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

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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: 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.

Requirement	Indicator	Data Source
Providers shall ensure that all participants meet the eligibility guidelines of Income; Residency; Proof of Legal Name and HIV Status.	Participant can demonstrate the amount of income and source. Must be updated annually.	**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.
	Participant can demonstrate residence within the Denver Transitional Grant Area (TGA). Document must be current and must contain the participant's name. Must be updated annually.	**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.
	Providers are to use the participant's legal name attained from a government issued document in all documentation.	**Participant's file** contains copy of a government issued document showing legal name (e.g. driver's license, social security card).
	The 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.
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 documentation that the participant has received the procedures is signed by the participant.

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

Requirement	Indicator	Data Source
Providers shall eliminate barriers to service caused by any of the following: Hours of Operation; Language, Culture and Special Assistance; Timeliness of Access; and Collaborative Networking.	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.	**Scope of service description** will be included in the contract, and the hours of service will be posted in a prominent place within the agency.
	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.
	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.

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**.**
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.

Requirement	Indicator	Data Source
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.
	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 Mayor's Office of HIV Resource** will be completed accurately and on time.
	A participant satisfaction process is conducted and documented annually.	**Annual Reports** indicate response rate, methodology and outcomes of annual participant satisfaction analysis.
	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 six weeks.	**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.

Requirement	Indicator	Data Source
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.

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.

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. 23 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.
	Miscellaneous emergencies: application fees; Colorado Bureau of Investigations (CBI) fee, trash, Current bill 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.
	Optical Visits: $100.00 maximum for the year	**Participant's file** contains a copy of the bill.
	Dental Visits: $220.00 maximum for the year	**Participant's file** contains a copy of the bill.
	Hotel Stays: One week maximum	**Participant's file** contains a copy of the bill.

Requirement	Indicator	Data Source
	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.
	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.

Requirement	Indicator	Data Source
	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.

Requirement	Indicator	Data Source
	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
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.
	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 will demonstrate how the participant will get medical care at least once every six months.	**Participant's file** contains Home Care Plan which demonstrates connections to medical care.

Requirement	Indicator	Data Source
	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.
	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.

Requirement	Indicator	Data Source
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, 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.**
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.	**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.

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.

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

Requirement	Indicator	Data Source
	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 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.	**Participant's file** demonstrates a secondary prevention component in service plan.
	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.

Requirement	Indicator	Data Source
	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, and a brief psychosocial history; as appropriate for the level and type of service provided.	**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
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.
	Treatments 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 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.
	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).

Non-Medical Case Management

Service Category Description

Non-medical Case Management includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
At the end of each 12-month period, participants brought in during that period will cease to be participants of the non-medical case manager. By this point, they will have transitioned to being seen by a Medical Case Manager or other components of the Ryan White system of care. The role of the non-medical case manager is to ensure that new participants are well established in the system.

Unit of Service: 1 Unit = 30 Minutes or less

Requirement	Indicator	Data Source
Non-medical case managers will conduct outreach programs within their communities to locate those who are not in care.	Non-medical case management includes the provision of advice and assistance in obtaining and maintaining medical, social, community, legal, financial, and other needed services.	**Participant's file** documents all provided services.
	The participant should work with the non-medical case manager for a total of 12-months by which time they will well established in the Part A system and medical case management.	**Participant's file** demonstrates referrals made to the Part A system and other services.
Every participant shall have an intake interview and assessment to collect data important for care.	Participants have an intake interview completed by the third face to face visit.	**Participant's file** demonstrates intake interview is completed by the third face to face visit.
	Initial assessment of a participant's functional and cognitive capacity, health, strengths, abilities, substance abuse, mental health, 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 30 day time period.

