HIV RESOURCES
DENVER PUBLIC HEALTH
& ENVIRONMENT

DENVER HIV RESOURCES PLANNING COUNCIL

Part A Service Standards

Denver TGA Ryan White HIV/AIDS Program

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Introduction

This Service Standards document was prepared by Denver HIV Resources with opportunities for community input and is regularly reviewed by the Denver HIV Resources Planning Council in order to guide the delivery of high-quality services for people living with HIV and AIDS. This document was established to:

- Define service standards and quality management indicators for Part A-funded services.
- Provide DHR with a basis to evaluate services funded through Part A.

Service Standards are the minimum requirements that programs are expected to meet when providing HIV care and support services funded by the Ryan White Denver TGA. Programs may exceed these standards. Service Standards are tied to multiple processes throughout the Part A system and changes reverberate throughout the entire system.

Definitions and Descriptions

Service Standards: The minimum level or service standard that agencies must follow in the provision of Part A funded services.

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

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

Active Referral: A referral in the which the client is provided assistance by the program to complete the referral and receive the needed services.

Passive Referral: A referral in which the program does not track the success of the referral.

Acronyms

ACCI	American Consortium of Certified Interpreters
ADA	Americans with Disabilities Act
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
AND	Aid to the Needy Disabled
ART	Antiretroviral Therapy
CAB	Community Advisory Board
CARE Act	Comprehensive AIDS Resources Emergency Act
CARES Act	Coronavirus Aid, Relief and Economic Security Act

CBC	Complete Blood Count
CD4	Cluster of differentiation 4
CDI	Certified Deaf Interpreter
CFR	Code of Federal Regulations
CM	Case Manager
DHHS	Department of Health and Human Services
DHRPC	Denver HIV Resources Planning Council
DHR	Denver HIV Resources
DORA	Department of Regulatory Agencies
EFA	Emergency Financial Assistance
EIS	Early Intervention Services
FPL	Federal Poverty Level
HAB	HIV/AIDS Bureau
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HRSA	Health Resources and Service Administration
LTC	Linkage to Care
MCM	Medical Case Management
MH	Mental Health
MSM	Men who have sex with men
NADI	National Association of Deaf Interpreters
OBH	Office of Behavioral Health
OMB	Office of Management and Budget
PDSA	Plan, Do, Study, Act
PVD	Peripheral Vascular Disease
RID	Registry of Interpreters for the Deaf
RSR	Ryan White Services Report
RTD	Regional Transportation District
RW	Ryan White
RWHAP	Ryan White HIV/AIDS Program
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SS	Service Standards
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STI	Sexually Transmitted Infection
TB	Tuberculosis
TGA	Transitional Grant Area
VA	Veteran's Administration

Universal Standards

I. Documentation and Eligibility Screening

Programs must have systems in place that meet the requirements outlined in HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A (April 2013) – Section B. The following information should be in all client charts and will be checked during site visits. Agencies should not use client self-report for any required documentation.

STANDARD	MEASURE	DATA SOURCE
A. Programs will ensure appropriate screening and reassessment (every six months) of all clients to determine eligibility.	**A.1.** Verification of the client's HIV status should be from a medical program (i.e. lab work results, a letter on letterhead signed by medical staff personnel, or a current ADAP card or confirmation of application/renewal).	**Client's file** contains confirmation of HIV status. This must be confirmed at initiation of services.
	A.2. Client must qualify as low income; a household income of less than or equal to 400 percent of FPL. Household income is what the client defines as their household. People who meet the following criteria should be included when computing the household size of the client: • A legal spouse with whom the client resides; • The client's child with whom the client resides, including children related to the client biologically or through legal adoption; • Other children for whom the client pays child support, whether or not the children reside with the client.	**Client's file** contains paycheck or stub, bank statement, current ADAP card, confirmation of ADAP application/renewal, AND/SSI/SSDI award letter or TPQY, electronic confirmation of Medicaid eligibility (Medifax, DentaQuest, etc.) or other adequate proof. If the client is reporting no income, then the program must document how the client is subsisting. This must be confirmed every six months.

	Early Intervention Services (EIS) may be provided to clients of any income level, however, client's above the eligible income level may not receive Ryan White Part A service once linkage is complete.	
	A.3. Client must demonstrate insurance status including: • Uninsured or underinsured status. • Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare. • For underinsured, document the client's ineligibility for service. • Veterans receiving VA health benefits are considered uninsured, thus exempting these veterans from the "payer of last resort" requirement.	**Client's file** contains proof of insurance, underinsured, or documentation of ineligibility for third party insurance including Medicaid and Medicare. Documentation may include copy of dated insurance card or statement of coverage, current ADAP card or confirmation of ADAP application/renewal, AND/SSI award letter or TPQY, SSDI award if after the 2-year waiting period, electronic confirmation of Medicaid eligibility (Medifax, DentaQuest, etc.). If client has no insurance, the TGA Insurance Screening Template or other tool can be used to sign/attest that the person has no insurance. This must be confirmed every six months
	A.4. Client must demonstrate residence within the Denver TGA. The Denver TGA is comprised of Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson Counties.	**Client's file** contains any of the following documents with current, valid Denver TGA address and client's name including: • An unexpired Colorado driver's license or state-issued identification card with a current valid Colorado address; • A lease mortgage, rent receipts, hotel receipts, or other evidence that the client has obtained and/or paid for housing in Colorado; • A utility bill with a Colorado service address in the client's name; • Another form of government-issued identification with a valid Colorado residential address.

		• Medicaid card • ADAP enrollment verification; • Ramsell face sheet; • Medication and Medical Copay Assistance Identification Card. In certain instances, a client may be unable to produce one of the preferred forms of documentation of Colorado residency due to homelessness, undocumented status, or other barriers. In such instances, acceptable forms of documentation are: • A signed letter from a person with whom the client resides or who otherwise provides housing for the applicant, verifying the clients' residence in Colorado. This letter should include contact information and a case manager should follow up to confirm statements made in the letter. • A signed letter from a case manager, social worker or other professional explaining why the client's claim of Colorado residency is supportable (for example, the case manager has visited the client's home or the client has presented evidence of continual employment in a position that requires local residency). It is not necessary to be a U.S. citizen to receive Ryan White Program services. Applicants do not have to document citizenship or immigration status in order to be eligible for services.

	A.5. Document that all staff involved with eligibility determination have participated in a comprehensive, internal or external training in eligibility determination requirements.	**Personnel file** of all staff involved with eligibility determination demonstrates that the staff member has completed a comprehensive, internal or external training in eligibility determination requirements.
	A.6. Ensure program's client level data reporting is consistent with funding requirements, and demonstrates that eligible clients are receiving allowable services.	**Client's file and CAREWare data** demonstrate that client receives only allowable services.
B. Every client's legal name will be documented and used in the creation of the eURN in CAREWare**.**	**B.1.** Programs are to use the client's legal name attained from a government issued document in data entry in CAREWare.	**Client's file** contains copy of a government issued document showing legal name (e.g. driver's license, social security card, matricula card, and passport). This must be confirmed at initiation of services.
C. Every program must have the ability to screen clients for RW Part A eligibility.	**C.1.** Programs must have an eligibility screening procedure.	**Program's Policies and Procedures** include a procedure on eligibility screening process.
	C.2. Programs must have the necessary staff and systems for screening procedure.	**Program's Policies and Procedures** demonstrate the necessary staff and systems for screening procedure.
D. Program will provide timely and responsive services to clients.	**D.1.** Program must maintain a maximum response time of 3 business days, best practice being 1 business day, when providing phone assistance to clients and phone access for setting appointments, answering questions, and resolving problems. Program must respond to internet or email inquiries within 3	**Program's Policies and Procedures** demonstrate process for responding to clients within 1 business day.

	business day, best practice being 1 business day.	
	D.2. Program shall cancel less than 10 percent of all client appointments. All cancelled appointments receive active follow up, including the offer of a new appointment within 10 business days.	**Client's file** shows cancellation and rescheduling rates within the established limits. **Program's Policies and Procedures** demonstrate a policy for following up with clients if the program cancels an appointment.

II. Staff and Volunteer Requirements and Training

The program's staff have sufficient education, experience, and skills to competently serve the HIV client population.

STANDARD	MEASURE	DATA SOURCE
A. Staff members and volunteers will have a clear understanding of their job definition and responsibilities.	**A.1.** Written job descriptions will be on file and signed by the staff or volunteers.	**Personnel/Volunteer file** contains signed job description**.**
B. Staff members will receive structured supervision from qualified supervisors.	**B.1.** Every employee working directly with clients will receive supervision on both clinical and job performance issues. Programs 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 program for a year or more**.**
C. Staff and supervisors are qualified to provide the necessary services to clients.	**C.1.** Staff and Supervisors have the appropriate licensure, education and experience.	**Personnel file** has proof of licensure and/or education appropriate for the specific position**.**

D. Initial orientation and training shall be given to new direct service staff.	**D.1** Newly hired staff are oriented within 6 months of employment on the following: • Cultural mindfulness • Basic HIV information including medical and support services • Ryan White (RW) Care Act Part A services and other funding sources • Program's policy and procedures • Other government and community programs • Behavioral health services and support • Denver TGA Part A service standards and requirements Training can be internal and external to the organization.	**Personnel File** demonstrates the type, amount (minutes or hours), and date of orientation and training that each staff receives both internally and externally.
E. Staff should receive the following training annually.	**E.1.** Every staff handling confidential information will receive an annual training concerning HIPAA and confidentiality.	**Personnel file** demonstrates the type and amount of training each staff received both internally and externally.
	E.2. Every staff receives annual training on Occupational Safety Health Administration regulations and universal precautions.	**Personnel file** demonstrates the type and amount of training each staff received both internally and externally.
	E.3. Every direct care staff receives 20 hours of job specific professional development training annually.	**Personnel file** demonstrates the type and amount of training each staff received both internally and externally.

F. Each program has a volunteer training program appropriate to support each volunteer position.	**F.1.** Initial orientation and training for volunteers working directly with clients must be completed prior to working directly with clients and should include, at a minimum, the following: • Cultural mindfulness • Basic HIV information • Basic client contact skills • HIPAA and confidentiality • Program's policy and procedures Training can be internal and external to the organization.	**Volunteer file** demonstrates the type and amount of orientation the volunteer received.
G. Staff or volunteers working with clients are to be screened in accordance with state and local laws.	**G.1.** Background checks must be obtained as required by state and local laws.	**Personnel or Volunteer file** contains background checks.
H. Staff or volunteers transporting clients will have a valid Colorado driver's license and proof of insurance.	**H.1.** Programs will ensure that they have a current valid driver's license and current insurance information for each staff or volunteer who transports clients.	**Personnel or Volunteer File** contains a copy of a valid driver's license for those staff or volunteer who transport clients.

III. Quality Management

Programs are responsible for ongoing quality management programs to improve funded programs, as well as to offer regular feedback to staff to help promote performance.

