guides their care.	The Home Health Care Plan will demonstrate how care is directly meeting the specific medical needs of the participant.	**Participant's file** contains Home Health Care Plan which demonstrates proper services are being implemented.
	Development of a Home Health 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 Health Care Plan that is completed within the required timeframe.
	The Home Health Care Plan contains goals which define how the participant's medical needs are met through home care.	**Participant's file** contains Home Health Care Plan with appropriate goals.
	Each participant's needs are reassessed every 60 days. Any changes documented and the Home Health Care Plan is updated as needed.	**Participant's file** documents that needs are reassessed every 60 days and that part Home Health Care Plan is updated when needed.

Requirement	Indicator	Data Source
Progress notes shall be completed after every contact with participant.	Progress notes demonstrate that the Home Health 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 Health Care Plan.
	Progress notes document that participants on antiretroviral therapy have treatment adherence assessed and described every four months.	**Participant's file** documents quantitative assessment in progress notes and drives Home Health Care Plan if relative.
Discharge shall be documented and proper referrals made if applicable.	Discharge from home health care provider will be completed at the request of the participant, a provider, or at death; using pre-established provider guidelines and criteria.	**Provider's policies and procedures** establish discharge guidelines and criteria and **Participant's file** demonstrates compliance with provider's procedures.
	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.
Caseload	Caseload size will be determined by individual providers. Caseload sizes shall be routinely assessed by supervisor.	**Provider's policies and procedures** and **Report from Provider on Caseloads.**
Home care provider Quality Measures	95% of participants have a completed biopsychosocial assessment done within one week of referral or determination of need.	**Participant's file** contains completed biopsychosocial assessment with all required components.
	95% of participants have been assessed and counseled for adherence.	**Participant's file** demonstrates that adherence has been assessed and counseling given if needed.
	90% of participants will have a current Home Health Care Plan.	**Participant's file** contains updated Home Health Care Plan.

APPENDIX: UNFUNDED SERVICES
SUBSTANCE ABUSE SERVICES INPATIENT

Service Category Description

The provision of treatment and/or counseling to address substance abuse problems shall be provided in a residential health service setting by professional providers licensed or authorized by the State or supervised by such an individual.

Unit of Service: 1 unit = Every 24 hours of care in Residential Treatment

Requirement	Indicator	Data Source
Providers of Substance Abuse Services must have the proper qualification and expertise to deliver services.	In order to practice as a substance abuse counselor, one must qualify to perform the service under current Alcohol and Drug Abuse Division (ADAD) regulations or have a masters degree plus two years experience in treating substance abuse issues and have training (college or outside) in Pharmacology and Substance Abuse/Addiction.	**Personnel file** contains copies of diplomas or other proof of degree or licensure.
Treatment will be offered in a timely manner.	The intake will occur within a reasonable time from the time of referral, if the participant is not is crisis. Participant can choose to stay on a waiting if they desire.	**Participant's file** provides documentation of the participant's initial request for services, as well as the intake date**.**
	If the participant is in immediate crisis, they will be seen immediately or proper referrals will be made.	**Participant's file** provides documentation of the participant's initial request for services, as well as the intake date or 3 referrals**.**

Requirement	Indicator	Data Source
Substance Abuse services include the following: Biopsychosocial assessments; Treatment planning; Treatment (Individual sessions, Couple sessions, Family sessions, Group sessions, and Case consultations); Crisis intervention; services associated with residential care; and other services as deemed clinically appropriate.	Documentation of all services provided.	**Participant's file** documents all services**.**
A biopsychosocial assessment will begin at intake and if need is ongoing.	Biopsychosocial will be completed in compliance with ADAD regulations.	**Participant's file** contains complete biopsychosocial assessment in compliance with ADAD regulations**.**
Every participant shall have a treatment plan which guides their care.	Treatment plan will be completed in compliance with ADAD regulations.	**Participant's file** contains treatment plan in compliance with ADAD regulations.
Progress notes shall be completed after every significant contact with participant.	Progress notes will be completed in compliance with ADAD regulations.	**Participant's file** includes progress notes in compliance with ADAD regulations.
Discharge shall be documented and proper referrals made if applicable.	Discharges will be documented in compliance with ADAD regulations.	**Participant's file** will demonstrate compliance with ADAD regulations around discharges**.**
Caseload	Caseloads policies will be compliance with ADAD regulations.	**Report from Provider on Caseloads** will demonstrate compliance**.**
Providers will follow ethical and legal requirements	Confidentiality procedures will be compliance with ADAD regulations.	**Provider's policies and procedures** demonstrate compliance with**.**
	Standards of supervision will be compliance with ADAD regulations or supervisor must have a masters degree in a related field with five years experience in treating substance abuse issues and has training (college or outside) in Pharmacology and Substance Abuse/Addiction.	**Provider's policies and procedures** and **Personnel file** will demonstrate compliance**.**

Requirement	Indicator	Data Source
Substance Abuse Quality Measures	90% of participants will have a current treatment plan based on a completed biopsychosocial assessment.	**Participant's file** contains treatment plan in line with standard**.**
	65% of participants will make progress (completing greater than 30% of objectives) on their Individual Service Plan.	**Participant's file,** for those who have completed the program there will be documentation that the participant is making progress on their treatment plan goals.
	65% of participants entering residential treatment will finish their stay successfully.	**Participant File** demonstrates success and **Provider's Report.**
Progress notes shall be completed after every significant contact with participant.	A minimum of 75% of participants will self-report that they are accessing medical care within one year.	**Participant's file** documents that medical care was received and **Provider's report.**