Requirement	Indicator	Data Source
	Participants may arrange to have their intake completed in an environment that is safe and comfortable for everyone.	**Participant's file** demonstrates a participant's request to have the intake in an alternative environment and that arrangements were made when appropriate.
Every participant shall have an individual Service Linkage Plan which guides their care.	The Service Linkage Plan will demonstrate how the participant will get medical care at least once every six months.	**Participant's file** contains services plan which demonstrates connections to medical care.
	Development of a Service Linkage Plan is based on the initial assessment and states how the non-medical case manager will transition the participant into appropriate HIV services and medical case management. The plan will be completed within two weeks of the assessment.	**Participant's file** contains services plan that is completed within the required timeframe.
	The Service Linkage Plan demonstrates that the participant is linked to all appropriate services needed.	**Participant's file** demonstrates referrals made to the Part A system and other services.
	The Service Linkage Plan contains goals which define what the participant needs to achieve by being in non-medical case management.	**Participant's file** contains services plan with appropriate goals.
	The Service Linkage Plan contains objectives for each goal, stating how the participant will reach the goals. Objectives are measurable and achievable, and are updated at least every six months.	**Participant's file** contains services plans with measurable and updated objectives.

Requirement	Indicator	Data Source
	The Service Linkage Plan must include a prevention component.	**Participant's file** demonstrates a secondary prevention component in service plan.
	Each participant's needs are reassessed every 6 months. This reassessment is documented in updates to the Service Linkage Plan at least every 6 months.	**Participant's file** documents that the Service Linkage 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 Service Linkage Plan is being implemented and followed or revised to meet the participant's changing needs.	**Participant's file** contains progress notes related to the service plan.
Discharge shall be documented and proper referrals made if applicable.	By the end of the 12-month period, the participant will cease to be a participant of the non-medical case manager. By this point, they will have transitioned to a Medical Case Manager and/or other components of the Part A system of care.	**Participant's file** demonstrates compliance with provider's procedures.
	Discharge from non-medical 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.	**Participant's file** states 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.	**Report from Provider on Caseloads.**

Requirement	Indicator	Data Source
Non-medical 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.**..**
	90% of participants will have a current Service Linkage Plan.	**Participant's file** contains a current Service Linkage Plan.
	75% of participants will make progress (completing greater than 30% of objectives) on their Service Linkage Plan.	**Participant's file** for those who have been in service for over six months.
	90% of participants will have successfully exited Non-Medical Case Management Services and referred into appropriate primary care and Medical Case Management services within 1 year.	**Participant's file** documents all referrals.

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.

Requirement	Indicator	Data Source
	A comprehensive pain assessment.	**Participant's file** contains signed, dated oral evaluation including pain assessment.
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 updated when participant's condition changes or at least annually.	**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.

Requirement	Indicator	Data Source
	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.
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.

Requirement	Indicator	Data Source
Dental Quality Measures	Establish treatment plans for 100% of active participants.	**Participant's file** contains treatment plan.
	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

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, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes 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).

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.

Requirement	Indicator	Data Source
	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.
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), 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 report demonstrate that practices have 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: General history, HIV treatment and staging, Mental health history, Substance use history, Sexual history, Psychosocial, Review of systems.	**Patient's file** will contain a comprehensive HIV-related history.

Requirement	Indicator	Data Source
Clinicians should obtain medical records from past medical providers whenever possible.	HIV-related records including confirmation of diagnosis and any treatment related to HIV care are particularly important.	**Patient's file** will contain evidence of a request for medical records from previous medical providers.
Clinicians should perform a baseline comprehensive physical examination and follow up examinations when appropriate.	Components of a comprehensive HIV-related physical exam include: Vital signs, weight, and symptoms, Pain assessment, Head, ears, eyes, nose, throat, Oral, dermatologic, lymph nodes, Endocrinologic, Pulmonary, Cardiac examination, Abdominal, genital, rectal, Musculoskeletal, and neuropsychological.	**Patient's file** will contain documentation of a comprehensive HIV-related exam at baseline and then annually.
Clinicians should order appropriate 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.	**Patient's file** will contain documentation of laboratory assessments and screening tests for appropriate to the patient's condition
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.	**Patients file** will show documentation of interval visits and will show documentation of recommended interval follow-up.