STANDARD	MEASURE	DATA SOURCE
A. Each program will have written policies on Quality Management, including how data will be used to improve each funded program.	**A.1.** Each program will collect client level data to support CAREWare reporting and other data reports as indicated.	**Reports from Denver HIV Resources** will be completed accurately and on time.
	A.2. Each program will adopt a quality improvement system (Chronic Care Model, PDSA Cycle, or other) to guide work plans and	**Program's Reports** documents the use of a quality improvement system.

	other quality management activities.	
B. Each program will have a Quality Management Plan (Quality resources, example plans, and free web training available at NationalQualityCenter.org).	**B.1.** Each program will have a quality plan to assess the quality of care provided, to ensure that deficiencies are identified and addressed, and to identify areas for improvement.	**Program's Reports** documents the use of a quality plan.
	B.2. Quality plan is updated annually**.**	**Program's Reports** document quality plan revisions.
C. Program will document quality management activities, including at least one quality improvement project focused on evaluating or improving HIV program services.	**C.1.** Quality improvement projects must be focused on improvement of health outcomes along the HIV Care Continuum.	**Program's files and reports** document quality management activities.
	C.2. QI projects are not administrative in nature for the purposes of the CQM Plan.	
	C.3. Programs will use a Plan Do Study Act (PDSA) model for improvement for reporting projects to Denver HIV Resources.	
D. Program will assure compliance with relevant service category definitions and Denver transitional grant area (TGA) service standards.	**D.1.** Program will conduct quality assurance activities as needed to comply with Denver TGA service standards.	**Program's files and reports** document quality assurance activities.
E. Program will implement structured and ongoing efforts to obtain input from clients regarding the design and delivery of services.	**E.1.** Program will maintain visible suggestion box or other client input mechanism.	**Site visit** inspection of program facility.
	E.2. Program will implement client satisfaction survey tool, focus groups, and/or public meetings, with analysis and use of results documented annually.	**Program's Files** demonstrate implementation of satisfaction survey tool, focus groups, and/or public meetings including analysis and use of results.

IV. Confidentiality

Programs must have systems in place to protect confidentiality according to best practices and applicable regulations.

STANDARD	MEASURE	DATA SOURCE
A. Programs shall have written policies and procedures addressing client confidentiality which are compliant with HIPAA.	**A.1.** Policies and procedures should address HIV-related confidentiality and program procedures, including those limiting access to passwords, electronic files, medical records, faxes, and release of client information.	**Program's Policies and Procedures** on confidentiality.
	A.2. Policies and Procedures are signed and dated by staff during orientation.	**Personnel file** has a signed statement by each staff that the staff has read and understood the program's policies and procedures regarding confidentiality.
	A.3. Major changes in policies and procedures are presented to all the staff they impact.	**Personnel file** indicates that staff have been trained on any major changes to policies and procedures.
B. All hard copy materials and records shall be securely maintained by the Program.	**B.1.** Records and hard copy materials are maintained under double lock (in locked files and in locked areas); secure from public access.	**Site Visit** observation**.**
	B.2. Each computer is password protected and staff/volunteers must change passwords at least every 120 days.	**Program's Policies and Procedures** on confidentiality demonstrate compliance.
C. There should be no release of client information without a signed, dated client release.	**C.1.** Clients must be informed of the release of information form and under what circumstances client information can be released.	**Client's File** contains a signed release of information form with all required elements appropriate to the services provided and information needed.
	C.2. There should be a signed, dated release of information form specific to HIV, TB, STI, substance misuse, mental health and any other confidential information prior	**Client's File** contains a signed release of information form with all required elements appropriate to the services provided and information needed.

	to the release or exchange of any information.	
D. Program must have a private space or appropriate accommodations to conduct confidential client meetings.	**D.1.** The program will make accommodations that ensure confidential client meetings in which others cannot hear the conversation (i.e. room with floor to ceiling walls and a door, white noise machine, etc.)	**Site Visit** inspection of program's facility**.**

V. Culturally Mindful and Linguistically Appropriate Service Delivery

Programs will provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural beliefs, practices, and experience, preferred languages, health literacy, and other communication needs. Interpretation services refer to oral and visual services and translation services refer to written services.

Standard	Measure	Data Source
A. Programs will ensure that clients receive from all staff members effective, equitable, understandable, respectful and quality care that is provided in a manner compatible with the client's cultural beliefs, practices, and experience.	**A.1.** All staff members receive appropriate cultural mindfulness training within the first year of employment and at least annually thereafter.	**Program's Policies and Procedures** contain requirements for culturally mindful training for all staff members. **Personnel files** demonstrate the type, amount (minutes or hours), and date of training that each staff receives both internally and externally.
	A.2 Programs shall adopt and implement the National Standards for Culturally and Linguistically Appropriate Services (CLAS) as relevant to their program.	
B. Programs recruit, retain, and promote a diverse staff and leadership that reflects the cultural and linguistic diversity of the community.	**B.1.** Programs have a strategy on file to recruit, retain, and promote qualified, diverse, and linguistically and culturally mindful administrative, clinical, and support staff who are trained and qualified to address the needs of people living with HIV.	**Program's Policies and Procedures** contain strategies to recruit, retain, and promote a diverse staff and leadership that reflects the cultural and linguistic diversity of the community.

C. Programs assess the cultural and linguistic needs, resources, and assets of its service area and focused population(s).	**C.1.** Programs collect and use demographic, epidemiological, and service utilization data in planning for focused population(s).	**Program's Policies and Procedures** contain strategies to assess the cultural and linguistic needs, resources, and assets of its service area.

D. Programs ensure access to services for clients with limited English proficiency.	**D.1.** Programs ensure access in one of the following ways (listed in order of preference):
	• Bilingual staff who can communicate directly with clients in their preferred language
	• Face-to-face interpretations provided by:
	  ○ Qualified staff, contract interpreters, or volunteer interpreters;
	  ○ Telephone interpreter services; or
	  ○ Video interpreter services.
	• Referral to programs with bilingual/bicultural clinical, administrative, and support staff and/or interpretation services by a qualified bilingual/bicultural interpreter.
		Personnel file includes relevant certifications for interpreters and/or bilingual staff or volunteers and documentation of skills.
		
		Program's Policies and Procedures cover how the program provides services for patients with limited English proficiency, including a directory of telephone interpreter services and a listing of programs that provide bilingual/bicultural services.
		
		Client's File contains documentation of preferred language.

	D.2. Family and friends are not considered adequate substitutes for interpreters because of confidentiality, privacy, and medical terminology issues. If a client chooses to have a family member or friend as their interpreter, the provider must obtain a written and signed consent in the client's preferred language. Family member or friend must be over the age of 18.	**Client's File** contains signed consent form that requests family member or friend to provide interpretation services.
E. Interpretation services are provided	**E.1.** Individuals providing interpretation services will have	**Personnel file** demonstrates the type, amount (minutes or hours), and date of training

by properly trained and certified staff.	completed a medical interpreter training that includes: • Proficient interpretation skills; • Information on healthcare (and HIV care preferred); • Cultural mindfulness; and • Communication skills for advocacy.	that each staff member receives both internally and externally.
	E.2. Sign language interpreters should be certified by the Registry of Interpreters for the Deaf (RID) at a minimum level of Certified Deaf Interpreter (CDI), by the American Consortium of Certified Interpreters (ACCI) at a minimum level IV (Above Average Performance), the National Association of Deaf Interpreters (NAD) at a minimum of Level IV, or have relevant experience.	**Personnel File** has proof of certification/ licensure for the position.

VI. Client Rights and Responsibilities

Informing clients of their rights and responsibilities encourages them to be active clients in their own healthcare, and ensures that services are accessible to eligible clients.

STANDARD	MEASURE	DATA SOURCE
A. Programs shall have an established grievance policy and procedure in place that allows clients to express concerns and/or file complaints if they are dissatisfied with the services provided. Clients must be informed of this policy.	**A.1.** Clients must read and sign a form outlining the grievance policy and procedure.	**Client's File** contains a copy of a signed and dated grievance form.
	A.2. Programs must review the grievance policy and procedure annually and update as appropriate.	**Program's Policies and Procedures** include a grievance policy and procedure.
	A.3. Programs are responsible for notifying DHR of any formal grievance filed against the program by a Ryan White funded client. Grievances must be reported at a minimum on quarterly narratives	**Program's Reports** document grievances.

	submitted to DHR with confidential information deducted as applicable.	
B. Program provides each client a copy of a client rights and responsibilities form that informs client of what they are allowed and what is required of them.	**B.1.** Client Rights and Responsibilities includes, at a minimum: • the program's expectations of the client as a participant of services • the client's right to file a grievance; • the client's right to receive no-cost interpreter services; • The reasons for which a client's case may be closed/inactivated from services, including due process for involuntary closure/inactivation.	**Program's Policies and Procedures** contains Client Rights and Responsibilities form
	B.2. Clients must read and sign a copy of the Client Rights and Responsibilities form	**Client's File** contains copy of signed and dated form.
C. Clients have the right to access their file.	**C.1.** Program has a policy on client file access that is sensitive to the client's concerns according to clinical best practice guidelines.	**Program's Policies and Procedures** contains a policy on client file access
	C.2. Client's files are retained for at least 7 years after the last day that the client accessed services	**Program's Policies and Procedures** contains a policy on file retention and destruction.

VII. Access to Services

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

STANDARD	MEASURE	DATA SOURCE
A. Programs shall eliminate barriers to service and ensure provision of services in a setting accessible to low-income individuals with HIV.	**A.1**. Medical care, pharmaceuticals, case management, and home health care shall provide accessible hours for service delivery.	**DHR Contract** will include the Scope of Service description, and the hours of service will be posted in a prominent place within the program.

	A.2. Program will comply with Americans with Disabilities Act (ADA) requirements.	**Program's files** will document ADA complaints and grievances, with documentation of complaint review and decision reached.
	A.3. Appropriate accommodations shall be made to meet language or other needs such as illiteracy, visual or hearing impairment.	**Program's Policies and Procedures** demonstrate how they provide services to those needing special accommodations.
	A.4. Program will ensure that the facility is accessible by public transportation or provides for transportation.	**Site visit** inspection of program facility.
	A.5. Programs will document efforts to inform low-income individuals of the availability of HIV-related services and how to access them. Program will maintain file documenting program activities for the promotion of HIV services to low- income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements.	**Program's Files** will document program activities for the promotion of HIV services to low-income individuals.
B. Program shall allow for the provision of services regardless of an individual's ability to pay for the service.	**B.1.** Program will have billing, collection, co-pay, and sliding fee policies that do not act as a barrier to providing services regardless of the client's ability to pay. See imposition of client charges policies and procedures.	**Program's Policies and Procedures** document their billing, collection, co-pay and sliding fee policies and that they do not act as a barrier to providing services regardless of the client's ability to pay.
	B.2. Program will maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from clients, with documentation of complaint review and decision reached.	**Program's files** will document individuals refused services with reasons for refusal specified; included in file are any complaints from clients, with documentation of complaint review and decision reached.

