



Denver Transitional Grant Area

**Standards of Care
Unit Costs of Service
Quality Management Indicators**

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

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

Final July 2008

TABLE OF CONTENTS

Acronyms	2
Introduction	3
Common Standards of Care	4
AIDS Pharmaceutical Assistance (local)	11
Emergency Financial Assistance	13
Food Bank/Home Delivered Meals	17
Home and Community – Based Health Services	20
Housing Services	23
Medical Case Management	26
Medical Transportation Services	29
Mental Health Services	31
Non-Medical Case Management	34
Oral Health Care	38
Outpatient/Ambulatory Medical Care	43
Substance Abuse Services Outpatient	47
Appendix: Unfunded Services	
Drug Reimbursement	51
Substance Abuse Services Inpatient	54

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.

All providers should distinguish between active and inactive participants	Any participant who has not had interaction with a provider within six months should be considered inactive.	Participant's file active files should be separate from inactive files. Participant lists should indicate active participants only (a separate list of inactive participants can also be maintained).
---	--	--

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.	Participant's file identifies any special needs and documents how those needs are met.
	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.	Participant's file reflects that the provider has effectively networked 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.
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.	Policies and Procedures should address HIV/AIDS-related confidentiality and provider procedures, including those limiting access to passwords, electronic files, medical records, faxes, sign in procedures, 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 polices 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.

<p>There should be no release of participant information without a signed, dated participant release.</p>	<p>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.</p>	<p>Participant's file contains signed releases appropriate to the services provided and information needed.</p>
---	--	--

AIDS PHARMACEUTICAL ASSISTANCE (LOCAL)

Service Category Description

AIDS Pharmaceutical Assistance (local): includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base awarded 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.
	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 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 is 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.

EMERGENCY FINANCIAL ASSISTANCE

Service Category Description

Emergency financial assistance includes the provision of short-term payment for essential utilities and for medication assistance when other resources are not available. The purpose of emergency financial assistance is to provide support in times of emergency. It is to be used for services that cannot be met through other resources. Emergency financial assistance is not an entitlement, nor is it meant to be an ongoing subsidy. Emergency financial assistance is based on the need of the individual, taking into account the participant's total resources.

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

Requirement	Indicator	Data Source
Participant eligibility is based on income level. Participants between 0-185% of FPL are eligible for \$800, combined Emergency Financial Assistance and Emergency Housing Assistance, for the current fiscal year. Participants between 186%-300% FPL are eligible for \$600 combined Emergency Financial Assistance and Emergency Housing Assistance for the current fiscal year. The following restrictions and procedures apply:	Phone: \$50 per request, 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	Participant's file contains a copy of the bill.
	Dental Visits	Participant's file contains a copy of the bill.
	No clothing covered	Participant's file contains no reimbursement for clothing.

<p>Providers will have structured procedures for participants to gain assistance, deny requests and handle inappropriate use of funds.</p>	<p>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.</p>	<p>Participant's file shows adherence to the provider's procedures and Emergency Financial Standards.</p>
	<p>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.</p>	<p>Participant's file shows adherence to the provider's procedures and Emergency Financial Standards.</p>
	<p>Case management agencies have the opportunity to appeal single payer decisions.</p>	<p>Provider's policies and procedures outline the appeal procedures.</p>
	<p>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.</p>	<p>Participant's file shows adherence to the provider's procedures and Emergency Financial Standards.</p>

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.
Emergency financial assistance quality standards.	100% of all check requests will be completed within 3 working days of referral from agencies	Participant's file demonstrates that the check request was completed in compliance with the Standard.
	100% of all participants accessing service have met eligibility requirements	Participant's file demonstrates participant eligibility.

FOOD BANK/HOME DELIVERED MEALS

Service Category Description

Food Bank and Home Delivered Meals include the provision of actual food, meals, or nutritional supplements. It does not include money to purchase food or meals. The provision of essential household supplies such as hygiene and household cleaning supplies can be provided in this service category.

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.
	If a provider is ever faced with the need to create a waiting list, it will first refer participants out to other agencies. Agencies will make every attempt to avoid creating waiting lists. If growth restrictions become inevitable, then programs will serve those most in need based on overall health.	Provider's policies and procedures demonstrate how waiting lists and referrals are managed.