Requirement	Indicator	Data Source
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.
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.
Clinicians should refer patients to Ophthalmology as indicated.	Patients with CD4 counts <50 cells/mm3 should be examined by an ophthalmologist at baseline and every 6 months.	**Patient's file** will show documentation of referral to an ophthalmologist as indicated.
Healthcare teams should use tracking strategies and outreach patients who have not received recommended care.	At 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.
Primary Care Quality Measures	85% of patients will have at least one primary care appointment within the last 6 months.	**Patient's file and/or provider's report** for those who have been in service for over six months.

Requirement	Indicator	Data Source
	90% of patients with HIV infection and a CD4 T-cell count below 200 cells/mm3 were prescribed PCP prophylaxis.	**Patient's file and/or provider's report** demonstrates compliance for patients appropriate for PCP prophylaxis.
	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).

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.
This includes methadone treatment, Biopsychosocial assessments; Treatment planning; Treatment (Individual sessions, Couple sessions, Family sessions, Group sessions, and Case consultations); Crisis intervention; Psychiatric Services and other services as deemed clinically appropriate

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 Department of Behavioral Health 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. Psychiatric services must be provided by a psychiatrist or licensed psychiatric nurse.	**Personnel file** contains copies of diplomas or other proof of degree or licensure.

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. Department of Behavioral Health 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 Department of Behavioral Health 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 Department of Behavioral Health regulations.	**Participant's file** contains complete biopsychosocial assessment in compliance with Department of Behavioral Health regulations.
Every participant shall have a treatment plan which guides their care (non-psychiatric only).	Treatment plan will be completed in compliance with Department of Behavioral Health regulations.	**Participant's file** contains treatment plan in compliance with Department of Behavioral Health regulations.
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 plans 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.

Requirement	Indicator	Data Source
Progress notes shall be completed after every significant contact with participant.	Progress notes will be completed in compliance with Department of Behavioral Health regulations.	**Participant's file** includes progress notes in compliance with Department of Behavioral Health regulations.
Discharge shall be documented and proper referrals made if applicable.	Discharges will be documented in compliance with Department of Behavioral Health regulations.	**Participant's file** will demonstrate compliance with Department of Behavioral Health regulations around discharges.
Caseload	Caseloads policies will be compliance with Department of Behavioral Health regulations.	**Report from Provider on Caseloads** will demonstrate compliance.
Providers will follow ethical and legal requirements	Confidentiality procedures will be compliance with Department of Behavioral Health regulations.	**Provider's policies and procedures** demonstrate compliance with.
	Standards of supervision will be compliance with Department of Behavioral Health 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. (non-psychiatric only)	**Provider's policies and procedures** and **Personnel file** will demonstrate compliance**.**

Requirement	Indicator	Data Source
Progress notes shall be completed after every significant contact with participant.	Progress notes will be completed in compliance with Department of Behavioral Health 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 Department of Behavioral Health regulations.	**Participant's file** will demonstrate compliance with ADAD regulations around discharges**.**
Caseload	Caseloads policies will be compliance with Department of Behavioral Health regulations.	**Report from Provider on Caseloads** will demonstrate compliance**.**
Providers will follow ethical and legal requirements	Confidentiality procedures will be compliance with Department of Behavioral Health regulations.	**Provider's policies and procedures** demonstrate compliance with**.**
	Standards of supervision will be compliance with Department of Behavioral Health 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. (non-psychiatric only)	**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 been in service for over six months, will document that the participant is making progress on their treatment plan goals.
	65% of substance abuse appointments are kept.	**Participant's file** documents kept and missed appointments.
	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.**
Substance Abuse 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).

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 develop 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.