C. Programs will ensure provision of services regardless of the current or past health condition of the individual to be served.	**C.1.** Eligibility Policies and Procedures state that services are provided regardless of pre-existing conditions.	**Program's Policies and Procedures** will document that services are provided regardless of pre-existing conditions.
	C.2. Maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from clients, with documentation of complaint review and decision reached.	**Program's files** will document individuals refused services with reasons for refusal specified; included in file are any complaints from clients, with documentation of complaint review and decision reached.
D. Programs will have a full range of service referrals available and will actively or passively direct clients to additional services appropriate to client situation, preference, and need.	**D.1.** To establish this base of referrals, programs 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.	**Program's policies and procedures** demonstrate that the program has established a full range of service referrals and maintains effective referral relationships with other programs.
	D.2. Programs may make an active referral or a passive referral based on the client's situation, preference, and need.	**Program's policies and procedures** demonstrate that the program has processes for making active and passive referrals.

VIII. Transition and Closure

Programs must have systems in place to ensure that client cases are closed fairly and with due process.

STANDARD	MEASURE	DATA SOURCE

A. The program has a comprehensive transition and closure procedure in place that is implemented for clients leaving services.	**A.1.** Policy includes that a client case may be closed if: • the client dies; • the client requests closure; • the client's needs change and they would be better served through services at another provider agency; • the client's actions put the agency, service provider, or other clients at risk; • the client sells or exchanges emergency assistance, child care, or transportation vouchers for cash or other resource for which the assistance is not intended; • the client moves/relocates out of the service area; or • the program is unable to reach a client after at least 3 attempts over a period of 3 months.	**Program's Policies and Procedures** outlines closure procedures. **Client's File** indicates reason for closure of client case.
B. Program has a due process policy in place for involuntary closure of client cases from services.	**B.1.** Policy covers the steps taken before involuntarily closing a client case, including numerous verbal and written warnings before final notice and closure.	**Program's Policies and Procedures** outline the necessary steps before a client case is closed. **Client's file** details all contact attempts made.
C. Program has a process for maintaining communication with clients who are active and identifying those who are inactive.	**C.1.** Clients are considered inactive if the program is unable to reach a client after at least 3 attempts over a period of 3 months. All communication attempts are documented.	**Client's File** contains details of communication attempts.
D. At the time of transition or closure, the program will make referrals to services and/or programs based on the requests and preferences of the client.	**D.1.** Referrals to programs and/or services at the time of transition or closure will be made in a timely manner and documented.	**Client's File** contains documentation of any referrals.

Service Category Service Standards

Early Intervention Services

An EIS program is a package of services designed to identify and link a newly diagnosed person to Outpatient/Ambulatory Health Services (OAHS), Medical Case Management (MCM), and Substance Use Outpatient Services (SAO), if indicated (see "Linked" definition below). The package of services is defined below, and includes screening for barriers and needs, creating a plan to address client needs, and health education and literacy. Once a client has been successfully linked to OAHS or SAO, the EIS engagement is complete. If a client needs ongoing support, the support would happen in MCM Services.

Early Intervention Services (EIS) for Part A may include targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV; referral services to improve HIV care and treatment services at key points of entry; access and linkage to HIV care and treatment services such as OAHS, MCM, and SAO. If an EIS program provides targeted testing, the program will coordinate testing services with other HIV prevention and testing programs to avoid duplication of efforts and ensure that HIV testing paid for by EIS does not supplant testing efforts paid for by other sources.

Definitions and Descriptions

The following indicates that the client has been "Linked":

- Client followed through on first HIV care appointments: and
- CD4 test and/or viral load test was completed: and
- If appropriate, referral to medical case management was made

Active referral process given to clients should include, at a minimum, referral to a named program, and release of information form (if refused by client this must be documented and communicated upon referral).

Targeted HIV testing is a focused effort for people who are unaware of their HIV status who may have increased chance of HIV exposure.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
DHR	Denver HIV Resources
DHRPC	Denver HIV Resource Planning Council
EIS	Early Intervention Services
HIV	Human Immunodeficiency Virus
MCM	Medical Case Management
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding

ROI	Release of Information
RWHAP	Ryan White HIV/AIDS Program
SS	Service Standards

Units of Service

1 unit = 30 minutes

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Programs funded for EIS Linkage services may provide targeted HIV testing services to vulnerable populations.	**A.1.** Programs providing HIV testing services must create a targeted testing plan.	**Program's policies and procedures** will contain an approved targeted HIV testing plan.
	A. 2. Protocols are in place documenting the connection between testing and linkage services, including clear roles, responsibilities, and processes.	**Program's policies and procedures** will contain the protocol detailing the connection between testing and linkage services, including clear roles, responsibilities, and processes
	A.3. Testing services must coordinate with other HIV prevention and testing programs to avoid duplication of effort.	**Provider's policies and procedures** will document that relationships will be maintained with other programs and documented via MOA, MOU, letter of support, or another source.
	A.4. Ryan White Part A is the payer of last resort and HIV testing covered by EIS under RWHAP cannot replace testing efforts paid for by other sources.	**Provider's policies and procedures** will document that RWHAP is the payer of last resort and testing services covered by EIS under RWHAP cannot replace testing efforts paid for by other sources.

B. EIS Services will be utilized to link individuals who are newly diagnosed with HIV or are aware of their status and currently not in care.	**B.1.** Clients eligible for EIS are individuals newly diagnosed with HIV or are aware of their status and currently not in care.	**Client's file** contains the date of a client's HIV diagnosis.
	B.2. EIS is a brief service to ensure linkage to medical care and other needed services. EIS services may be as short as one interaction, or last up to 90 days. If additional time is needed, the reason must be clearly documented.	**Client's file** documents the dates of service and reflect that services lasted no longer than 90 days. If additional time is needed the reason is documented and includes a timeline for expected completion of services.
	B.3. If at any time during this process a Linkage Referral is made to another EIS Linkage Provider (for example a referral for confirmatory testing), the responsibility for linking the client to an HIV medical provider, and/or MCM services will transition to the new EIS Provider. The referral to the new EIS Provider should be documented following the Linkage Referral guidance defined above.	**Client's file** will contain the Linkage Referral and documentation confirming the client connected to the new EIS Provider.
C. EIS client will be assessed utilizing an approved screening tool to identify needs and barriers to services. This screening will be used to develop a Linkage Plan.	**C.1.** EIS provider will schedule an EIS screening session within three business days of HIV diagnosis.	**Client's file** will contain documentation regarding contact with the client, documentation that the client was scheduled to be screened within 3 business days of a new diagnosis and an identified need for EIS.

	C.2. The approved screening tool will include but is not limited to the assessment of: • Barriers to medical care; • Client's behavioral health; • Substance use; • Financial situation; • Housing situation; • Payer source for medical care; and • Health education, risk reduction, and health literacy needs.	**Client's file** contains a completed EIS screening that includes the date of diagnosis, date of the screening, and the identified priority need areas.
D. EIS program will link client to a HIV medical provider within 30 days and not to exceed 90 days of entry into EIS.	**D.1.** Clients will be referred to a HIV medical provider. A release of information will be established between the EIS program and the medical provider.	**Client's file** documents the date of the linkage referral release of information between EIS program and the medical provider. If the ROI is refused by client, this is documented in the file.
	D.2. EIS program will confirm client has linked to a HIV medical provider within 30 days and not to exceed 90 days of entry into EIS.	**Client's file** documents the date of the confirmed medical appointment, and labs (CD4 and/or Viral Load) reflecting that it was within 30 and did not exceed 90 days of entry into EIS.
E. EIS providers will make a linkage referral to a Medical Case Management program within 30 days of entry if MCM services are needed and if the client agrees.	**E.1.** If the EIS screening indicates MCM services are needed, and the client agrees, a linkage referral will be made to an MCM program. If the client does not agree, they will be offered information about available MCM programs.	**Client's file** will contain documentation of referral and if the client accepted the referral. If the client does not accept the referral, the EIS program will document the information that was provided.
	E.2. Linkage referrals to MCM services will occur within 30	**Client's file** documents the date of linkage

	days of entering EIS not to exceed 90 days.	referral reflecting that it was within 30 days of entry into EIS and did not exceed 90 days.
	E.3. A release of information will be established between the EIS provider and the MCM program.	**Client's file** documents the date of the linkage referral release of information between the EIS program and the MCM program.
F. All EIS clients must have a Linkage Plan.	**F.1.** The Linkage Plan will document a plan to address the needs identified in the EIS screening. The plan will contain goals, objectives, action steps, and outcomes.	**Client's file** contains a Linkage Plan.
	F. 2. The Linkage Plan will be created at the time of screening, or within one week of the EIS screening.	**Client's file** contains a Linkage Plan that identifies the date of when the plan was created.
	F. 3. The linkage plan will document when EIS services have been completed.	**Client's file** contains a Linkage Plan that identifies the date when the plan was completed.
	F. 4. If at the end of 90 days there continue to be barriers to accessing care, a new Linkage Plan will be established.	**Client's file** contains a new Linkage Plan that identifies the barriers and actions to alleviate those barriers with a timeline for service completion.
G. Progress notes will be completed after every contact with the client and every contact related to the client that lasts at least 15 minutes or is significant to care.	**G.1.** Progress notes demonstrate that the Linkage Plan is being implemented and followed or revised to meet the client's needs.	**Client's file** contains progress notes.

Emergency Financial Assistance

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist a RWHAP Part A client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

The Denver Part A RWHAP currently funds Medical Transportation, Housing Services, and Food Bank / Home-delivered Meals service categories.

Acronyms

ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
DHR	Denver HIV Resources
DSS	Division of Service Systems
EFA	Emergency Financial Assistance
FPL	Federal Poverty Line
HIV	Human Immunodeficiency Virus
PLWH	Person(s) Living With HIV
RWHAP	Ryan White HIV/AIDS Program

Units of Service

1 unit = any assistance request (including denied requests)

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Client eligibility is based on income level. **Clients between 0 - 400 percent of Federal Poverty Level (FPL)** are eligible for emergency financial assistance not to exceed $1,000 for the current fiscal year.	**A.1.** Payments may be made for the following services, and may include past due charges, but do not include items in collections: **- Phone, Internet, Cable:** Cable cannot be paid for as a standalone. **- Water** **- Trash**	**Client's file** contains documentation, such as a bill that documents the reason for the request, dollars needed, and the vendor to be paid. Documentation shows that client is at 400% FPL, or below.