	Programs will meet all City of Denver and State of Colorado grocery and/or restaurant health code regulations whether or not the program is subject to mandatory inspections. All programs will undergo voluntary health inspections a minimum of every two years.	Voluntary inspection results.
	Food services are meant to supplement participants' nutritional needs, not be the sole source of nutrition.	Participant's file demonstrates services provided.
Food banks shall make sure their services are convenient and convenient for their participants	Food banks hours will be accessible to participants with variable schedules.	Scope of services description in contract and posted hours of service.
Home delivered means shall meet participant's nutritional and life needs	Participants will be given a delivery time period within which they can expect to receive their meals.	Provider's policies and procedures address communication and standards around delivery of food.
	Meals will have a minimum average of 900-1100 calories per meal.	Provider's menus demonstrate each meal's average calories.
	Meals will average the following nutritional content: 15-40% protein; 35-55% carbohydrate; and no more than 30% fat, depending on the individual participant's dietary needs.	Provider's menus demonstrate each meal's nutritional content.
	A registered dietician reviews the provider's menu to ensure it meets the participants' nutritional needs.	Documentation that registered dietician signed off on the menu.
Food bank and home delivered meals quality standards	80% of participants will report that because of Food Bank/Home Delivered Meals services they have maintained or improved access to food and/or have less stress around food acquisition.	Participants satisfaction survey results

	70% of participants will report that because of access to Food Bank/Home Delivered Meals they have maintained or improved their successful involvement in their prescribed health regimen.	Participants satisfaction survey results
--	--	--

HOME AND COMMUNITY - BASED HEALTH SERVICES

Service Category Description

Home and Community Based Health includes supportive services delivered in a residential setting. Services are delivered for activities that the participant can not do on their own without assistance. Home and Community Based Health is well coordinated with Medical Case Management, Primary Care, and other Denver TGA services.

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 file will demonstrate intake interview was completed within a week of referral or request for services
	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.
	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.

	<p>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.</p>	<p>Participant's file contains Home Care Plan with measurable and updated objectives.</p>
	<p>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.</p>	<p>Participant's file documents that the Home Care Plan is updated every six months.</p>
<p>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)</p>	<p>Progress notes monitor participant services to ensure that services are related to the Home Care Plan.</p>	<p>Participant's file contains progress notes related to the Home Care Plan.</p>
	<p>Progress notes demonstrate that the Home Care Plan is being implemented and followed or revised to meet the participant's changing needs.</p>	<p>Participant's file contains progress notes related to the Home Care Plan.</p>
<p>Discharge shall be documented and proper referrals made if applicable.</p>	<p>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.</p>	<p>Provider's policies and procedures establish discharge guidelines and criteria and Participant's file demonstrates compliance with provider's procedures.</p>
	<p>Participants should be referred to appropriate providers upon discharge when appropriate.</p>	<p>Participant's file states the reason for discharge and that proper referrals are made.</p>
<p>Caseload</p>	<p>Caseload size will be determined by individual providers. Caseload sizes shall be routinely assessed by supervisor.</p>	<p>Provider's policies and procedures and Report from Provider on Caseloads.</p>
<p>Home care provider Quality Measures</p>	<p>85% of participants will have at least one primary care appointment within the last 6 months.</p>	<p>Participant's file for those who have been in service for over six months.</p>

90% of participants will have a current Home Care Plan.	Participant's file contains updated Home Care Plan.
75% of participants will make progress (completing greater than 30% of objectives) on their Home Care Plan.	Participant's file for those who have been in service for over six months.

HOUSING SERVICES

Service Category Description

Emergency Housing Assistance includes the provision of short-term assistance to support temporary or transitional housing to enable an individual or family to gain or maintain medical care. Category includes assessment, search, placement and the fees associated with them. NOTE: if housing services include other services (e.g. meals, case management) these services should be reported in the appropriate categories. The purpose of Ryan White emergency housing assistance is to provide support in times of emergency. It is to be used for necessary housing services that cannot be met through other resources. Emergency housing assistance is not an entitlement, nor is it meant to be an ongoing subsidy. Emergency housing assistance is based on the need of the individual, taking into account the individual's total resources.