Requirement	Indicator	Data Source
	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.
	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

Requirement	Indicator	Data Source
	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: NEWLY FUNDED CATEGORIES
EARLY INTERVENTION SERVICES

Service Category Description

Early intervention services (EIS) include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

Unit of Service: 1 Unit = 30 Minutes or less

Requirement	Indicator	Data Source
EIS is utilized to connect those not in care to the services they need to manage their HIV/AIDS	Participants eligible for services are those who are: 1) Newly diagnosed; 2) Have been out of primary HIV care for more than 6 months; 3) Are identified as not being connected to services needed to maintain their HIV care.	**Participant's file** will demonstrate that the participant is eligible for EIS services.
	EIS are designed to connect the participant with primary care and other needed services and follow up to ensure these services are implemented. 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** will demonstrate that referrals are made in a timely manner or documentation exists to explain why services continue past three months.
	Appointment will be set with a primary care provider within 90 days of entry into EIS. However, providers should recognize that expedited entry into primary care is best practice.	**Participant's file** will document an appointment date and referral to primary care within 90 days of entering EIS.

Requirement	Indicator	Data Source
	If appropriate, a referral to a medical case management provider will occur within 45 days of entering EIS.	**Participant's file** will document linkage referral to medical case management within 45 days. If not appropriate for referral this reason is documented.
Provider will perform a confirmatory HIV test to newly diagnosis participants, including CD4 enumeration and accurate medical interpretation of such labs.	Laboratory screening performed upon referral.	**Participant's file** will document of date at which laboratory tests completed and specific lab values.
Every participant shall have an intake interview and needs assessment to collect data important for proper referrals.	Provider shall schedule an intake interview within two business days of a positive diagnosis or within one week of an identified need.	**Participant's file** will demonstrate an intake interview was scheduled within two days of a positive diagnosis or within one week of an identified need.
	During the intake interview the staff will work with the participant to gather all eligibility data (income, residency, HIV status, and legal name).	**Participant's file** contains copies of the necessary eligibility data.
	Initial assessment of a participant's functional capacity, health (including oral health), mental health, substance abuse, health literacy, resources, insurance eligibility and needs will be completed within the first two meetings. Mental health and substance abuse must be assessed with a standardize assessment tool.	**Participant's file** has initial assessment 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 services.	The Referral Plan will demonstrate how the participant's needs (identified in their assessment), 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 weeks of the assessment.	**Participant's file** contains Referral Plan that is completed within the required timeframe.
	The Referral Plan contains goals for referrals and care adherence and should be time limited to three months of EIS services.	**Participant's file** contains Referral Plan with appropriate goals.
	At the end of three months of EIS services, the Referral Plan should be updated to show that goals have been accomplished. If services are continued new goals should be established for existing needs.	**Participant's file** contains Referral Plan with documented progress and new goals 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
Discharge shall be documented and proper referrals made if applicable.	Discharge from EIS will be completed at the request of the participant, a provider, after allotted EIS timeline or at death, using pre-established provider guidelines and criteria. A summary of services provided should be documented in the discharge summary.	**Participant's file** states the reason for discharge and summary of services.
Caseload	Caseload size will be determined by individual provider organizations. Caseload sizes shall be routinely assessed by supervisor.	**Provider's policies and procedures** and **Report from Provider on Caseloads.**
EIS will ensure that participant has initiated services with primary care six months after discharge from EIS services.	EIS staff will follow-up with medical provider six months after EIS discharge to ensure participant has initiated services in primary care.	**Participant's file** demonstrates participant is initiated in primary care six months after EIS discharge.
	If participant is has not initiated in primary care, EIS staff will outreach to participant to reengage in EIS services.	**Participant's file** documents outreach efforts and demonstrates that participant is initiated in EIS if they have fallen out of primary care. If participant refuses to reengage the file documents the participant's reason.
EIS Quality Measures	85% of participants determined eligible for EIS services will have a primary medical appointment within a 90 days of becoming a participant of an EIS program.	**Participant's file** documents a medical appointment for those within 90 days.
	90% of participants will have a Referral Plan.	**Participant's file** contains a Referral Plan.
	90% of participants will be referred out of EIS within the three month service period.	**Participant's file** will document discharge within the service period.

APPENDIX: NEWLY FUNDED CATEGORIES
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.	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.	**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. Participants may receive up to $8,400 annually of insurance premium payment.	No more than $700/month or $2,100/quarter is expended for any one participant for premiums	**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 - $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.
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

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
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**.**

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 intake date or 3 referrals**.**
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**.**

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