EFA funds may not be used for clothing, or direct cash payments	- **Utilities:** Payments may be made for electric, gas, and sewer. - **HIV-related medication** not covered by ADAP (single occurrence or short duration) - **Food and essential household supplies**, if there is no separate food bank at the provider. - **Transportation**, if there is no separate medical transportation service available - **Medical and Insurance:** Payments may be made for medical premiums and pharmacy copayments secondary to ADAP. Utilization of ADAP must be ruled out first. Includes past due charges, however charges may not be in collections. Payments cannot be made to a current Ryan White Part A Program. **Optical:** Payments may be made for copayments, prescription eye wear, but not the exam. Request must include letter from HIV Medical Provider documenting HIV medical necessity. Payments cannot be made to a current Ryan White Part A Program. - **ID Cards** - **Colorado Bureau of Investigation (CBI) background investigation fees** - **Housing Related Application Fees** - **Child Care Services:** Payments can be made to provide intermittent child care through a licensed child care provider that will enable an HIV positive adult or child to secure needed medical, or support services, or to participate in Ryan White	

	HIV/AIDS program-related activities.	
B. Programs will have procedures for clients to gain EFA assistance, deny EFA requests, and handle inappropriate use of funds. Eligibility criteria will be applied equally to all clients regardless of program.	**B.1.** The client and program will meet in a way that allows client participation (i.e. in person, virtually, by email, or by phone) to process the housing request.	**Client's file** contains documentation of client participation in the process**.**
	B.2. The client and the program will develop a complete plan, including financial planning, applying for available benefits and subsidies, and creating a plausible budget. The program will give the client a list of financial planning resources when creating a plan.	**Client's file** contains a copy of the financial plan or a program specific planning tool.
	B. 3. A client can be suspended from EFA for up to three months, for misrepresentation of expenses, income or other policy violations. If a client is suspended from accessing EFA, the program will notify the client and the single payer within three business days of the suspension effective date and the client will be made aware of how to appeal the suspension.	**Client's file** documents verbal or written communication to the client and the single payer regarding the misrepresentation of expenses, income, or other policy violations that led to subsequent suspension, as well as communication on how the client can appeal the suspension. **Program's policies and procedures** demonstrates a process for notifying the client and the single payer of the suspension.
C. Single payer will respond to check requests in a timely manner and maintain payment records.	**C.1.** Checks for EFA will be issued by the contracted single payer program.	**Single payer records** contain check information.
	C. 2. Checks will be sent to the vendor address listed on the request. Checks cannot be payable or issued to clients.	**Single payer records** demonstrate that checks will be sent to the vendor.
	C. 3. The single payer will maintain electronic records of checks related to EFA.	**Single payer records** contain check information.

	C. 4. Approved check request will be completed within three business days of the request date.	**Single payer records** demonstrate that check requests were completed in a timely manner.

Food Bank and Home-Delivered Meals

Food bank and home-delivered meals involves the provision of actual food items or prepared meals. This includes the provision of both frozen and hot meals. It does not include finances to purchase food or meals but may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items, household cleaning supplies, and water filtration/purification systems in communities where issues of water safety exist should be included in this item.

Definitions and Descriptions

Food Services include home delivered meals, food bank services, food vouchers and essential hygiene items, household cleaning supplies, and water filtration/ purification systems in communities where issues with water purity exist.

Registered Dietitian Nutritionist is an expert in food or nutrition who has completed the following:

- A Bachelor's, Master's or Doctorate degree in nutrition and related sciences;
- A supervised dietetic internship or equivalent; and
- A national exam which credentials her/him as an RD by the Commission on Dietetic Registration.

Food Banks are distribution centers that warehouse food and related grocery items including nutritional supplements and other miscellaneous items.

Home-delivered Meals is the provision of prepared meals that meet the client's nutritional and dietary requirements. This includes the provision of frozen, cold and hot meals.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ASO	AIDS Services Organization
CBO	Community Based Organization
DHR	Denver HIV Resources
DTR	Dietetic Technician Registered
HIV	Human Immunodeficiency Virus
RD	Registered Dietitian

Units of Service

Service units of Food Bank/Home Delivered Meals services are defined as the number of meals or bags of groceries provided to eligible clients.

1 unit = 1 meal

1 unit = 1 bag of groceries

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Staff and volunteers have appropriate skills, relevant training, and knowledge about HIV and safe food handling.	**A.1.** Staff or volunteers involved in food preparation and/or food distribution will complete a food safety class equivalent to State of Colorado standards.	**Personnel files** document staff and volunteer training hours.
	A.2. Supervisory staff will stay current with the latest information on HIV and nutrition by attending trainings on an annual basis.	**Personnel file** will document topic specific training.
B. Funding for Food Bank/Home-delivered Meals will cover HRSA-approved food items and essential non-food items.	**B.1.** Allowable costs include: Food items: • The provision of actual food items; • Provision of frozen, cold, or hot meals; and • A voucher program to purchase food. Essential non-food items: • Personal hygiene products; • Household cleaning supplies; and • Water filtration/ purification systems in communities where issues with water purity exist.	**Program's policies and procedures** will document allowable costs under RWHAP.
	B.2. Unallowable costs include: • Household appliances; • Pet foods;	**Provider's policies and procedures** will document un-

	• Permanent water filtration systems for water entering the house; and • Other non-essential products.	allowable costs under RWHAP.
	B.3. Documentation that: • Services supported are limited to food bank, home- delivered meals, and/or food voucher program; • Types of non-food items provided are allowable; and • If water filtration/ purification systems are provided, community has water purity issues.	**Program's policies and procedures** document allowable and unallowable costs under RWHAP.
C. Food services will comply with current food safety guidelines.	**C.1.** Food services will comply with Colorado food safety regulations, USDA dietary guidelines for Americans, FDA food safety guidelines, Office of Disease Prevention and Health Promotion guidelines.	**Documentation** that agency has participated in an annual food safety inspection.
D. If the program has a waitlist, the waitlist is appropriately managed.	**D.1.** If a provider is ever faced with the need to create a waiting list, the program must provide documentation explaining the need for a wait list.	**Program's policies and procedures** demonstrate how waiting lists and referrals are managed.
	D.2. The program will maintain referral relationships with other Food Bank/Home delivered meal programs in the area.	**Program's policies and procedures** details networking strategy and list of referral relationships.
	D.3. The wait list is managed in an equitable manner. If growth restrictions become inevitable, then programs will serve those most in need based on overall health.	**Policies and procedures** demonstrate how waiting lists are managed.

I. Food Bank Service Components

Food banks are distribution centers that warehouse food and related grocery items including nutritional supplements and other miscellaneous items. They are required to ensure services are convenient for and accessible to participants through removing barriers to service or developing an innovative approach to ensure access.

STANDARD	MEASURE	DATA SOURCE
A. Food banks will make sure their services are accessible for clients.	**A.1.** Food bank hours will be accessible to participants with variable schedules and must include operating hours that are outside of 9am-5pm Monday-Friday.	**Program's Policies and Procedures** document accessible food bank hours.
	A.2. Program should be accessible via public transportation.	**Program's Policies and Procedures** document program accessibility via public transportation.

II. Home-Delivered Meals Service Components

Home delivered meals is the provision of prepared meals that meet the client's nutritional and dietary requirements. This includes the provision of frozen, cold, and hot meals. Home delivered meals are provided for clients experiencing physical or emotional difficulties related to HIV that render them incapable of preparing nutritional meals for themselves.

STANDARD	MEASURE	DATA SOURCE
A. Home delivered meals will be provided in a manner convenient to the client and will meet the client's nutritional needs.	**A.1.** Participants will be given a delivery time period within which they can expect to receive their meals.	**Provider's policies and procedures** address communication and standards around delivery of food.
	A.2. Meals will have caloric and nutritional content to meet the individual participant's dietary needs.	**Program's Menus** demonstrate each meal's average caloric and nutritional content.
	A.3. Menus will be made in conjunction with RD to ensure it meets the participants' nutritional needs.	**Program's Policies and Procedures** contain documentation that registered dietitian signed off on the menu.
B. Home delivered meal services will follow accepted standards of practice of the Academy of	**B.1.** Home delivered meals services will follow accepted standards of practice of the Academy of Nutrition and Dietetics, and	**Program's Policies and** Procedures contain documentation that program is following

Nutrition and Dietetics and HIV/AIDS Evidence-Based Nutrition Practice Guidelines.	HIV/AIDS Evidence-Based Nutrition Practice Guidelines.	accepted nutrition standards.
C. Program must assess needs of each client receiving home-delivered meals at least once a year to assure compliance with service requirements.	**C.1** Provider assesses client needs and status at least once a year and includes: • Dietary and cultural food needs; • Food preferences; and • Client's ability to access services.	**Client's file** show annual assessment of need.

Housing Services

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Acronyms

AIDS	**Acquired Immunodeficiency Syndrome**
DHR	Denver HIV Resources
FPL	Federal Poverty Level
HIV	Human Immunodeficiency Virus
PLWH	People Living With HIV

Units of Service

1 unit = any assistance request (including denied requests)

Service Components

STANDARD	MEASURE	DATA SOURCE

A. Client eligibility is based on income level. Clients between 0-400 percent of FPL are eligible for housing assistance not to exceed $1,200 for the current fiscal year. Housing services funds may not be used for subsidized housing, rental deposits, or mortgage payments.	**A.1.** Payments may be made for the following services, and may include past due charges, but do not include items in collections: **Rental Assistance**: Payments may be made for rent assistance. **Hotel/Motel:** Payments may be made for a hotel, or motel.	**Client's file** contains documentation including a lease, letter, or other proof of dollars needed and vendor to be paid. If it is a sublease, the vendor must be the property owner. If property owner is an individual, not a company, owner must be verified using the assessor's website(s).
B. Programs will have procedures for clients to gain housing assistance, deny housing requests, and handle inappropriate use of funds. Eligibility criteria will be applied equally to all clients regardless of program.	**B.1.** The client and program will meet in a way that allows client participation (i.e. in person, virtually, by email, or by phone) to process the housing request.	**Client's file** contains documentation of client participation in the process**.**
	B.2. The client and the program will develop a complete plan, including a short, and long term housing plan, applying for available benefits and subsidies, and creating a plausible budget. The program will give the client a list of financial planning resources when creating a plan.	**Client's file** contains a copy of the financial plan or a program specific planning tool.
	B. 3. A client can be suspended from housing services for up to three months, for misrepresentation of expenses, income or other policy violations. If a client is suspended from accessing housing services, the program will notify the client and the single payer within three business days of the suspension effective date and the client will be made aware of how to appeal the suspension.	**Client's file** documents verbal or written communication to the client and the single payer regarding the misrepresentation of expenses, income, or other policy violations that led to subsequent suspension, as well as communication on how the client can appeal the suspension.

		Program's policies and procedures demonstrates a process for notifying the client and the single payer of the suspension.
C. Single payer will respond to check requests in a timely manner and maintain payment records.	**C.1.** Checks for housing services will be issued by the contracted single payer program.	**Single payer records** contain check information.
	C. 2. Checks will be sent to the vendor address listed on in the request. Checks will not be payable or issued to clients.	**Single payer records** demonstrate that checks will be sent to the vendor.
	C. 3. The single payer will maintain electronic records of checks related to housing services.	**Single payer records** contain check information.
	C. 4. Approved check request will be completed within three business days of the request date.	**Single payer records** demonstrate that check requests were completed in a timely manner.

Medical Case Management

Medical Case Management is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services in order to improve health outcomes in support of the HIV care continuum. MCM provides coordination, guidance, active and passive referrals, and assistance in accessing medical, social, community, legal, financial, income related activities, and/or other needed services. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g. face-to-face, phone contact, and any other forms of communication). The primary goal of MCM is to improve client health care outcomes by helping clients address barriers directly affecting their abilities to adhere to medical advice. MCM's hallmark characteristic is having the case manager work directly with the client's HIV medical providers to address these issues. Whereas, the services provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Key activities include:

- Initial assessment of service needs;

- Development of a comprehensive, individualized care plan;
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care;
- Continuous client monitoring to assess the efficacy of the care plan;
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems;
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments;
- Client-specific advocacy and/or review of utilization of services; and
- Coordination with medical providers.