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

Requirement	Indicator	Data Source
<p>Participant eligibility is based on income level. Participants between 0-185% of FPL are eligible for \$800, combined Emergency Financial Assistance and Emergency Housing Assistance, for the current fiscal year. Participants between 186%-300% FPL are eligibility for \$600 combined Emergency Financial Assistance and Emergency Housing Assistance for the current fiscal year.</p>	<p>Participant's proof of income.</p>	<p>Participant's file shows proof of income.</p>
<p>Providers will have structured procedures for participants to gain assistance, deny requests and handle inappropriate use of funds.</p>	<p>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.</p>	<p>Participant's file show adhere to the providers procedures</p>

	Funds cannot be used for deposits.	Participant's file shows adherence to the provider's procedures and Emergency Financial Standards.
	If a participant's request is denied, the participant should be given the opportunity to appeal to the respective case management provider. The reconsideration should be based on the broader appeal guidelines that apply to all provider activities in relation to direct participant service provisions.	Participant's file shows adherence to the provider's procedures and Emergency Financial Standards.
	Case management agencies have the opportunity to appeal single payer decisions.	Provider's policies and procedures outline the appeal procedures
	If a participant is suspended from services due to misrepresentation of expenses or income or fraudulent behavior, any case management provider can suspend that participant, give a timeframe for the suspension, report the suspension and timeframe to the single payer, and the suspension will be honored across all case management agencies.	Participant's file shows adherence to the provider's procedures and Emergency Financial Standards.
Distributed checks must insure that needs are met and limit possibilities of fraud.	Checks for emergency housing assistance will be issued by the contracted single payer provider.	Participant's file contains a copy of the check issued by the single payer provider.
	Checks will be issued to the vendor. Checks cannot be payable or issued to participants.	Participant's file contains a copy of the properly written check
	A copy of the check is placed in the participant's file.	Participant's file contains a copy of the check

	Approved check request will be completed within 3 working days from the referral from agencies.	Participant's file demonstrates that the check request was completed in a timely manner.
Emergency financial assistance quality standards.	100% of all check requests will be completed within 3 working days of referral from agencies	Participant's file demonstrates that the check request was completed in compliance with the Standard.
	100% of all participants accessing service have met eligibility requirements	Participant's file demonstrates participant eligibility.

MEDICAL CASE MANAGEMENT

Service Category Description

Case management includes a range of participant-centered services that links participants with primary medical care, psychosocial and other services to ensure timely, coordinated access to medically-appropriate levels of health and support services and continuity of care.

Unit of Service: 1 Unit = 30 Minutes or less

Requirement	Indicator	Data Source
Scheduling and access to services.	Upon request for services, initial contact with participant must be made within one week.	Participant's file will show time between requested services and initial contact (progress notes).
	Participant will be assigned to a Medical Case Manager or be placed on a waiting list and filtered into a caseload as soon as a space becomes available.	Participant's file will show timely case manager assignment.
	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.	Participant's file will demonstrate time on a waiting list and indicate referrals to other providers.
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.
	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.
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.
	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 monitor participant services to ensure that services are related to the Individual Service Plan.	Participant's file contains progress notes related to the Individual Service Plan.
	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.	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 .
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 Individual Service Plan.	Participant's file contains updated Individual Service Plan.
	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.

MEDICATION TRANSPORTATION SERVICES

Service Category Description

Transportation services provided, directly or through voucher or tokens, to a participant in order to access primary medical care or psychosocial support 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.	Participant's file demonstrates appropriate use of funds.
	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 need.
Proper information regarding transportation shall be available to participants who qualify.	Information about community and public transportation is provided to all participants requesting services in order to empower and encourage self-sufficiency and to assist participants with maintaining quality of living.	Site Visit demonstrates that information is available on site.
	Information regarding the provider's specific programs, i.e. taxi vouchers and bus tokens, programs for the disabled and discount fares shall be researched and information distributed to program staff for quick reference and participants should be made aware of these services upon intake and on an on-going basis.	Site Visit demonstrates that information is available on site.

	Information regarding ambulance services should be available to all participants requesting such information.	Site Visit demonstrates that information is available on site.
Transportation Quality Management Indicators.	100% of 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 need and use for core services.
	100% of tokens will be purchased at a discounted rate	Provider's documentation or procedures show compliance.