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
MCM	Medical Case Management
DHR	Denver HIV Resources
HIV	Human Immunodeficiency Virus
DHRPC	Denver HIV Resources Planning council

Units of Service

1 unit = 15 minutes or less

Service Components

STANDARD	MEASURE	DATA SOURCE
A. The program will initiate screenings within one week of initial contact with client. If the program has a waitlist, the program will appropriately manage	**A.1.** The program will schedule the eligibility screening and admissions process within one week of the initial contact or be placed on a waiting list and filtered into a caseload as soon as a space becomes available. If the client	**Program's Policies and Procedures** demonstrate their intake process, per the regulations, and how waiting lists are managed.

the waitlist to mitigate wait times for clients.	has urgent needs, services or referrals will be provided immediately.	
	A.2. If the program is ever faced with the need to create a waiting list, the program must provide documentation explaining the need for a wait list, and an accurate assessment of how long it takes to receive care once placed on the wait list.	**Program's policies and procedures** demonstrate how waiting lists and referrals are managed.
	A.3. The program will maintain referral relationships with other case management programs in the area and make referrals when appropriate to mitigate wait times for clients.	**Program's policies and procedures** details networking strategy, list of referral relationships, and documentation of referrals when they are made.
B. The program will conduct an intake interview and needs assessment following assignment to a medical case manager.	**B.1.** The program will schedule an intake appointment within two weeks of assignment to a medical case manager.	**Client's file** will demonstrate an intake interview was conducted within two weeks of assignment.
	B.2. A needs assessment will be completed within three appointments of the intake interview which will include, but is not limited to, an assessment of: • Client's functional and cognitive capacity; • Health; • Strengths; • Abilities; • Mental health; • Substance use; • Resources; and • Needs.	**Client's file** has initial assessment with all necessary information completed within the one-month period.
C. An Acuity Assessment shall be completed for each client to determine level of MCM.	**C.1.** Every client will be assessed for acuity at intake or within 30 days of initiating MCM services, utilizing the TGA MCM Acuity Assessment Tool, or other tool approved by DHR.	**Client's file** documents assessment was administered at intake or within 30 days of initiating MCM.
	C.2. Every client should be re-assessed for acuity, as life changes indicate, or	**Client's file** documents appropriate re-assessment.

	at a minimum based on the acuity level: • Intensive Level: every three to six months; • Moderate Level: every six months; and • Monitoring Level: annually.	
D. The program will assess client for adherence to their HIV medication at least annually utilizing an approved tool.	**D.1.** Every client should be assessed for adherence to their HIV medication at least annually, utilizing an approved tool.	**Client's file** will contain an annual assessment of adherence to their HIV medication.
	D.2. If an adherence barrier is identified during the adherence assessment, the case manager should provide adherence counseling and/or make a referral to a medical provider or pharmacist to ensure adherence counseling is provided to the client.	**Client's file** documents date and content of adherence discussion or referral.
E. Every client will have an Individual Service Plan which guides their care.	**E.1.** Development of an Individual Service Plan is based on the initial and ongoing acuity assessment and meets the client's needs and preferences. The plan will be completed within two weeks of the assessment.	**Client's file** contains Individual Service Plan which demonstrates connections to medical care.
	E.2. The Individual Service Plan will demonstrate that the client will get medical care at least once every six months, or as medically indicated. This includes addressing barriers to care and establishing plans for engagement.	**Client's file** contains Individual Service Plan that is completed within the required timeframe.
	E.3. The Individual Service Plan demonstrates that the client is linked to all appropriate services needed.	**Client's file** documents all referrals.
	E.4. The Individual Service Plan contains objectives for each goal, stating how the client will reach the goals. Objectives are measurable and achievable.	**Client's file** contains Individual Service Plan with measurable and updated objectives.
	E.5. Each client's needs are reassessed as life changes indicate, or at a minimum based on the MCM Level determined by the MCM Acuity Assessment:	**Client's file** documents that the Individual Service Plan is updated as required by MCM Level.

	• Intensive Level: every three to six months; • Moderate Level: every six months; and • Monitoring Level: annually. This reassessment is documented in updates to the Individual Service Plan.	
F. Progress notes will be completed after every contact with the client that relates to the client's care.	**F. 1.** Progress notes demonstrate that the Individual Service Plan is being implemented and followed or revised to meet the client's changing needs.	**Client's file** contains progress notes related to the Individual Service Plan.
G. The program will collaborate and coordinate with medical providers.	**G.1.** The case manager will coordinate and collaborate with the HIV medical care team based on the MCM level determined by the MCM Acuity Assessment at a minimum: • Intensive Level: coordination and collaboration required at least once annually, and can include case conferencing; • Moderate Level: coordination and collaboration recommended; • Monitoring Level: coordination and collaboration recommended on an "as needed basis." Coordination may take the form of shared service planning, acuity assessment, phone and secure email communication, and case conferences.	**Client's file** documents compliance.
H. Case closure shall be documented, and proper referrals made if applicable.	**H.1.** MCM case closure will be completed at the request of the client, the program, or at death; using pre-established guidelines and criteria. Clients should be referred to appropriate providers upon closure when appropriate. For more guidance on case closure, please refer to section VIII of the Universal Standards.	**Client's file** states the reason for closure and that proper referrals are made.
I. Caseload size will be determined by individual	**I.1.** The following guidance should be utilized in consultation with DHR.	**Program's policies and procedures** will

programs and based on acuity of clients.	• Intensive level: 40-60 clients; • Moderate Level: 60-100 clients; • Monitoring Level: 100-200 clients. Caseloads may have mixed levels of acuity and may not fall neatly in these categories. Caseload sizes shall be routinely assessed by supervisor.	document how caseloads are managed.

Medical Transportation Services

Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

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

Definitions and Descriptions

Rideshare: a service where a passenger pays for travel in a private vehicle driven by its owner for a fee, usually arranged by a website or app. Ex: Uber or Lyft.

Acronyms

DHR	Denver HIV Resources
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
RTD	Regional Transportation District-Denver
RW	Ryan White

Units of Service

1 unit = 1 bus trip (bus trip = one ticket)
1 unit = cab voucher (1 one-way voucher)
1 unit = 1 vehicle mileage reimbursement
1 unit = 1 one-way rideshare trip

Service Components

STANDARD	MEASURE	DATA SOURCE

A. Transportation allows clients to connect to HIV-related health and support services who do not have the means to access them on their own or need vehicle mileage reimbursement assistance.	**A. 1.** Transportation funds will be used in a manner that is most cost effective and appropriate for the client.	**Program's Policies and Procedures** demonstrate how transportation funds are delivered and how they ensure cost effectiveness.
	A. 2. Transportation services will be delivered to clients with transportation barriers to access HIV-related health and support services.	**Client's file** documents barriers and how transportation funds are used to access HIV-related health and support services.

	A. 3. Distribution of transportation service must document:
	• Client name or other identifier
	• Type of distribution:
	  ○ cab voucher;
	  ○ mileage reimbursement;
	  ○ bus ticket; or
	  ○ rideshare trip.
	• Units distributed
	• Date
	• Purpose
	• Type of distribution:
	  ○ Bus ticket
	  ○ Cab voucher: must include origin and destination
	  ○ Mileage reimbursement: must include 1) trip origin and destination, 2) Google Maps, Map Quest, etc. documentation of trip distance, 3) signed certification by destination HIV-related service provider confirming destination, and 4) amount of reimbursement provided
	  ○ Rideshare: must include 1) trip origin and destination, and 2) a receipt from
		Client's file documents the distribution of the transportation service.

	rideshare trip that is signed by service provider.	
B. The program will provide mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical and other support services.	**B. 1.** The program has a system for providing mileage reimbursement (through a non-cash system) that does not exceed the federal per-mile reimbursement rate for the current calendar year.	**Program's Policies and Procedures** document that vehicle mileage is reimbursed *after the trip* at the federal per-mile reimbursement rate.
C. The program utilizes RTD discount purchase programs when possible.	**C. 1.** Transportation services will be purchased at a discount rate from RTD when possible.	**Program's Policies and Procedures** show that transportation services are purchased at a discounted rate when possible.
D. Rideshare services can be provided by the program, or the client can be reimbursed through a non-cash system for using a personal rideshare account.	**D.1.** If the program uses its own account to provide transportation via rideshare, the rideshare program used must be HIPAA compliant, for example Uber Health and Lyft Business.	**Program's Policies and Procedures** detail which rideshare services the program partners with, and evidence of HIPAA compliance.
	D.2. If the program reimburses clients for rideshare trips where the client uses a personal account, then reimbursement can operate like mileage reimbursement (through a non-cash system) for use of a personal vehicle. However, reimbursement for a rideshare trip can only cover the established rate for federal programs and may not cover the full amount the client paid for the trip.	**Client's File** contains a receipt (email, screenshot, etc.) of the client's rideshare trip, and the amount reimbursed based on the federal mileage rate.

Mental Health Services

Mental health services are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. They are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

In some cases, a client may be seen for a brief intervention. A brief intervention, also known as a brief conversation, occurs in various settings, such as a primary healthcare setting and lasts a short duration with anticipation that each session could be the last session. In contrast, ongoing mental health services take place when there is the expectation that an individual will receive ongoing care and treatment. The standards that apply to both brief interventions and ongoing care are listed first under "All Mental Health Services Components," the standards that apply to only ongoing care are listed under "Ongoing Mental Health Services Components," and the standards that apply only to brief interventions are listed under "Brief Intervention Service Components."

Definitions and Descriptions

Measurable – Using methods including but not limited to the who, what, when, where, why, how, and how often method or the SMART method.

Acronyms

DHR	Denver HIV Resources
DORA	Department of Regulatory Agencies
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
MHS	Mental Health Services
OBH	Office of Behavioral Health, Colorado Dept. of Human Services
RW	Ryan White

Units of Service

1 unit = 30 minutes or less

All Mental Health Services Components

STANDARD	MEASURE	DATA SOURCE
A. Providers of mental health services must have the proper qualification and expertise to deliver services.	**A.1.** Mental health services can be provided by a: • Psychiatrist; • Licensed Psychologist; • Licensed Psychiatric Nurse Practitioner; • Licensed Marriage and Family Therapist; • Licensed Professional Counselor; • Licensed Clinical Social Worker;	**Personnel File** has proof of certification/ Licensure for the position.

	• Licensed Behavioral Health Specialist;	
	A.2. Mental health services can be provided by unlicensed registered clinicians or graduate level student interns with appropriate supervision per licensure or internship regulations and in compliance with Colorado Mental Health statutes found at https://sehd.ucdenver.edu/cpce-internships/files/2010/08/Statute.pdf.	**Personnel File** clearly designates a supervisor.
B. Providers of mental health services will utilize a mandatory disclosure form in compliance with Colorado mental health statutes.	**B.1.** Therapeutic disclosure will be reviewed and signed by all clients and must be compliant with Colorado Mental Health statutes: https://sehd.ucdenver.edu/cpce-internships/files/2010/08/Statute.pdf. At a minimum, the disclosure must include: • Therapist's name; • Degrees, credentials, certifications, and licenses; • Business address and business phone; • DORA description and contact information; • Treatment methods and techniques • Option for second opinion; • Option to terminate therapy at any time; • Statement that in a professional relationship, sexual intimacy is never appropriate and should be reported to DORA; and • Information about confidentiality and the legal limitations of confidentiality.	**Client's file** contains a copy of the therapeutic disclosure, signed and dated by both client and therapist.
C. Referrals made to services related to the service plan shall be made	**C.1.** Referrals to qualified practitioners and/or services will occur if clinically indicated. If the client is in immediate	**Client's File** will contain

and documented in a timely manner.	crisis, they will be seen immediately or proper referrals will be made.	documentation of referrals.
D. Progress notes shall be completed after every contact with the client.	**D.1.** Progress notes should: • Be a written chronological record; • Document any change in physical, behavioral, cognitive, and functional condition; • Document any action taken by staff to address the client's changing needs; and • Be signed and dated by the author at the time they are written, with at least a first initial, last name, degree and/or professional credentials.	**Client's File** contains copies of progress notes.

I. Ongoing Mental Health Service Components

STANDARD	MEASURE	DATA SOURCE
E. Treatment will be offered in a timely manner.	**E.1.** Treatment will be offered within 15 business days from the time of referral, if the client is not in crisis. If the client is in immediate crisis, they will be seen immediately or proper referrals will be made.	**Client's File** contains a dated referral, and evidence of the date of first treatment.
F. A biopsychosocial assessment will begin at the first session and be completed by the second session.	**F.1.** The biopsychosocial assessment will be completed within the first two sessions for all clients seeking ongoing treatment and will include, but is not limited to: • Presenting problem; • Medical and psychiatric history; • Family history; • Treatment history; • Cultural issues; • Spiritual issues when pertinent; • Brief psychosocial history; and • Diagnosed mental health illness or condition	**Client's File** contains a copy of the biopsychosocial assessment.
G. A mental status exam/assessment will be completed within the first three sessions.	**G.1.** The mental status exam/assessment will be completed within the first three sessions for all clients seeking ongoing treatment.	**Client's File** contains results from mental status exam/assessment.

H. Every client shall have a treatment plan which guides their care.	**H.1.** All treatment plans will: • Be based on the biopsychosocial assessment and mental status exam/assessment indicating the client's needs and preferences; • Contain goals which define what the client expects to achieve during treatment; • Contain measurable, reasonable, and achievable objectives for each goal, stating how the client will reach the goals; and • Be updated every six months.	**Client's File** contains copy of treatment plan.
	H.2. In addition to the requirements in F.1., for patients receiving non-psychiatric care, treatment plans will: • Be completed by the fourth session; and • Contain an estimated case closure date.	**Client's File** contains copy of treatment plan.
	H.3. In addition to the requirements in H.1., for patients receiving psychiatric care, treatment plans will: • Be completed by the third session; and • Include reason if prescribing a medication that has the potential to interact negatively with the client's HIV drugs, and a plan for monitoring of the client's health.	**Client's File** contains copy of treatment plan.
I. Upon termination of active mental health services, a client case is closed and contains a closure summary documenting the case disposition.	**I.1.** Closure summaries shall be completed within five business days after closure and documented in progress notes. Records shall contain a written closure summary to include, but not limited to the following information where applicable: • Reason for admission; • Reason for closure; • Primary and significant issues identified during course of services; • Diagnoses;	**Client's File** contains copy of closure summary, if patient's case has been closed.

	• Summary of services, progress made, and outstanding concerns; • Coordination of care with other service providers; • Advance directives developed or initiated during course of services; • Summary of medications prescribed during treatment, including the client's response(s) to the medications; • Documentation of referrals and recommendations for follow-up care; and • Information regarding the death of the client.	
J. The program will assess client adherence to mental health services, HIV medical appointments, and HIV medications.	**J.1.** The program will document appointment adherence and monitor clients for participation in mental health services.	**Client's File** contains documentation of scheduled appointments and attendance.
	J.2. The program will document appointment adherence to HIV medical appointments that are provided by the program and by other providers.	**Client's File** contains documentation of scheduled appointments and attendance.
	J.3. The program will document which HIV medications the client is taking and adherence to medication schedule.	**Client's File** contains documentation of HIV medications and adherence including reports from EMR.
K. The program must use evidence-based practices or care supported by empirical evidence.	**K.1.** The program uses evidence-based practices, including but not limited to: • Motivational Interviewing; • Harm Reduction; • Cognitive Behavioral Therapy; • Dialectical Behavior Therapy; • Trauma-Informed Treatment; and • Psychoeducation.	**Program's Policies and Procedures** documents which practices are implemented.

II. Brief Intervention Service Components

STANDARD	MEASURE	DATA SOURCE
L. A biopsychosocial assessment will be completed at the first session.	**L.1.** A brief biopsychosocial assessment given the depth of interaction with the client will include, but is not limited to: • Presenting problem; • Medical and psychiatric history; • Treatment history; and • Brief psychosocial history.	**Client's File** contains a copy of the biopsychosocial assessment.
M. A mental status exam/assessment will be completed at the first session.	**M.1.** The mental status exam/assessment will be completed at the first session for all clients seeking a brief intervention.	**Client's File** contains results from mental status exam/assessment.
N. Every client shall have a treatment plan which guides their care.	**N.1.** All treatment plans will: • Be based on the biopsychosocial assessment and mental status; exam/assessment indicating the client's needs and preferences; • Contain goals which define what the client expects to achieve during treatment; and • Contain measurable, reasonable, and achievable objectives for each goal, stating how the client will reach the goals.	**Client's File** contains copy of treatment plan. Treatment plan can be part of a session note or other EMR record.
	N.2. Include reason if prescribing a medication that has the potential to interact negatively with the client's HIV drugs, and a plan for monitoring of the client's health.	**Client's File** contains copy of treatment plan and prescribed medications.
O. The program will assess the client's adherence to HIV medications.	**O.1.** The program will document which HIV medications the client is taking and adherence to medication schedule.	**Client's File** contains documentation of HIV medications and adherence.
P. The program will refer to other services for ongoing care or psychiatric care as needed.	**P.1.** The program will document referrals to internal or external care and services.	**Client's File** contains documentation of referrals.
	P.2. The program will maintain referral relationships with other programs.	**Program's Files** contains documentation of referral relationships.

Oral Health Care

Oral health care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, licensed to provide health care in the State or jurisdiction, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

The goal of the Oral Health service category is to prevent and control oral and craniofacial disease, conditions, and injuries, and improve access to preventive services and dental care for eligible PLWH. Services shall be provided in a manner that has the greatest likelihood of ensuring maximum participation in the program involved.

Oral Health Care Services include emergency, diagnostic, preventive, basic restorative including removable partial and complete prosthetics, limited oral surgical and limited endodontic services.

Definitions and Descriptions

Phase 1 completion reflects that the patient has been moved to stable oral health. This is the minimal and expected level of care for all patients.
Phase 2 completion reflects restoration of complete function and esthetics for the patient that requires laboratory-based treatments.

Acronyms

ADAPP	American Dental Association Dental Practice Parameters
AIDS	Acquired Immunodeficiency Syndrome
DHR	Denver HIV Resources
DHRPC	Denver HIV Resources Planning Council
FPL	Federal Poverty Level
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
OHF	Oral Health Fund
RDA	Registered Dental Assistant
RDH	Registered Dental Hygienist

Units of Service

1 unit = 1 visitation of any duration

Service Components

STANDARD	MEASURE	DATA SOURCE

A. Providers of dental care services must have the proper qualifications and expertise to deliver services.	**A.1.** Dentists must be licensed to practice dentistry by the State of Colorado.	**Personnel file** contains copies of diplomas or other proof of degree or licensure. Any outcomes passed by the State Board will be in the Dentist's file.
	A.2. If a program utilizes the services of dental students, these students must be supervised according to their program guidelines and work under the license of a program's dentist.	**Program's policies and procedures** demonstrate how students are supervised to ensure high levels of quality.
B. Treatment will be offered in a timely and appropriate manner.	**B.1.** Program can demonstrate that waiting list procedure properly manages the wait time for new clients.	**Program's Policies and Procedures** demonstrate how the program handles waiting lists. **Client's File** shows that there are no unnecessary delays in getting services.
	B.2. Program determined emergencies will be addressed or referred to another provider within 24 hours.	**Client's File** demonstrates that emergencies are addressed in a timely manner and documents that the patient was seen by the referred provider and follow up was completed. **Program's Policies and Procedures** outline how emergencies are handled in a timely manner.
C. A comprehensive oral evaluation will be given to people with HIV presenting for dental services.	**C.1.** The evaluation will include: • Documentation of patient's presenting complaint; • Caries charting; • Radiographs or panoramic and bitewings and selected periapical films; • Complete periodontal exam or PSR (periodontal screening record);	**Client's File** will have a signed and dated oral evaluation on file in patient chart.

	• Comprehensive head and neck exam; • Complete intra-oral exam, including evaluation for HIV associated lesions; • Pain assessment; • Dental and Medical History; • Psychological and behavioral health histories; • Dental Treatment Plan; and • Oral Health Education.	
	C.2. An assessment of general dental and medical needs and histories are conducted and if the client is not in primary care, the program will help the client access care. This should be updated at least annually.	**Client's File** contains a medical needs evaluation and a referral to primary care if necessary.
	C.3. Provider clinical decisions are supported by the American Dental Association Dental Practice Parameters.	**Program's Policies and Procedures** reference the American Dental Association Dental Practice Parameters.
D. A comprehensive treatment plan is developed based upon the initial examination of the client.	**D.1.** Completed treatment plan in client file at the subrecipient location, submitted by dentist.	**Client's File** contains a treatment plan.
	D.2. For non-emergent care, the treatment plan should be completed after the evaluation and before the first treatment.	**Client's File** contains treatment plan that is completed and documents the medical necessity of restorative care.
E. Treatment plan is reviewed and updated as deemed necessary by the dental provider.	**E.1.** Updated treatment plan in client file at the subrecipient location, submitted by dentist, and revised and approved by dental program director.	**Client's File** contains an updated treatment plan.
F. Progress notes shall be completed after every contact with the client.	**F.1.** Progress notes demonstrate that the phase 1 treatment plan is being implemented, followed, and completed within 12 months of establishing a treatment plan, excluding external factors outside	**Client's File** contains progress notes related to treatment plan.

	of the dental provider's control (e.g. client missing appointments).	
	F.2. Progress notes demonstrate that the client received oral health education at least once in the measurement year.	**Client's File** contains progress notes showing client received oral health education.
G. Providers will follow ethical and legal requirements.	**G.1.** Providers will act in accordance to Colorado State law and the American Dental Association's Principles of Ethics and Code of Professional Conduct, and respective agencies code of ethics.	**Client's File** demonstrates the provider is acting ethically and in the best interest of the client.
H. Closure shall be documented and proper referrals made if applicable.	**H.1.** Closure from dental care services will be completed at the request of the client, the dental care provider, or at death; using pre-established program guidelines and criteria. Clients should be referred to appropriate provider on closure, if appropriate. (See Universal Standards)	**Client's File** states reason for closure and that proper referrals are made.
	H.2. Any treatment performed shall be with concurrence of the patient and the dentist. If the patient's requested treatment is outside of the scope of the dentist's practice, then the patient needs to be communicated of this limitation and the dentist should attempt to make a referral.	**Client's File** shows proper treatment is given based on the dentist's professional opinion.
I. Programs shall strive to retain patients in oral health treatment services.	**I.1.** Programs shall develop a missed appointment policy to ensure continuity of service and retention of clients.	**Program's Policies and Procedures** contain a written policy for missed appointments.
	I.2. Programs shall provide regular follow-up procedures to encourage and help maintain a client in oral health treatment services.	**Client's File** contains documentation of attempts to contact in signed, dated progress notes. Follow-up may include:

		• Telephone calls; • Written correspondence; or • Direct contact.