MENTAL HEALTH SERVICES

Service Category Description

Mental health services include psychological and psychiatric treatment, as well as counseling services to individuals with a diagnosed mental illness. Services shall be conducted in a group or individual setting, provided by a mental health professional licensed or authorized within the State to render services.

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 qualification 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 degree or 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 copies of diplomas or other proof of degree or licensure.
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 in 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 mental health session.
	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 first mental health session or which referrals were provided.
Mental Health Services include the following: Biopsychosocial assessments; Treatment planning; Psychotherapeutic treatment (Individual sessions, Couple sessions,	Documentation of all services provided.	Participant's file documents all services.

Family sessions, Group sessions, and Case consultations); Crisis intervention; other services as deemed clinically appropriate.		
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.	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 in 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 and update treatment plan every three months.	Participant's file includes treatment plans which are updated at least every three months.
Progress notes shall be completed after every significant contact with participant. (Significant contact is defined as	Progress notes demonstrate the monitoring of participant services to ensure that services are related to the treatment plan.	Participant's file contains progress notes related to the treatment plan.

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.
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.	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 provider on 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.
Mental Health 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 mental health 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 .

Non-Medical Case Management

Service Category Description

Non-medical case managers conduct outreach programs within their communities to locate those who are not in care. The non-medical case managers refer new participants to a primary care provider and other support services such as food bank, housing assistance, and transportation.

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 Part A 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.
Scheduling and access to services.	Upon request for services, initial contact with participant must be made within two business days.	Participant's file will show time between requested services and initial contact.
	Non-medical case management services will include accessible, language specific to the participant, and culturally appropriate HIV disease education.	Participant's file demonstrates compliance.

Every participant shall have an intake interview and needs assessment to collect data important for care.	Participants have an intake interview completed within two weeks or the third face to face visit after opening the case.	Participant's file contains: Intake/financial eligibility forms, date of referral or service request and date of intake/financial eligibility assessment, record reflects name of assigned case manager and date of assignment.
	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.
	Participants may arrange to have their intake completed in an environment that is safe and comfortable for everyone.	Participant's file demonstrates a participant centered approach to the intake environment if 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 Part A 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.
	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 monitor participant services to ensure that services are related to the Service Linkage Plan.	Participant's file contains progress notes related to the service plan.
	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.	Participant's file states the reason for discharge and that proper referrals were made.
	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.
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 be referred to Part A funding within 1 year of being non-medical case management services	Participant's file documents all referrals.

ORAL HEALTH CARE

Service Category Description

The Dental Care category includes diagnostic, preventative, and therapeutic oral health care and services provided by dentists, dental hygienists, and similar professional practitioners.

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.
	Providers will ensure that active participants will be seen no longer than two weeks from the participant requests an appointment.	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.

<p>A comprehensive oral evaluation will be conducted at the first non-emergent appointment and will be ongoing if necessary.</p>	<p>The participant's presenting complaint, concerns and expectations should be considered by the dentist</p>	<p>Participant's file contains a signed and dated oral evaluation containing the participant's presenting complaint.</p>
	<p>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.</p>	<p>Participant's file contains signed, dated oral evaluation which includes relevant histories.</p>
	<p>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.</p>	<p>Participant's file contains a medical needs evaluation and a referral to primary care if necessary.</p>
	<p>A comprehensive oral and neck exam is conducted including an intra-oral exam evaluating for HIV associated lesions.</p>	<p>Participant's file contains signed, dated oral evaluation including a head and neck exam.</p>
	<p>Radiographs may include panoramic, bitewings and selected periapical films are conducted as treatment indicates.</p>	<p>Participant's file contains signed, dated oral evaluation, including appropriate diagnostic tools.</p>
	<p>Complete intra-oral exam, including evaluation for HIV associated lesions.</p>	<p>Participant's file contains signed, dated oral evaluation, including intra-oral exam.</p>
	<p>Complete periodontal exam or periodontal screening record.</p>	<p>Participant's file contains signed, dated oral evaluation, including periodontal exam or record.</p>

	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 the monitoring of participant services to ensure that services are related to the treatment plan.	Participant's file contains progress notes related to treatment plan.
	Progress notes demonstrate that the treatment plan is being implemented and followed or revised to meet the participant's changing dental, medical, and psychological/behavioral needs.	Participant's file contains progress notes related to treatment plan.
	Progress notes demonstrate that the participant's medical needs are being addressed and/or proper referrals are made.	Participant's file demonstrates that the dentist takes in consideration the participant's general medical condition and makes referrals as appropriate.
	A six month or shorter recall schedule will be used to monitor any changes.	Participant's file contains progress notes showing attempt to schedule appointments in compliance with indicator.