I. Oral Health Fund

The Oral Health Fund is a percentage of the Oral Health Care service category allocations annually decided upon by the Denver HIV Resources Planning Council in alignment with regulations from the Health Resources and Services Administration (HRSA).

Units of Service

1 Unit = Any assistance request (including denied requests)

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Program will assess client eligibility for dental assistance.	**A.1.** Client eligibility is based on income level, residence in the Denver TGA, and HIV status. Clients between 0 - 400 percent of Federal Poverty Level (FPL) are eligible for dental assistance not to exceed $5,000 for the current fiscal year.	**Client's file** contains documentation that shows client eligibility for dental assistance.
	A.2. Clients with dental assistance needs that exceed $5,000 may submit an oral health financial assistance waiver requesting additional funds. The requestor, working with the client, will submit the waiver to DHR for approval.	**Client's file** contains the submitted oral health waiver with DHR staff signature, if approved.
B. Dental assistance payments can be made for client out-of-pocket costs for oral health care services.	**B.1.** Dental assistance payments can be made for client out-of-pocket costs for emergency, diagnostic, preventive, basic restorative oral health care services including, but not limited to removable partial and complete prosthetics, limited oral	**Program's Policies and Procedures** documents dental services paid for by Ryan White Part A funds.

	surgical and limited endodontic services.	
	B.2. Oral health funds cannot be used for direct cash payments to clients.	**Program's Policies and Procedures** demonstrates that direct cash payments are not made to clients.
C. Program will assist the client with accessing and receiving dental assistance, including scheduling and coordinating dental appointments.	**C.1.** The client and program will meet in a way that allows client participation (i.e. in person, virtually, by email, or by phone) to process the dental assistance request.	**Client's file** contains documentation of client participation in the process.
	C.2. The program will schedule and coordinate all initial dental appointments and educate the client about scheduling any follow up appointments.	**Client's file** includes documentation of scheduled appointments.
E. Single payer will respond to check requests in a timely manner and maintain payment records.	**E.1.** Checks for dental assistance will be issued by the contracted single payer program.	**Single payer records** contain check information.
	E. 2. Checks will be sent to the vendor address listed on the invoice or delivered directly to the vendor on the day of service. Checks cannot be payable or issued to clients.	**Single payer records** demonstrate that checks are issued directly to the vendor.
	E. 3. The single payer will maintain electronic records of checks related to dental assistance requests.	**Single payer records** contain check information.
	E. 4. Approved check request will be completed within three business days of the request date.	**Single payer records** demonstrate that check requests were completed in a timely manner.
E. Upon approval of a dental assistance request, the single payer will hold the requested dollar amount for 90 days.	**E.1.** The single payer will maintain records of each dental assistance request approval, the 90-day holding period of the requested dollar amount, and the request expiration date.	**Single payer records** contain documentation of pertinent dental assistance request information.
	E.2. The single payer will inform the requestor of the approval and availability of the requested dollar amount for 90 days, with	**Single payer records** contain a process for communicating with the requestor.

	the date of expiration explicitly stated.	
	E.3. Requests approved on or after November 30th will expire on the last day of the fiscal year.	**Single payer records** contain documentation of dental assistance request expiration dates.
F. In alignment with the payer of last resort legislative requirement, the program will make reasonable effort to secure other funding sources prior to requesting dental assistance from the Ryan White Part A Program.	**F. 1.** The requestor will explore payment options through the client's insurance and other funding sources prior to submitting a Ryan White Part A dental assistance request.	**Client's file** will demonstrate that other funding sources were explored.

Outpatient Ambulatory/Health Services

Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Settings include clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits. Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category. Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

Allowable activities include diagnostic testing (including HIV confirmatory and viral load testing), early intervention and risk assessment, preventive care and screening, physical examination, medical history taking, treatment and management of physical and behavioral health conditions, behavioral risk assessment, subsequent counseling, and referral, preventive care and screening, pediatric developmental assessment, prescription and management of medication therapy, treatment adherence, education and counseling on health and prevention issues, and referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology. Primary medical care for the treatment of HIV includes the provision of care that is consistent with the U.S. Department of Health and Human Services guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
DHR	Denver HIV Resources
HIV	Human Immunodeficiency Virus
PLWH	Person(s) Living With HIV

USDHHS	United States Department of Health and Human Services

Units of Service

1 unit = 1 service

Service Components

STANDARD	MEASURE	DATA SOURCE
A. The program will ensure that clients have timely access to medical care.	**A.1.** The program has policies and procedures in place that address identifying new and established patients as having emergent, urgent, and acute needs.	**Program's Policies and Procedures** indicate how emergent, urgent, and acute needs are identified.
	A.2. The program has policies and procedures that facilitate timely, appropriate care determined by the level of need of the client.	**Program's Policies and Procedures** indicate how emergent, urgent, and acute needs are managed.
	A.3. The program will have availability to see new clients diagnosed with HIV within 30 days of referral or first contact.	**Program's Policies and Procedures** detail how new clients are accepted, processed, and scheduled.
B. Clients will have access to information about how to obtain care and health information.	**B.1.** The program should, at a minimum, inform the client about: • How to access emergency services; • How to schedule appointments; and • How to obtain laboratory or other diagnostic screening results.	**Program's Policies and Procedures** demonstrate how they educate patients on access to care and health information.
	B.2. The program will provide health literacy assistance, when necessary.	**Program's Policies and Procedures** demonstrate how they assess and address health literacy.
C. If a client is in need of inpatient care, the program must be able to refer or provide the client with inpatient care.	**C.1.** Outpatient programs that do not provide inpatient care will maintain referral relationships with other programs that provide inpatient care to PLWH.	**Program's Policies and Procedures** demonstrate the process by which clients are referred to inpatient care.

D. At baseline and through ongoing clinical evaluation and monitoring, the program will obtain a comprehensive HIV-related history, perform a comprehensive physical examination, and conduct relevant laboratory tests according to the USDHHS guidelines.	**D.1**. The program will obtain a comprehensive HIV-related history, perform a comprehensive physical exam, and conduct relevant laboratory tests according to USDHHS guidelines: https://aidsinfo.nih.gov/guidelines	**Client's File** contains a comprehensive HIV-related history, evidence of physical exams, and relevant laboratory results.
	D.2. The program will schedule regular client visits based on provider recommendation and according to the USDHHS guidelines: https://aidsinfo.nih.gov/guidelines	**Client's File** contains documentation of client visits and provider recommendation for frequency of client follow-up visits.
E. The program will assist the client with management of medication therapy and treatment adherence.	**E.1.** The program will have access to medication therapy and medication financial assistance programs, and prescribe medication based on the USDHHS guidelines: https://aidsinfo.nih.gov/guidelines	**Program's Policies and Procedures** outline access to medication therapy and medication financial assistance programs.
	E.2. The program will develop, implement, and monitor strategies to support treatment adherence and retention in care.	**Program's Policies and Procedures** outline strategies to support treatment adherence and retention in care.
F. If the client needs specialty care, the program must be able to refer them to a specialty care provider.	**F.1.** The program establishes and maintains relationships with specialty care providers. Specialty care providers can include clinical sub-specialties (i.e. cardiology, neurology, gynecology, etc.) and other services relevant to PLWH including substance use treatment, oral health, and case management.	**Program's Policies and Procedures** contain documentation of the process for making referrals to specialty care providers. **Client's File** indicates care coordination with or referral to specialty care provider.
G. The program will systematically assess retention of clients.	**G.1.** The program will use monitoring and outreach strategies for clients who have not received recommended care.	**Program's Policies and Procedures** outline strategies to outreach clients.

		Client's File indicates that the program used outreach strategies to attempt to reengage client in care.
	G.2. The program will outreach clients who have missed visits or who have not been seen for a medical follow-up according to the provider's recommendation.	**Program's Policies and Procedures** contains follow-up procedures that encourage client retention in medical treatment.

Psychosocial Support Services

Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities funded under Psychosocial Support Services may include:

- Bereavement counseling;
- Child abuse and neglect counseling;
- HIV support groups;
- Nutrition counseling provided by a non-registered dietitian;
- Pastoral care/counseling services; and
- Support services may be provided by the program to increase participation in one-on-one or group sessions including food, transportation, or child care.

Funds under Psychosocial Support Services may not be used to provide nutritional supplements and social/recreational activities or to pay for a client's gym membership.

Definitions and Descriptions

Facilitator: A facilitator may be either a staff member or a group member, provided the group member has sufficient training and support.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ASL	American Sign Language
CDI	Certified Deaf Interpreter
HIV	Human Immunodeficiency Virus
LEP	Limited English Proficiency
RID	Registry of Interpreters for the Deaf
DHR	Denver HIV Resources

Units of Service

1 unit = 30 minutes or less

Service Components

STANDARD	MEASURE	DATA SOURCE
A. The program offers services to reduce the client's sense of social isolation, through either one-on-one sessions and/or group sessions.	**A.1.** The services offered will help the client to: • Develop and enhance social and communication skills; • Improve sense of self-efficacy; • Improve self-advocacy skills; • Improve coping skills; and • Reduce feelings of social isolation and stigma.	**Client's File** contains documentation of the encounter, topics discussed, and strategies used to reduce the client's sense of social isolation.
B. Psychosocial support group sessions will have established ground rules to guide behavior, discussion, and ensure a safe environment.	**B.1.** Facilitator(s) and session participants will develop and use ground rules, which at a minimum cover: • Confidentiality; • Safety; • Interpersonal relations; • Preferred communication styles; • Grievance procedures; • Description of session topic and purpose; and • Mandatory reporting, if applicable.	**Program's File** contain a copy of the ground rules with the sessions' records.
	B.2. Ground rules are in written form and verbally discussed at each session.	
C. Psychosocial support sessions may be open to PLWH regardless of whether they are current service recipients at the program providing the service.	**C.1.** Programs may permit attendance for PLWH not receiving Ryan White Part A services and affected individuals in need of social support. If an attendee does not currently receive other Ryan White Part A services, the program will determine attendee eligibility for Ryan White Part A services.	**Program's Policies and Procedures** demonstrate a process for determining client eligibility for attendees and how service utilization will be documented.

D. Psychosocial support services must be open to all eligible clients regardless of religious affiliation.	**D.1**. If the program provides pastoral counseling, it must be available to all eligible clients regardless of religious denominational affiliation.	**Program's Policies and Procedures** indicates that services are open to all eligible clients regardless of religious affiliation.
E. The program will refer clients to behavioral health services, medical case management, and/or other core and support services, as appropriate.	**E.1.** The program will have a process for referring clients to programs that provide behavioral health services, medical case management, and/or other core and support services.	**Program's Policies and Procedures** documents process of referring clients to the appropriate services.
F. The structure, content and logistics of psychosocial support groups will be based on the clients' needs and interests identified through formative evaluation or group discussion.	**F.1.** To ensure groups are responsive to the needs of clients, the facilitator(s) and/or program should conduct formative evaluations or group discussions which consider the following: • Location; • Length of meeting; • Time of day; • Meeting frequency; • Minimum and maximum number of participants; • Topics of conversation; • Meeting content; • Meeting structure; • Ground rules; • Need for supplemental media or other resources to enhance content; • Need for transportation, food or child care; • If applicable, how to recruit new members; • If applicable, when and how to end the group, if no longer needed; and • Whether affected individuals and/or partners are permitted to attend the group sessions.	**Program's Files** contain formative evaluation findings or minutes of discussion on the group's structure, content, and logistics. These files must be made available to clients.

G. Programs may create up-to-date, medically accurate print or electronic media that supplement the services provided.	**G.1.** Medical information included in print or electronic media created by the program will be reviewed by a medical professional for accuracy.	**Program's Files** will contain electronic or hard copies of the media created that are signed and dated by the medical professional who reviewed them, and details about distribution including quantity and dates.
H. Facilitators will receive ongoing orientation, training, supervision and clinical supervision as applicable.	**H.1.** Facilitators will be given orientation prior to providing services.	**Program's Files** document orientation curriculum and evidence that the facilitators received training, for example a signed and dated sign-in sheet from an orientation session.
	H.2. All facilitators will be supervised by qualified program staff.	**Program's Policies and Procedures** documents how facilitators are supervised.
	H.3. The facilitator's supervisor routinely evaluates psychosocial services.	**Program's Files** contain signed and dated form that outlines responsibilities, obligations, and liabilities of each facilitator.
	H.4. Facilitators will receive training so they can help participants improve their communication skills, sense of self efficacy, self-advocacy, coping skills, and reduce feelings of social isolation and stigma. Trainings to be considered include: HIV 101; legal and ethical issues, including discrimination; facilitator self-care; referrals; stigma; boundaries; crisis management; safety;	**Program's Files** contain evidence of the facilitator's training, for example a training certificate.

	use of self; conflict management; coping skills; facilitation and group process; and communication skills.	
I. It is recommended that sessions be facilitated by trained peer and trained professional. It is encouraged that facilitators be reimbursed for their time and at least one facilitator be living with HIV.	**I.1.** The facilitator(s) are culturally aware and have training or experience in group process, facilitation and communication skills.	**Personnel File** demonstrates facilitators' experience and/or training.

Substance Abuse Outpatient Care

Substance use services (outpatient) are medical or other treatment and/or counseling to address substance use problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel. They include limited support of auricular detox services to HIV-positive clients provided by registered, certified, or licensed practitioners and/or programs.

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

- Pre-treatment/recovery readiness programs, such as, the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program;
- Harm reduction;
- Mental health counseling to reduce depression, anxiety and other disorders associated with substance use;
- Outpatient drug-free treatment and counseling;
- Medication Assisted Therapy (e.g., suboxone, buprenorphine, naloxone, methadone, naltrexone);
- Neuro-psychiatric pharmaceuticals;
- Relapse prevention; and
- Other evidence-based methods with evidence provided.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ASAM	American Society of Addiction Medicine
DHR	Denver HIV Resources
HIV	Human Immunodeficiency Virus

OBH	Office of Behavioral Health, Colorado Department of Human Services

Units of Service

1 unit = individual or group session of 30 minutes or less

1 unit = methadone or other chemical treatment dispensing visit

1 unit = medical visit of 30 minutes or less

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Providers of substance use services must have the proper qualifications and expertise to deliver service.	**A.1.** In order to practice as a substance use counselor, one must qualify to perform the service under current Colorado mental health statutes, found here: https://sehd.ucdenver.edu/cpce-internships/files/2010/08/Statute.pdf Psychiatric services must be provided by a psychiatrist or a licensed psychiatric nurse practitioner, psychiatric physician's assistant, or addiction medicine providers.	**Personnel File** details staff qualifications.
	A.2. Standards of supervision will be in compliance with current Colorado mental health statutes, found here: https://sehd.ucdenver.edu/cpce-internships/files/2010/08/Statute.pdf	**Program's Policies and Procedures** indicate standards of supervision.
B. The program will utilize a mandatory disclosure form in compliance with Colorado mental health statutes.	**B.1.** Therapeutic disclosure will be reviewed and signed by all clients. At a minimum, the disclosure must include: • Therapist's name, degrees, credentials, certifications, and licenses; • Business address and business phone; • OBH description and contact information; • Treatment methods and techniques;	**Client's File** contains a copy of the disclosure.

	• Options for second opinion; • Option to terminate therapy at any time; • Statement that in a professional relationship, sexual intimacy is never appropriate and should be reported to OBH; • Information about confidentiality and the legal limitations of confidentiality; and • Space for the client and therapist's signature and date.	
C. Treatment will be offered in a timely manner.	**C.1.** If the client is not in crisis, a scheduled treatment appointment will be offered within 5 business days from the time of first contact or referral. If the client is in crisis, they will be seen immediately or proper referrals will be made. During the waiting period, other harm reduction support services will be provided.	**Client's File** documents date of first contact or referral, and whether or not the client is in crisis.
D. A comprehensive evidence-based or best practices assessment shall be completed in a timely manner for each client.	**D.1.** The assessment will be completed upon admission and no later than seven business days after enrollment into services.	**Client's File** contains a comprehensive assessment.
	D.2. The assessment is completed in compliance with OBH regulations and ASAM criteria. https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=8387&fileName=2%20CCR%20502-1 https://www.asam.org/resources/the-asam-criteria/about	**Client's File** contains a comprehensive assessment.
E. An initial service plan shall be developed with the client based on the comprehensive assessment.	**E.1.** The initial service plan will: • Identify the type, frequency, and duration of services for the client; • Address the immediate needs of the client; • Document referrals; • Be developed no later than 15 business days after the assessment, and signed by both the therapist and the client; and	**Client's File** contains an initial service plan.

	• Include specific, measurable, and attainable goals and objectives, with a realistic expected date(s) of achievement.	
	E.2. The service plan will demonstrate that the client will get HIV medical care as medically indicated.	**Client's File** contains service plan demonstrating client's connection to HIV medical care.
	E.3. If the initial or any subsequent service plan includes prescribing a medication that has the potential to interact with the client's HIV drugs, the reason for this decision is documented and a plan for monitoring the client's health is included in the service plan, if clinically indicated.	**Client's File** documents which, if any medications are prescribed and potential interactions with HIV drugs.
F. All service plans will be reviewed and updated on a regular basis.	**F.1.** Service plan revisions shall be completed and documented when there is a change in the client's level of functioning or service needs and no later than: • Medication assisted treatment: every 3 months; and • Outpatient: every 6 months.	**Client's File** documents revisions of the service plan.
	F.2. The service plan review shall include documentation of progress made in relation to planned treatment outcomes and any changes in the client's treatment focus.	**Client's File** documents revisions of the service plan.
G. The program must use evidence-based practices or care supported by empirical evidence.	**G.1.** The program uses evidence-based practices, including but not limited to: • Motivational Interviewing; • Cognitive Behavioral Therapy; • Harm Reduction; • Relapse Prevention; • Trauma-Informed Treatment; and • Psychoeducation.	**Program's Policies and Procedures** documents which practices are implemented.
H. Referrals made to services related to the service plan shall be made in a timely manner and documented.	**H.1.** Referrals to qualified practitioners and/or services will occur, if clinically indicated. If the client is in immediate crisis, they will be seen immediately, or proper referrals will be made.	**Client's File** contains documentation of any referrals.

I. Progress notes shall be completed after every contact with the client.	**I.1.** Progress notes should be a written chronological record, documented after every contact with the client.	**Client's File** contains progress notes.
	I.2. Progress notes should document: • Any change in physical, behavioral, cognitive, and functional condition; • Action taken by program staff to address the clients changing needs; and • An assessment of the client's adherence to substance use treatments.	
	I.3. Progress notes shall be signed and dated by the author at the time they are written, with at least a first initial, last name, degree and/or professional credentials.	
J. The program, at least once yearly, will assess client adherence to SAO medications, SAO appointments, HIV medical appointments and HIV medications.	**J.1.** The program will document adherence to SAO and HIV medical appointments that are provided by the program and by other providers.	**Client's File** contains documentation of scheduled appointments and attendance.
	J.2. The program will document which SAO and HIV medications they prescribe to the client, adherence to the medication schedule, and whether the client's substance use impacts medication adherence.	**Client's File** contains documentation of HIV medications and adherence.
K. Upon termination of active substance use services, a client case is closed and contains a closure summary documenting the case disposition.	**K.1.** Closure summaries shall be completed within thirty business days after closure and documented in progress notes. Records shall contain a written closure summary to include, but not limited to the following information where applicable: • Reason for admission; • Reason for closure; • Primary and significant issues identified during course of services; • Diagnoses; • Summary of services, progress made, and outstanding concerns;	**Client's File** contains copy of closure summary, if patient's case has been closed.

	• Coordination of care with other service providers; • Advance directives developed or initiated during course of services; • Summary of medications prescribed during treatment, including the client's response(s) to the medications; • Documentation of referrals and recommendations for follow-up care; and • Information regarding the death of the client.	

CARES Act Supplemental Funding Allowable Costs

On Wednesday, April 15, 2020, HHS through HRSA awarded $90 million for Ryan White HIV/AIDS Program (RWHAP) recipients to prevent, prepare for, and respond to coronavirus disease 2019 (COVID-19). This funding is provided by the fiscal year 2020 Coronavirus Aid, Relief and Economic Security (CARES) Act, which President Trump signed into law on Friday, March 27, 2020.

This funding supports 581 Ryan White HIV/AIDS Program recipients across the country, including city/county health departments, health clinics, community-based organizations, state health departments, and AIDS Education and Training Centers, in their efforts to prevent or minimize the impact of this pandemic on people with HIV.

The Denver TGA Ryan White Part A program was awarded $540,961 in additional funding, and the allocation for this funding was approved by the Denver HIV Resources Planning Council on Thursday, May 7, 2020 with the following allocation:

Service Category	Percent Allocation	Dollar Amount Allocation
Emergency Financial Assistance	25%	$127,466
Housing Services	25%	$127,466
Outpatient Ambulatory Health Services	35%	$178,749
Food Assistance	7%	$35,690
Behavioral Health	8%	$40,494
Total Service Allocation	100%	$509,865
DHR Admin	6%	$31,096
Total Award	100%	$540,961

FY2020 CARES Act Supplemental Funding Allowable Costs:

Please follow these links for more information about CARES Act supplemental funding allowable costs:

FY2020 CARES Act Funding for Ryan White HIV/AIDS Program Recipients
Examples of Allowable Uses of Funds – Prevent, Prepare, Respond
Examples of CARES Act Supplemental Funding Uses by Service Category
CARES Act Funding Frequently Asked Questions (FAQ)