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.	Provider's policies and procedures concerning discharge procedures.
	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. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist shall decline to provide treatment.	Participant's file shows proper treatment is given based on the dentist's professional opinion.
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 3 to 6 months as needed.	Participant's file documents frequency of hygiene appointments.

75% of active participants will make progress in their treatment (completing greater than 50% of their treatment plan).

Participant's file documents progress for those who have been in service for over twelve months.

OUTPATIENT/AMBULATORY MEDICAL CARE

Service Category Description

The Primary Care category includes the provision of professional diagnostic and therapeutic medical services rendered by a physician, physician’s assistant, clinical nurse specialist or nurse practitioner in an outpatient setting. Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service’s health service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis, treatment of opportunistic infections and combination antiretroviral therapies.

Unit of Service: 1 Unit = 1 Service

Requirement	Indicator	Data Source
Practices should assure that patients have timely access to medical care.	Practices will have policies and procedures to handle care requests for patients new to the practice. Ideally, patients who disclose HIV + status and symptoms will be able to speak with a medical professional capable of assisting the patient to obtain medically appropriate care.	Provider's policies and procedures indicate how new patients will be admitted to the practice.
	Practices will have policies and procedures that facilitate timely, medically appropriate care. Ideally, practices will be able to see acutely symptomatic HIV + patients “same day” or will facilitate appropriate referral to urgent care or the emergency department.	Provider's policies and procedures indicate how emergent, urgent and acute needs of established patients are managed.
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.
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, Ophthalmologic, Head, ears, 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.
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/mm ³ 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 retain patients in care.
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.

	<p>90% of patients with HIV infection and a CD4 T-cell count below 200 cells/mm³ were prescribed PCP prophylaxis.</p>	<p>Patient's file and/or provider's report demonstrates compliance for patients appropriate for PCP prophylaxis.</p>
	<p>90% of patients with AIDS are prescribed HAART.</p>	<p>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).</p>

SUBSTANCE ABUSE SERVICES OUTPATIENT

Service Category Description

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

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 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 first session will occur within 3 weeks from the time of referral, if the participant is not in crisis. Participant can choose to stay on a waiting list longer than three weeks if they desire.	Participant's file provides documentation of the participant's initial request for services, as well as the first session.
	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.

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

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 .

APPENDIX: UNFUNDED SERVICES

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.
	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
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.

<p>Provider works to establish relationships with other health professionals and drug companies to ensure the best services are given to the participant.</p>	<p>Supply participant refill history directly to participant's health provider whenever possible or requested.</p>	<p>Provider's policies and procedures demonstrates how this is done in compliance with HIPAA Regulations.</p>
	<p>Provide pharmaceutical care and assist the medical team with adherence and monitoring of the patient while on antiretroviral therapy.</p>	<p>Participant's file demonstrates communication with medical team concerning adherence and monitoring when necessary.</p>
	<p>Inform other service providers about the Drug Reimbursement Program so they can refer participants whenever appropriate.</p>	<p>Provider can demonstrate how they market their program to other service providers.</p>
	<p>Access drug company sponsored patient assistance programs for medications and participants not covered by the drug reimbursement program whenever possible.</p>	<p>Provider can demonstrate how they utilize drug company sponsored assistances</p>
<p>Drug Reimbursement Quality Measures</p>	<p>100% of patients will have a drug profile in the pharmacy.</p>	<p>Participant's file review.</p>
	<p>All of prescriptions are filled properly.</p>	<p>Participant's file and Provider Report on properly filled prescriptions.</p>

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 in crisis. Participant can choose to stay on a waiting list if they desire.	Participant's file provides documentation of the participant's initial request for services, as well as the intake date.
	If the participant is in immediate crisis, they will be seen immediately or proper referrals will be made.	Participant's file provides documentation of the participant's initial request for services, as well as the intake date or 3 referrals.

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

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 .
	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 .